How do you move a children's hospital? With plenty of practice.

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At sunrise on a recent morning, several dozen people gathered in an unused unit at Women & Children's Hospital and surveyed the beds, monitors and equipment in five rooms.

Cassandra Church, who is overseeing the move in November to the new John R. Oishei Children’s Hospital on the Buffalo Niagara Medical Campus, checked that someone from every department that needed to be there was there.

Security, plant operations, infection control, environmental services, performance improvement, clinical engineering – all good to go. Three health consultants watched from the side. Truck drivers and elevator operators stood ready.

"We do not wait for anything," said Church. "The goal is to keep moving."

This was the first major practice run in preparation for the real thing later this year, a chance to learn what works and what doesn't. An intern clicked a stopwatch, and they set to work over the next hour and 17 minutes cleaning, bar code scanning, packing, loading and driving the equipment to the new hospital, where everything was scanned again, re-cleaned and placed in unfinished rooms.

Moving a hospital is not like stuffing items in cardboard boxes with handwritten labels. In this case, it will be a hugely complex, $8 million one-day operation planned with military precision to ensure hundreds of patients and staff, and the thousands of pieces of equipment that they depend on travel a little more than a mile away as smoothly and safely as possible.

"You try to anticipate as much as you can," said Church about a plan that must consider the smallest details – potholes along the route, for instance – as well as potential disasters like a mass casualty incident.

'Ready for anything'

Here's the reality Church has learned from having done this before: Things happen.

When she worked a similar move in 2016 at Inova Fairfax Children’s Hospital in Falls Church, Va., bells and whistles clanged all over the new building because monitor volumes had been accidentally turned up. Some of the electrical outlets didn't work.

"You can't over-promise. The idea is to be ready for anything," said Church, who was hired earlier this year as clinical project manager and director of the neonatal intensive care unit.

The mock move offers a snapshot of tens of thousands of hours spent planning and training that has involved all of the 1,400 staff members at Women and Children's, and that will touch the lives of its patients – newborns, children and women – as well as their families. More exercises like this one, including a drill with pretend patients, will take place.
The old hospital was the first pediatric facility in New York State, starting in 1892 in a renovated home on Bryant Street. Today, 125 years later, the new $270 million hospital on Ellicott Street incorporates floor plans and features that reflect advances in health care building design. Among the changes is a neonatal intensive care unit with private rooms instead of an open-floor plan, widespread adoption of couplet care, in which mothers and newborns remain together for the entire hospital stay, and a completely revised layout for same-day surgery.

In addition to getting ready for the move, doctors, nurses and other staff must be prepared to work in the new spaces the moment the patients and their equipment arrive.

"Training to work in a different set of walls is a big deal, and that’s something we are trying to get out of the way before we move," said Church.

It’s a tremendous effort that includes sessions to simulate scenarios and practices in mocked up spaces of the new rooms. Move-day alone will require significantly more personnel than normal – about 150 percent staffing – to provide medical attention at both locations simultaneously as the relocation unfolds in stages and on the clock.

"We need to be far enough out from the date to practice and produce the best move and do it on time," said Lisa Schmidt, chief operating officer at Buffalo General Medical Center, which connects to the new hospital by a pedestrian skybridge.

**Lessons from Millard Fillmore**

One of the first things Church and others involved in planning the move tell employees is that Women and Children's transports patients every day. It's not a foreign concept.

In 2016, for instance, the Neonatal Transport Team provided emergency ground or air transport to 281 critically ill or premature newborns in need of immediate care in the hospital's neonatal intensive care unit. About one-third of the NICU's admissions come via transported newborns from outlying hospitals. The Pediatric Transport Team brought 621 children by ambulance or helicopter to the hospital from a host of locations, including urgent care centers and physician offices throughout and beyond Western New York.

Kaleida Health also learned lessons from the move in 2012 of Millard Fillmore Hospital at Gates Circle into the Gates Vascular Institute on the Medical Campus.

"We've got some experience in this," said Jessica Mabie, director of strategic planning and implementation at Women & Children’s.

The plan calls for moving in uninterrupted, timed stages from sunrise to sunset, using 15 ambulances to make round trips on a designated route. At least two trucks will haul equipment, some of which, such as newborn isolettes, will be reused. Emergency departments, labor and delivery services, and operating rooms will remain open in both buildings until the last patient relocates.

The hospital anticipates 120 to 150 patients on the day of the move, excluding those in the emergency room. The pediatric intensive care unit, which handles as many as 20 patients, will go first. Because
Women & Children's operates the regional pediatric trauma center, it's imperative the new pediatric intensive care unit be up and running as soon as possible.

It will be followed by patients in labor and delivery and the neonatal intensive care unit, which has a maximum of 64 babies at any time. Those services need to go together because, day to day, they work together. After those, the hospital will move mothers waiting to give birth and those, with their babies, who recently delivered. The children in the pediatrics department go next and, finally, children or teens with blood diseases and cancer.

Every patient will get a wristband with a bar code that is scanned at both sites, where command centers will operate to monitor the action. Officials will rely on detailed manifests to track every patient and piece of equipment, and every leader at Kaleida Health will support a leader at Women & Children's with some aspect of the move.

The least-acute patients can travel with paramedics and, if needed, a nurse. Mothers in labor will ride with a nurse and, potentially, a doctor. It's only a small number of ill babies who will require the most attention – those on high-frequency ventilation or ECMO, a treatment that uses a pump to circulate blood through an artificial lung back into the bloodstream. These therapies depend on devices and attached tubes potentially disturbed by a bump in the road, so the patients will travel with an entourage that includes two nurses, a respiratory therapist and a physician.

The equipment move must occur separately from the patient move, with teams breaking down rooms in stages and moving them ahead of the patients.

"The whole thing is going to be like a well-orchestrated ballet," said Mabie.

**Timing is everything**

The drill reflected a microscopic attention to detail.

Workers from environmental services cleaned the equipment with disposable wipes. Plant operations dismantled the rooms, everything from electrical cables to monitors to beds, while a clinical engineering team assisted by tradesmen packed up items in plastic bags and placed them in large plastic bins. Note-keepers with clipboards followed along writing comments.

George Armele, the plant manager, for example, noticed workers needed a different cleaner, something less aggressive, for the monitors. He and others also expressed concern over the "dead time" as workers waited for an elevator. There are a limited number of elevators devoted to moving equipment, and they can't cause bottlenecks by making unnecessary stops.

"We need to eliminate as much dead time as possible," Armele said.

It took 33 minutes to pack up the rooms, and that's important to know, said Peter Murphy, director of facilities.

"We'll do this again and see how we improve. But, by learning how many minutes it took now, we can extrapolate a worst-case scenario for timing the move," Murphy said.
When the exercise ended on the 11th floor of the new building, Church did a debriefing – what went right, what didn't.

A Pepsi truck blocked a ramp, for instance. They needed carts for storing oxygen tanks. Someone suggested it might be faster to use wipes with a bucket of cleaning solution instead of individual wipes. Stickers with numbers performed well as backup to bar code scans. There was a sense of teamwork.

The drill highlighted the stark differences between the sites. The spaces in Oishei, although still not completed, look sleek and spacious. Big windows in patient rooms offer stunning views of the city.

Armele and Murphy are longtime veterans of the old hospital. They both had children who were born there and feel nostalgic at the thought of the building's closure. Still, they're looking forward to the move.

"We've been here a long, long time, but it's exciting," said Murphy. "The new building is really something – modern and nice."

http://buffalonews.com/2017/05/24/childrens-hospital-practices-move-downtown/