Arkansas Hospital
Pandemic Template

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Arkansas Hospital Pandemic Template

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Executive Summary

The overall goal of this template is to provide a standardized plan that would be consistent across the state and that would be effective toward avian flu or any novel strain of influenza or other comparable communicable disease. The following template was designed by healthcare personnel across the state, data and information from governmental agencies and plans from across the nation.

The plan is consistent with federal and state guidelines and utilizes the Hospital Incident Command System. Blanks in the template should be filled in by each hospital depending on their organizational chart, contact information, and other data or specific operating guidelines. Standard operating procedures within the hospital can be added.

The plan is organized into Interpandemic and Pandemic Alert Periods as defined by HHS as outlined below:

Interpandemic and Pandemic Alert Periods (Phase 1, 2, 3, 4, and 5)

The Phases within these periods include:

Phase 1 - No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.

Phase 2 - No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.

Phase 3 - Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.

Phase 4 - Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.

Phase 5 - Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).

Pandemic Period

Phase 6 - Pandemic: increased and sustained transmission in general population.

In addition, phases are noted as either inside or outside of the United States.
1) Pandemic Planning and Hospital Infection Control

- Set up and begin meeting of planning committee. (See Appendix 1 for example of preparedness committee makeup and HHS Checklist)
- Coordinate efforts of the hospital planning committee with the local community pandemic planning committee if one is in place.
- Utilize hospital infection control plan. (Insert or refer to individual hospital plan.)

Develop and educate employees and medical staff regarding infection control plan for pandemic influenza. (See Appendix 2.)
2) Surveillance Plan

Interpandemic and Pandemic Alert Periods (Phase 1, 2, 3, 4 and 5)

- Global surveillance – monitor news and governmental reports
- Syndromic – daily monitoring of ED visits and admissions and employee absences
- Reporting requirements – report/collaborate trends to ______________ (i.e., ED, Infection Control, Infectious Disease, hospital administration, County Public Health, and Arkansas Department of Health). To report communicable diseases, follow the Department of Health’s policy. Call (501) 661-2893 (8 a.m. – 4:30 p.m., Monday through Friday. Call (800) 554-5738 after hours and on weekends. To report non-emergency diseases, call (800) 482-8888 or fax a disease report to (501) 661-2428.
- Clinical laboratory operations – continue standard laboratory operations and screening for seasonal influenza

Pandemic Periods (Phase 6)

- Outside the United States
  - Prepare to active institutional pandemic influenza plan
  - Heighten hospital surveillance for pandemic influenza in incoming and already admitted patients
  - Testing for avian flu or any novel strain of influenza is indicated for hospitalized patients with:
    - Radiographically confirmed pneumonia, Acute Respiratory Distress Syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, AND
    - History of travel within 10 days of symptom onset to a country with documented novel strain of influenza in poultry and/or humans
  - Testing for avian flu or any novel strain of influenza should be considered on a case-by-case basis in consultation with county or district public health office or the Arkansas Department of Health (501) 661-2136 or (800) 554-5738 for hospitalized or ambulatory patients with:
    - Documented temperature of >100.4°F with one or more of the following: cough, sore throat, shortness of breath, AND
    - History of contact with poultry (e.g., visited a poultry farm, a household raising poultry, or a bird market) or a known or suspected human case of avian flu or any novel strain of influenza in an affected country within 10 days of symptom onset.
    - If the above criteria are met, we must call the county health office. The state can also be contacted at (501) 661-2136 or (800) 554-5738.

- Inside the United States
Notify _________________ (ED, Infection Control, Infectious Disease, hospital administration, County Public Health, and Arkansas Department of Health)

- Active institutional pandemic influenza plan
- Test for influenza with split specimen being obtained on all individuals with influenza-like symptoms (patients and employees) as directed by the Arkansas Department of Health and Human Services – Division of Health
- Notify employees to report their flu-like symptoms immediately to _________________ (Employee Health, ED, Infection Control)
- Implement hospital infection control plan for incoming and already admitted patients

Inside Arkansas

- Notify _________________ (ED, Infection Control, Infectious Disease, hospital administration, County Public Health, and Arkansas Department of Health)
- Activate Hospital Command Center / Emergency Operations Center using the Hospital Incident Command System (HICS)
- Self assessment flu-like symptoms (including temperature, sore throat, cough, shortness of breath). Notify employees to report their flu-like symptoms immediately to _________________ (Employee Health, ED, Infection Control)
- Refer to the Arkansas Department of Health on-line publication and CDC web page
- Institute hospital vaccination plan

Post-Pandemic Period (evidence of influenza activity returned to pre-pandemic level)

- Continue surveillance activity as per Interpandemic and Pandemic Alert Period above in anticipation of second-wave influenza
- Assess and report the following to _________________ (Infection Control, Infectious Disease, Hospital Administration, County Public Health, and Arkansas Department of Health)
  - How many individuals treated for influenza
  - How many employees treated for influenza
  - Numbers of all mortality cases from influenza and/or complications of influenza
  - Numbers for all hospitalized admissions for influenza.
  - Evaluation of how surveillance plan worked
  - Effectiveness of vaccine and antiviral distribution
  - After Action Reports and modify plan based on that review

Isolation and Personal Protective Equipment (PPE) precautions

Interpandemic and Pandemic Alert Periods (Phase 1, 2, 3, 4 and 5)
• Patients exhibiting symptoms (coughing or sneezing) offered a courtesy mask or tissue.
• Surgical or procedure masks must be used by healthcare personnel during evaluation of patients with respiratory symptoms. Use existing hospital infection control measures including gowns and gloves.
• Special procedures with the risk of aerosolization will require a higher level of protection.
• Stockpile PPE and rotate with normal use.

**Pandemic Periods (Phase 6)**
• Patients exhibiting symptoms (coughing or sneezing) will wear a mask or tissue if respiratory symptoms prohibit the use of a mask.
• Patients will be moved into a private room if available or cohort if necessary to a multi-patient unit.
• At a minimum, a surgical mask must be worn and the N95 masks should be considered for use by healthcare personnel during evaluation of patients with respiratory symptoms. Any procedure that causes aerosolization would require the use of N95, gloves, gown, face and eye protection if available.
• Stockpile PPE and rotate with normal use.
• Once worn in the presence of a patient with pandemic influenza, the surgical mask or disposable N-95 respirator should be removed and appropriately discarded. ([See Pandemic Flu.gov website.](https://www.pandemicflu.gov/))

**Day-to-day operations during a pandemic**
- Hand hygiene and respiratory hygiene
- Infectious waste control

**Reference existing infection control plans**

**Loss of utilities, laundry**

*Reference existing hospital emergency plans in the event of loss of utilities or infrastructure support in the executive summary*
3) **Education and Training Plan**

**Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)**

- Create and provide employee education (consistent with CDC) to address needs of staff, patients, family members, and visitors.
- Establish methods and a schedule for general education/training of all staff (and a mechanism for documenting participation) regarding each element of the hospital specific Pandemic Influenza Plan.
- Provide and evaluate education to employees, the public, colleague agencies and providers including medical staff according to education plan. (See [Appendix 4](#).)
- Identify specific ethical issues that will be included with the training, including what staff should expect during a pandemic. (See [Appendix 5](#) for HHS Supplement 11 for Psychosocial Support.)
- Encourage staff to develop personal emergency plans that include child, elder and pet care. (See [Appendix 6](#) for HHS Family Planning Guide and Checklist.)
- Offer “Train the Trainer” sessions for influential community leaders.
- Work with the Medical Executive Committee to develop an awareness programs for physicians and their offices. (See [Appendix 7](#) for HHS Medical Office Pandemic Planning Checklist.)

**Pandemic Period (Phase 6)**

- Continually educate and cross-train employees as needed.
- Provide peer counseling during the pandemic regarding ethical and psychosocial issues.

**Post-Pandemic Period**

- Review with all staff possibility of second wave.
- Assure brochures and other educational materials regarding pandemic influenza are still available to general public.
- Evaluate effectiveness of education programs and refine as needed.
- Review Pandemic Influenza Education Plan to assess need for revisions/updates.
- Employee family emergency plan. Refer to existing programs, e.g., CDC, Ready.Gov, or Red Cross.

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4) **Hospital Communication Plan**

**Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)**

An **External Communication Plan** should be developed. 
*The External Communication Plan is executed by the following individuals in conjunction with Hospital Administrative personnel.*

- Person responsible for updating public health reporting _________________.
  - Consider Bioterrorism Coordinator or Infection Control Practitioner
- Clinical spokesperson for the facility _________________.
- Media spokesperson for the facility _________________.
- Public communication plan developed to route patients to alternate care sites.

**Key points of contact** outside the facility have been identified.

- See **Appendix 20** for detailed list.
  - County health unit
  - Division of Health
- Designate ________________ (individual) for notification of any of the following if necessary. *(Within the Incident Command Structure, this individual is typically the Liaison Officer; consider your Bioterrorism Coordinator or Emergency Preparedness official for your facility)*
  - County OEM
  - ADEM
  - Local infrastructure
  - Local coroner
  - Media contacts
- Periodically review and revise Communication Plan as appropriate. (See **Appendix 3**.)
- Make Hospital Pandemic Influenza Plan available to employees and medical staff.
- Establish a list serve and phone list of all local communications officers for health and social service agencies and government.
- Establish routine communication system between Hospital community relations leadership, county health unit, other local agencies, state public health office, and the CDC. ________________ (Ex: Community Relations)
- Establish ____________ (radio, TV, newspaper, etc.) as the vehicle through which to communicate pandemic flu news with _____ employees. (Public relations or outside group representing your hospital.)
- Widely advertise the flu hotline (___________) to provide guidance on what people should do to be ready in case of a pandemic. *(This number would be distributed to hospitals and physicians by the Arkansas Department of Health when necessary.)*
- Post signs for respiratory hygiene / cough etiquette in public areas, i.e.: ER, Waiting Rooms. Monitor **CDC**, national, local and international news media.
- Create home-care kits for those individuals who will be turned away from the hospital. Kits will include instructions on home-base self-care and possibly other minimal supplies, such as a thermometer, acetaminophen, non-carbonated sports/electrolyte replacement drinks, masks, gloves, and hand sanitizer.
• Develop education/communication tools including brochures for the public and staff as needed.
• Develop plans for communicating up-to-date information to all employees and medical staff including emergency notification information in coordination with Public Health.
• Ensure that your institution has a plan in place to communicate the following:
  Public service announcements
  o Self-assessments for public
  o Where the Public Screening/Triage Centers are (see below)
• Develop public screening locations away from hospitals
  (Each Hospital & region should develop plans to operate screening/triage centers)
  o Drive-by screenings (TO BE IMPLEMENTED DURING Phase 6)

Pandemic Period (Phase 6)

Internal communication
• Plan should be developed to communicate with administrators as well as hospital personnel, patients, and visitors to inform them of the ongoing impact of pandemic influenza on the facility and the community.
  o Email
  o Handouts
  o Intranet
  o Voice mail
• Communications will escalate as pandemic increases.
• Notify employees and medical staff of the state’s declaration of the current pandemic level.
• In coordination with the state and county public health offices, issue a local community statement within 48 hours of a declaration of Pandemic Alert.
• Work closely with the county public health office to determine if daily briefings should be held. Provide updates on hospital website or through other communication means as to: the current situation and numbers, what is not known, what we are doing to address unknowns, and what people should do
• Distribute respiratory etiquette kits / flu kits to ER, Occupational Health, and __________________________. (Consider clinical personnel in this group and all that may come in contact with flu victims.)
• Post door signs directing patients, volunteers, family, and employees to appropriate entrance. (See Facility Access / Security Plan.)
• Conduct meetings of the team on a daily basis.
• Distribute educational brochures.
• Regional health care contacts and Arkansas Department of Health updated regarding number of flu patients and bed utilization through EM Systems as well as transmitting illness data to the Arkansas Department of Health on a regular basis (Syndromic Surveillance)
Post-Pandemic Period

- Notify employees of the State’s declaration of the current pandemic level and when it is safe to return to work.
- Notify general community through the above communication methods of the State’s declaration of the current pandemic level.
- Consider producing a narrative of the events of the pandemic period.
5) Facility Access/Security Plan

Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)
Administration must determine appropriate criteria for temporary closings and restriction of transfers, particularly during Phase 6. These criteria must be decided upon and in place prior to Phase 1 and should be known to the regional leadership, member hospitals, and the Division of Health.

- Determine the criteria and procedures that will be used to limit access to the facility if pandemic influenza spreads through the community. (Reference Hospital Security and Access Plan, sometimes referred to as “All Hazards Plan.”)
- Develop criteria or triggers for temporarily closing of the hospital to new admissions and transfers and cancellation of elective surgeries and procedures. The criteria will consider:
  - Staffing ratios
  - Isolation capacity
  - Risks to non-flu patients

A. Security

- Determine how to involve hospital security services in enforcing access controls. Consider meeting with local law enforcement officials of other groups (i.e., Arkansas National Guard, local police, county sheriff) in advance to determine what assistance, if any, they can provide. (Note that local law enforcement might be overburdened during a pandemic and have limited ability to assist healthcare facilities with security services.) As per “Use and Administration of Vaccines and Antiviral Drugs”, discuss need for vaccination of these groups if they are used to supplement hospital security.
- Define “essential” and “non-essential” visitors with regard to the hospital and the population served.
- Develop protocols for limiting non-essential visitors.

B. Facility Access

- Develop criteria or “triggers” for temporary closing of the hospital to new admissions and transfers and cancellation of elective surgeries and procedures. The criteria should consider staffing ratios, isolation capacity, and risks to non-influenza patients. As part of this effort, hospital administrators should: 1) determine who will make decisions about temporary closings and how and to whom these decisions will be communicated, and 2) consult with state and local health departments on their roles in determining policies for hospital admissions and transfers.
- Develop and produce signage in multiple languages based on community diversity. (See Appendix 8 for examples of signs.)
- Develop access controls and identify procedures for implementation.
- Ensure procedures are in place for the following:
  - Loss of utilities, power, trash pick-up
  - Dietary plan
Pandemic Period (Phase 6)

- Implement Hospital Security and Access Plan.
- Lock-down
  - Local law enforcement/hospital staff
  - Employee training to control access to hospital
- Triage outside before admissions.
- Limit facility access.
- Limit visitors.
- Enforce hospital access by hospital security services.
- Inform Local law enforcement of the implementation of the hospital security plan.
- If local law enforcement is used, implement vaccine administration plan as appropriate.
- Activate area to be used in the event employees must bring family members (children, elderly) and/or pets.

Post-Pandemic Period

- Review with all staff possibility of second wave.
- Review Pandemic Influenza Security and Facility Access Plan to assess need for revisions/updates.
6) **Triage, Clinical Evaluation and Admission Plan**

**Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)**

- Develop and test a triage plan that includes strategies for triage, diagnosis, and isolation of possible pandemic influenza patients using various methods. (See Hospitals All Hazards Plan and Appendix 9 for Triage Plan.)
- Consider initiating case detection and clinical management using Appendix 10 on Clinical Guidelines for Phase 1 and Appendix 11 on Clinical Guidelines for Phase 2, 3, 4, 5, and 6.
- Establish a plan to screen all employees that report to work, particularly during Phase 6.
- Establish protocols on how to isolate and treat employees that show symptoms of influenza.
- Establish contingency plans that allow for employees in non-clinical capacities to work from home or phased staffing.

**Pandemic Period (Phase 6)**

- Implement the Triage Plan.
- Activate Employee Screening, Isolation, & Treatment Plan.
- Assign a triage coordinator to manage patient flow.
- If _______________ (location for triage) becomes overwhelmed with influenza patients, the _______________ will be converted to Flu Outpatient area where triage and initial treatment can be done.
- Non-influenza patients will be treated per usual in the ER, with overflow going initially to________________, then to________________.
- See Surge Capacity Plan (or “alternative care site plan”) for inpatient patient flow management.

**Post-Pandemic Period**

- Review with all staff possibility of second wave.
- Review Pandemic Triage Plan to assess need for revisions/updates.
7) **Employee Health Plan**

*Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)*

- Periodically review and revise Employee Health/Occupational Health Plan as appropriate.
- Plan and implement education/training for occupational health activities (see Education Plan, Appendix 4.)
- HR, in consultation with Employee Health/Infection Control and Administration, develops new enforcement rules, guidelines for calling-in sick, and pay policies.
- Verify employee seasonal influenza vaccine status and immunize as appropriate.
- Consider administrative mandate that all Health Care Workers (HCW) will receive their annual flu shot.
- Establish plan for detecting signs and symptoms of influenza in HCW.
- Implement a system for early detection and treatment of healthcare personnel who might be infected with the pandemic strain of influenza.
- Review Hospital Pandemic Influenza Plan.
- Instruct employees to report to Employee Health / Occupational Health (OH) Department and/or their PCP when exhibiting influenza-like symptoms before duty.
- Require testing for employees who have influenza-like symptoms and who have recently traveled to a place where bird flu has been identified.
- Plan for the ongoing emotional well-being of staff who report to work, including place for staff to sleep and to “escape” for brief periods of time, arrangements for staff to contact their family while at work, protective measures for family of staff who work as directed by public health, and finally critical stress debriefing.
- Plan for quick access to the hospital Ethics Committee and counseling services for staff when needed.
- Create an Employee Screening Plan and staffing resources to screen all employees, document results and to alert supervisors of ill employees. This will be recorded on an employee log (See Appendix 12.). See Appendix 13 for “Fit for Work” guidelines.

*Pandemic Period (Phase 6)*

- Message communicated to all staff explaining procedures for screening, new enforcement rules, and new guidelines for calling in sick.
- Incident Command to activate employee screening plan under the direction of Employee Health.
- Any employees who develop flu-like symptoms during their workday will return to the employee screening area for evaluation and disposition.
- Evaluate employees with flu symptoms for influenza per CDC protocol.
- Ill employees who cannot work will either go home with instructions or be admitted as a patient.
- All non-ill employees will report to their workstation after screening. If pandemic vaccination/ antivirals available, give to these employees (See Section 8 “Use and Administration of Vaccines and Antiviral Drugs.”)
- Personnel at high risk of complications (e.g. pregnant, immunocompromised persons) may be reassigned to low risk duties (e.g. non-influenza patient care, administrative duties that do not involve patient care, phone bank/triage or placed on furlough).
- Assign appropriate personnel who are members of the Ethics Committee to be available for staff to discuss difficult issues.
- Provide peer or professional counseling during the pandemic regarding ethical and psychosocial issues.

**Post-Pandemic Period**

- Reinforce continuous precautionary procedures, such as hand hygiene, respiratory etiquette, etc. in anticipation of second wave.
- Maintain list of all employees and volunteers who recovered from cases of pandemic flu.
- Gather electronic numbers to report how many employees tested for influenza, and the results of those tests.
- Gather electronic numbers of all employee mortality cases from influenza and/or complications of influenza.
- Gather electronic numbers for all employees hospitalized for influenza.
- Conduct evaluation of how the Employee Health Plan worked.
- Assess the effectiveness of vaccine and antiviral distribution for employees.
- Provide for critical stress debriefing of staff who are deactivated following the response.
8) **Use and Administration of Vaccines and Antiviral Drugs**

Note: This plan does not follow the same format as other components of the plan. It is organized by types of influenza medication, rather than by pandemic levels.

A. **Pandemic Influenza Vaccine**

*Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)*

- Monitor CDC recommendations on development, distribution, and use of vaccine.
- Coordinate with State and local health departments for plans for distribution and priority use of vaccine.
- If available, obtain and stockpile vaccine according to Federal and State guidelines.
- Estimate the numbers of vaccine needed for established priorities.
- Develop a plan to prioritize vaccination use in the organization. Include plan for re-vaccination 1 month later to assure effectiveness. Plan to allocate half of available doses for first round of vaccinations, and the second half for the second round of vaccinations to the same individuals.
- Plan secure storage area for vaccine inventory.
- Work with state and local public health to develop plans for distribution and administration of vaccine to local communities after priority groups vaccinated.
- Review list of personnel who can vaccinate. Coordinate with local public health nursing.
- Develop a vaccination education plan to include information on the vaccine, administration, contraindications, adverse effects, monitoring and treatment following CDC guidelines.
- Prepare a vaccination kit for each site to include: Vaccination administration guidelines for staff, patient handouts (Quarantine / Self-Care information), syringes, needles, alcohol swabs, gloves, needle boxes, non sterile 2x2 gauze pads, band aids, epinephrine, and diphenhydramine.
- Check on legal exemptions and liability protection for healthcare workers and organization.
- Communicate plan for timelines and vaccine distribution locations coordinated with Public Health.
- Coordinate with security and refer to the All Hazards Plan for security at sites and accountability of supplies.

*Pandemic Period (Phase 6)*
(Before vaccine becomes available)

- Review and update vaccine plan using HHS and CDC recommendations.
- Notify the medical community about status of plan and expected availability of vaccines.
- Conduct training for personnel involved in distributing and administration of vaccine.
**Pandemic Period (Phase 6)**

(After vaccine becomes available)

- Implement vaccination plan: employees; volunteers; community personnel, such as law enforcement; and others as directed by local public health.
- Increase security for vaccine, including during transportation, storage, distribution, etc., similar to narcotic control.
- Vaccinate persons in priority groups. (See Appendix 14.) See also Part 1, Appendix D of HHS Pandemic Influenza Plan.
- Provide second dose, if required, at recommended interval.
- Monitor vaccine supply, distribution and use.
- Monitor and investigate adverse effects. Report to Public Health.
- When adequate supplies of vaccine are available, phase in vaccination of population per Arkansas Department of Health recommendations.

**Post-Pandemic Period**

- Evaluate all response activities including vaccine tracking and delivery, adverse effects, and effectiveness of communications.
- Continue to vaccinate population following Arkansas Department of Health guidelines.

**B. Anti-Viral Medication**

**Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)**

- Establish list of priority groups to receive antiviral medication, including patients, per Arkansas Department of Health guidelines.
- Estimate the number of doses needed for addressing - Predetermined priority groups and local community.
- Identify sources of antiviral drugs.
- In accordance with State plan, procure and create local stockpile.

**Pandemic Period (Phase 6)**

- Administer anti-viral medication as recommended by Arkansas Department of Health guidelines.
- Monitor supply of anti-viral medication.

**Post-Pandemic Period**

- Evaluate all response activities including vaccine tracking and delivery, adverse effects, and effectiveness of communications.
- Continue to vaccinate population following Arkansas Department of Health guidelines.
C. Seasonal Influenza Vaccine

*Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)*

- Increase vaccination for seasonal influenza of vulnerable persons.
- Refer to current recommendations from CDC
- Refer to Standing Orders (see Appendix 15.)
- Refer to Consent Form (see Appendix 16.)

*Pandemic Period (Phase 6)*

- Administer influenza vaccine as recommended by Arkansas Department of Health guidelines.
- Monitor supply of influenza vaccine.

*Post-Pandemic Period*

- Evaluate all response activities including vaccine tracking and delivery, adverse effects, and effectiveness of communications.
- Continue to vaccinate population following Arkansas Department of Health guidelines.

D. Pneumonia Vaccine

*Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)*

- Increase pneumococcal vaccination of persons at high risk for a secondary bacterial infection including:
  - Persons aged >/= 65 years
  - Immunocompromised persons <= 2 years who are at increased risk for illness and death associated with pneumococcal disease because of chronic illness
  - Persons aged >/= 2 years with functional or anatomic asplenia
  - Persons >/= 2 years living in environments in which the risk of disease is high
  - Immunocompromised persons aged >/= 2 years who are at high risk for infection

*Pandemic Period (Phase 6)*

- Administer pneumonia vaccine as recommended by Arkansas Department of Health guidelines.
- Monitor supply of pneumonia vaccine.

*Post-Pandemic Period*

- Evaluate all response activities including vaccine tracking and delivery, adverse effects, and effectiveness of communications.
- Continue to vaccinate population following Arkansas Department of Health guidelines.
E. Antibiotics

Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)

- Inventory stock of antibiotics for pneumonia complications. (Suggest maintain 3-mos. Supply.)

Pandemic Period (Phase 6)

- Closely monitor use and availability of antibiotics.
- Increase stock as needed.

Post-Pandemic Period

- Evaluate all response activities including vaccine tracking and delivery, adverse effects, and effectiveness of communications.
9) **Surge Capacity Plan**

- Evaluate current surge capacity plan including staff who will be responsible for the planning (staffing, bed capacity, consumable and durable supplies, and continuation of essential medical services should be sections to this plan)

**A. Staffing**

*Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)*

- Build a list of essential support personnel who are needed to maintain hospital operations.
- Based on CDC estimates, determine number of patients hospital is projected to receive.
- Create a list of non-essential positions that can be re-assigned to support critical hospital services.
- Review and/or revise contingency staffing plans for a minimum duration of eight weeks.
- Define what would constitute a “staffing crisis” that would enable the use of emergency staffing and alternative medical care levels.
- Establish a plan, after consulting with state professional licensing boards, for rapidly credentialing health-care professionals during a pandemic, considering adding an emergency clause into regular credentialing process. (Include web based licensure check for physicians, physician assistants and nurses.)
- Identify key position in incident command center to coordinate staffing during an event.
- Create a list of non-essential positions that can be placed on administrative leave or who could telecommute to limit the number of persons in the hospital.
- Consider creating a plan and involve employees in the discussion of day care and eldercare for family.
- Create plan for special needs patients to isolate from flu patients.

*Pandemic Period (Phase 6)*

- Activate staffing pool that has been established and maintained by HR.
- Activate the Incident Command System. The Incident Commander will coordinate with HR, who will coordinate and assign pool of volunteers, staff, retirees, etc. in order to see that staffing needs are met.
- Activate plan for rapidly credentialing healthcare professionals.
- Increase cross-training of personnel to provide support for essential patient care areas at times of severe staffing shortages (e.g. in ED, ICU, Med-Surg, etc.).
- Departments update their list of essential support personnel who are needed to maintain hospital operations.
- Review the list of non-essential positions that can be re-assigned to support critical hospital services.
- Determine needs of outlying medical offices and facilities, per Incident Command System.
B. Bed Capacity

_Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)_

- Determine threshold when to cancel elective admissions and surgery.
- Review rapid discharge policies and procedures and appropriate outside agencies to expedite transfer of patients out of the hospital.
- Identify rooms, beds and supplies in the hospital that could be utilized for expanded bed capacity if needed.
- Identify areas that could accept overflow capacity if needed.
- Develop areas that could be used for cohorting influenza patients. (See Surge Plan or Alternative Care Site Plan.)
- Participate with local health unit and RCH for additional hospital capacity needs.
- Identify position in incident command center to oversee bed capacity and patient flow.

_Pandemic Period (Phase 6)_

- Determine if other hospitals have capacity to take non-influenza, non-critical patients in transfer. Review and update on a daily basis or as requested.
- Institute Surge Capacity Plan.

C. Consumable and Durable Supplies

_Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)_

- Evaluate the existing system for tracking medical supplies to determine if it can detect rapid consumption and respond to growing needs.
- Stockpile enough consumable goods (soaps, hand gels, masks, gloves, and other isolation supplies) for duration of pandemic (6-8 weeks).
- Determine trigger-point to order additional supplies.
- Determine food supplies in the hospital – how many days worth in-house.
- Determine trigger-point when additional supplies are needed.
- Maximize the storage capacity of fuel oil and propane gasses during this period.

_Pandemic Period (Phase 6)_

- Implement surge capacity plan.
- Procure additional supplies as available and as needed.
D. Continuation of Essential Medical Services

*Interpandemic and Pandemic Alert Period (Phase 1, 2, 3, 4, and 5)*

- Determine and address how essential services will be maintained for persons with chronic medical problems served by the hospital (e.g. hemodialysis, oncology, wound clinic, etc.) including moving these services to off-site facilities to limit exposure to influenza infection (e.g. ________________).
- Consider re-establishing these services in-house if the Pandemic Influenza appears to be waning, as per direction of Incident Command.

*Pandemic Period (Phase 6)*
- Incident Command will determine when to implement plan to move essential services.

*Post-Pandemic Period*
- Evaluate effectiveness of surge capacity plan.
- Reestablish essential medical services.
- Return to pre-pandemic supply levels.
10) **Mortuary Plan**

**Interpandemic and Pandemic Alert Periods (Phase 1, 2, 3, 4, and 5)**

- Evaluate current infection control plan regarding post mortem care to determine needed changes to reflect current practice. Refer to the [CDC website](http://www.cdc.gov) link for the most recent information.
- Assure adequate inventory of body bags. Use CDC estimates to help determine quantity.
- Confirm areas for body storage such as temporary morgue facilities and refrigeration if needed. Consider cold storage trucks or warehouses.
- Work with local county planning committee and public health to arrange for potential local storage facilities or a trucking company for temporary morgue facility. Seek other possible sites.
- If temporary morgue facility is needed, plan for location and consider power /diesel fuel requirements.
- Address security concerns.
- Plan for rapid removal and disposition of bodies.
- Work with local community planners and emergency management agencies planners under ESF 8 to make arrangements with local morticians.
- Establish list of local funeral homes and crematories.

**Pandemic Periods (Phase 6)**

- Establish Incident Command.
- Using Incident Command System, assign responsibility for removal and transport of bodies.
- In the event there are a number of bodies in the morgue, do not stack the bodies.
- Keep on-going record of associated costs involved in mortuary issues.
- Cooperate with local funeral homes in the ultimate disposition of all bodies.

**Post-Pandemic Period**

- Cancel contracts as appropriate, keeping in mind the potential for a second-wave of Pandemic Influenza.
- Explore reimbursement from local, state and federal sources for cost associated with emergency mortuary services.
- Review plan and revise as needed.
Appendix 1
Preparedness Committee and HHS Checklist

1) The __________________ multidisciplinary planning committee will have the responsibility for pandemic influenza preparedness and response. The members of this committee should include representatives of administration, representative members of the medical staff (hospital and community-based physicians, infection control, disaster planning, safety officer, public relations, physical plant, security, ED and ICU, respiratory services, laboratory, and diagnostic services, and ex-official members from the community. A pre-existing all-hazards preparedness team (e.g., established for bioterrorism or SARS response) might assume this role. (Make specific for hospital; see below for suggestions for the committee)

<table>
<thead>
<tr>
<th>Hospital staff</th>
<th>Adjunct staff members</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Administration/senior management (including fiscal officer)</td>
<td>o Infectious diseases</td>
</tr>
<tr>
<td>o Legal counsel/risk management</td>
<td>o Mental health (psychiatry, psychology)</td>
</tr>
<tr>
<td>o Infection control/hospital epidemiology</td>
<td>o Union representatives</td>
</tr>
<tr>
<td>o Hospital disaster/emergency coordinator</td>
<td>o Human resources</td>
</tr>
<tr>
<td>o Safety Officer / industrial hygienist</td>
<td>o Social work</td>
</tr>
<tr>
<td>o Nursing administration</td>
<td>o Director of house staff/fellowship and other training programs</td>
</tr>
<tr>
<td>o Medical staff (including hospital and community-based members)</td>
<td>o Critical care medicine</td>
</tr>
<tr>
<td>o Intensive-care unit</td>
<td>o Pathology</td>
</tr>
<tr>
<td>o Emergency department</td>
<td></td>
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<tr>
<td>o Laboratory services</td>
<td></td>
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<tr>
<td>o Respiratory therapy</td>
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<tr>
<td>o Nutrition and food services</td>
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<tr>
<td>o Pharmacy</td>
<td></td>
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<tr>
<td>o Environmental services (housekeeping, laundry)</td>
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<tr>
<td>o Public relations</td>
<td></td>
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<tr>
<td>o Security</td>
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<tr>
<td>o Materials management</td>
<td></td>
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<tr>
<td>o Education/training/staff development</td>
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<tr>
<td>o Occupational health</td>
<td></td>
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<tr>
<td>o Diagnostic imaging</td>
<td></td>
</tr>
<tr>
<td>o Information technology</td>
<td></td>
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</tbody>
</table>

2) The committee should identify the local health unit administrator or their designee for local issues and the Hospital Preparedness Section Chief for the Arkansas Department of Health designated as liaison for hospital pandemic influenza preparedness planning and response. If possible, include this person(s) on the committee.
3) The facility infection control practitioner or other designated individual should review the CDC and HHS websites for pandemic influenza information on a frequent basis in order to identify changes in national recommendations or declaration of human-to-human transmission and the declaration of a pandemic.

4) The Preparedness Committee should focus on the following actions per the HHS Pandemic Influenza Plan (S3-2):
   a) Develop planning and decision-making structures for responding to pandemic influenza. Consider identifying a response coordinator/incident commander to direct the facility’s planning and response efforts and a core group from the multidisciplinary planning committee to work with the response coordinator and assist with decision-making during the pandemic. (The pandemic influenza response team should plan to remain active throughout the pandemic period, which could be several weeks or months.)
   b) Develop written plans that address: disease surveillance, hospital communications, education and training, triage and clinical evaluation, facility access, occupational health, use and administration of vaccines and antiviral drugs, surge capacity, supply chain and access to critical inventory needs, and mortuary issues.
   c) Participate in pandemic influenza response exercises and drills, and incorporate lessons learned into response plans.
   d) Implement the HHS Preparedness Checklist for hospitals and correct areas of deficiency (Attachment A).
   e) Understand that a number of different scenarios can occur depending on the size of the pandemic, the resources available, and actions/directives of local and federal authorities.
Attachment A
Hospital Preparedness Checklist

1. Structure for planning and decision making

- An internal, multidisciplinary planning committee for influenza preparedness has been created.
- A person(s) has been designated as the influenza preparedness coordinator. (Insert name)
- Members of the planning committee include the following hospital staff members (insert names)

  Administration
  Legal counsel
  Infection control
  Hospital disaster coordinator
  Risk management
  Facility engineering
  Nursing administration
  Medical staff
  Intensive care
  Emergency Department
  Laboratory services
  Respiratory therapy
  Psychiatry
  Environmental services
  Public relations Security
  Materials management
  Staff development
  Occupational health Diagnostic imaging
  Pharmacy Information technology
  Other members
  Other members

- A state or local health department person has been identified as a committee liaison. (Insert name)
- A linkage with local or regional emergency preparedness groups has been established. (Planning organization)
2. Development of a written pandemic influenza plan

A written plan has been completed or is in progress that includes the elements listed in #3 below.
• The plan specifies the circumstances under which the plan will be activated.
• The plan describes the organization structure that will be used to operationalize the plan.
• Responsibilities of key personnel related to executing the plan have been described.
• A simulation exercise has been developed to test the effectiveness of the plan.
• A simulation exercise has been performed.
   (Date performed ___________________)

3. Elements of an influenza pandemic plan

A surveillance plan has been developed.
• Syndromic surveillance has been established in the emergency room.
• Criteria for distinguishing pandemic influenza are part of the syndromic surveillance plan.
• Responsibility has been assigned for reviewing global, national, regional, and local influenza activity trends and informing the pandemic influenza coordinator of evidence of an emerging problem. (Name ______________________)
• Thresholds for heightened local surveillance for pandemic influenza have been established.
• A system has been created for internal review of pandemic influenza activity in patients presenting to the emergency department.
• A system for monitoring for nosocomial transmission of pandemic has been implemented and tested by monitoring for non-pandemic influenza.

A communication plan has been developed.
• Responsibility for external communication has been assigned.
• Person responsible for updating public health reporting ______________________
• Clinical spokesperson for the facility ______________________
• Media spokesperson for the facility ______________________

Key points of contact outside the facility have been identified.
• State health department contact _________
• Local health department contact _________
• Newspaper contact(s) ______________
• Radio contact(s) _____________________
• Public official(s) _________________

A list of other healthcare facilities with which it will be necessary to maintain communication has been established.

A meeting with local healthcare facilities has been held to discuss a communication strategy.

A plan for updating key facility personnel on a daily basis has been established.
A system to track pandemic influenza admissions and discharges has been developed and tested by monitoring non-pandemic influenza admissions and discharges in the community.

A strategy for regularly updating clinical, ED, and outpatient staff on the status of pandemic influenza, once detected, has been established. (Responsible person __________________)

A plan for informing patients and visitors about the level of pandemic influenza activity has been established.

- An education and training plan on pandemic influenza has been developed.
- Language and reading level-appropriate materials for educating all personnel about pandemic influenza and the facility’s pandemic influenza plan have been identified.
- Current and potential sites for long-distance and local education of clinicians on pandemic influenza have been identified.
- Means for accessing state and federal web-based influenza training programs have been identified. A system for tracking which personnel have completed pandemic influenza training is in place.
- A plan is in place for rapidly training non-facility staff brought in to provide patient care when the hospital reaches surge capacity.

The following groups of healthcare personnel have received training on the facility’s influenza plan:

- Attending physicians
- House staff
- Nursing staff
- Laboratory staff
- Emergency Department personnel
- Outpatient personnel
- Environmental Services personnel
- Engineering and maintenance personnel
- Security personnel
- Nutrition personnel

A triage and admission plan has been developed.

- A specific location has been identified for triage of patients with possible pandemic influenza.
- The plan includes use of signage to direct and instruct patients with possible pandemic influenza on the triage process.
- Patients with possible pandemic influenza will be physically separated from other patients seeking medical attention.
- A system for phone triage of patients for purposes of prioritizing patients who require a medical evaluation has been developed.
- Criteria for determining which patients need a medical evaluation are in place.
- A method for tracking the admission and discharge of patients with pandemic influenza has been developed.
- The tracking method has been tested with non-pandemic influenza patients.
A **facility access plan** has been developed.
- Criteria and protocols for closing the facility to new admissions are in place.
- Criteria and protocols for limiting visitors have been established.
- Hospital Security has had input into procedures for enforcing facility access controls.

An **occupational health plan** has been developed.
- A system for rapidly delivering vaccine or antiviral prophylaxis to healthcare personnel has been developed.
- The system has been tested during a non-pandemic influenza season.
- A method for prioritizing healthcare personnel for receipt of vaccine or antiviral prophylaxis based on level of patient contact and personal risk for influenza complications has been established.
- A system for detecting symptomatic personnel before they report for duty has been developed.
- This system has been tested during a non-pandemic influenza period.
- A policy for managing healthcare personnel with symptoms of or documented pandemic influenza has been established. The policy considers:
  - When personnel may return to work after having pandemic influenza
  - When personnel who are symptomatic but well enough to work, will be permitted to continue working
- A method for furloughing or altering the work locations of personnel who are at high risk for influenza complications (e.g., pregnant women, immunocompromised healthcare workers) has been developed.
- Mental health and faith-based resources that will provide counseling to personnel during a pandemic have been identified.
- A strategy for housing healthcare personnel who may be needed on-site for prolonged periods of time is in place.
- A strategy for accommodating and supporting personnel who have child or elder care responsibilities has been developed.

A **vaccine and antiviral use plan** has been developed.
- A contact for obtaining influenza vaccine has been identified. (Immunizations Division of the Arkansas Department of Health)
- A contact for obtaining antiviral drugs has been identified. (Strategic National Stockpile Pharmacy Consultant, Arkansas Department of Health)
- A priority list (based on Arkansas Department of Health guidance for use of vaccines and antivirals in a pandemic when in short supply) and estimated number of patients and healthcare personnel who would be targeted for influenza vaccination or antiviral treatment has been developed.
  Number of first priority personnel _____
  Number of second priority personnel ______
  Number of remaining personnel ______
  Number of first priority patients _______
  Number of second priority patients _____
Issues related to **surge capacity** have been addressed.

- A plan is in place to address unmet staffing needs in the hospital.
- The minimum number and categories of personnel needed to care for a group of patients with pandemic influenza has been determined.
- Responsibility for assessing day-to-day clinical staffing needs during an influenza pandemic has been assigned.
- Persons responsible are: (titles)
- Legal counsel has reviewed emergency laws for using healthcare personnel with out-of-state licenses.
- Legal counsel has made sure that any insurance and other liability concerns have been resolved. Criteria for declaring a "staffing crisis" that would enable the use of emergency staffing alternatives have been defined.
- The plan includes linking to local and regional planning and response groups to collaborate on addressing widespread healthcare staffing shortages during a crisis.
- A priority list for reassignment and recruitment of personnel has been developed.
- A method for rapidly credentialing newly recruited personnel has been developed.
- Mutual AID Agreements (MAAs) and Memoranda of Understanding/Agreement (MOU/As) have been signed with other facilities that have agreed to share their staff, as needed.

Strategies to increase bed capacity have been identified.

- A threshold has been established for canceling elective admissions and surgeries MOAs have been signed with facilities that would accept non-influenza patients in order to free-up bed space
- Areas of the facility that could be utilized for expanded bed space have been identified
- The estimated patient capacity for this facility is ________
- Plans for expanded bed capacity have been discussed with local and regional planning groups
- Anticipated durable and consumable resource needs have been determined.
- A primary plan and contingency plan to address supply shortages has been developed
- Plans for obtaining limited resources have been discussed with local and regional planning and response groups.

A strategy for handling increased numbers of deceased persons has been developed.

- Plans for expanding morgue capacity have been discussed with local and regional planning groups.
- Local morticians have been involved in planning discussions.
- Mortality estimates have been used to estimate the number of body bags and shrouds.

Supply sources for [postmortem](http://www.postmortem) materials have been identified.
## Appendix 2
### Isolation Precaution Standards

**SUMMARY OF INFECTION CONTROL RECOMMENDATIONS FOR CARE OF PATIENTS WITH PANDEMIC INFLUENZA**  
*Adapted from CDC. See [http://www.hhs.gov/panflu/plan/pdf/S05.pdf](http://www.hhs.gov/panflu/plan/pdf/S05.pdf)*

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>STANDARD PRECAUTIONS</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Hygiene</td>
<td>Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items; after removing gloves; and between patient contacts. Hand hygiene includes both handwashing with either plain or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams) that contain an emollient and do not require the use of water. If hands are visibly soiled or contaminated with respiratory secretions, they should be washed with soap (either non-antimicrobial or antimicrobial) and water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience.</td>
<td></td>
</tr>
<tr>
<td><strong>Personal protective equipment (PPE)</strong></td>
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<td></td>
</tr>
<tr>
<td>• Gloves</td>
<td>For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and nonintact skin.</td>
<td></td>
</tr>
<tr>
<td>• Gown</td>
<td>During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.</td>
<td></td>
</tr>
<tr>
<td>• Face/eye protection (e.g., surgical or procedure mask and goggles or a face shield)</td>
<td>During procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, excretions.</td>
<td></td>
</tr>
<tr>
<td>Safe work practices</td>
<td>Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to patient care (e.g., door knobs, keys, light switches).</td>
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</tr>
<tr>
<td><strong>Patient resuscitation</strong></td>
<td>Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.</td>
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</tr>
<tr>
<td><strong>Soiled patient care equipment</strong></td>
<td>Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves if visibly contaminated; perform hand hygiene after handling equipment.</td>
<td></td>
</tr>
<tr>
<td><strong>Soiled linen and laundry</strong></td>
<td>Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (given if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.</td>
<td></td>
</tr>
<tr>
<td><strong>Needles and other sharps</strong></td>
<td>Use devices with safety features when available; do not recap, bend, break or hand-manipulate used needles; if recapping is necessary, use a one-handed scoop technique; place used sharps in a puncture-resistant container.</td>
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</tr>
<tr>
<td><strong>Environmental cleaning and disinfection</strong></td>
<td>Use EPA-registered hospital detergent-disinfectant; follow standard facility procedures for cleaning and disinfection of environmental surfaces; emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces).</td>
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</tr>
<tr>
<td><strong>Disposal of solid waste</strong></td>
<td>Contain and dispose of solid waste (medical and non-medical) in accordance with facility procedures and/or local or state regulations; wear gloves when handling waste; wear gloves when handling waste containers; perform hand hygiene.</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory hygiene/cough etiquette</strong></td>
<td>Cover the mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacles; perform hand hygiene after contact with respiratory secretions; wear a mask (procedure or surgical) if tolerated; sit or stand as far away as possible (more than 3 feet) from persons who are not ill.</td>
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</table>

February 20, 2007
RESPIRATORY HYGIENE/COUGH ETIQUETTE
To contain respiratory secretions, all persons with signs and symptoms of a respiratory infection, regardless of
presumed cause, should be instructed to:
- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions.
- Dispose of tissues in the nearest waste receptacle after use.
- Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.

Healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene/cough etiquette in
waiting areas for patients and visitors:
- Provide tissues and no-touch receptacles for used tissue disposal.
- Provide conveniently located dispensers of alcohol-based hand rub.
- Provide soap and disposable towels for hand washing where sinks are available.
- During periods of increased respiratory infection in the community, persons who are coughing should be
  offered either a procedure mask (i.e., with ear loops) or a surgical mask (i.e., with ties) to contain
  respiratory secretions.
- Coughing persons should be encouraged to sit as far away as possible (at least 3 feet) from others in
  common waiting areas.
- Some facilities may wish to institute this recommendation year-round.
Appendix 3
Communication Plan

Develop a communication plan that addresses the following areas: (Your facility may have a current communication plan that can be modified if needed to include some of the components.)

- Assign responsibility for external communication about pandemic influenza; identify a person responsible for updating public health reporting (e.g., infection control), a clinical spokesperson (e.g., medical director), and a media spokesperson (e.g., public information officer).
- Identify points of contact among local media (e.g., newspaper, radio, television) representatives and public officials and community leaders.
- With guidance from state or local health departments, determine the methods, frequency, and scope of external communications.
- Determine how communications between local and regional healthcare facilities will be handled.
- Consult with state or local health departments on plans for coordinating or facilitating communication among healthcare facilities. In the absence of such a plan, consider organizing a meeting of local health facilities to determine an optimal communications strategy.
- Identify key topics for ongoing communication (e.g., staffing needs, bed capacity, durable and consumable medical equipment and device needs, supplies of influenza vaccine and antiviral drugs).
- Assign responsibility within the hospital for communications with other healthcare facilities.
- Consult with local or state public health officials regarding the hospital’s role in communicating with the media and the public.
- Determine the type of hospital-specific communications (e.g., press releases, community bulletin board) that might be needed, and develop templates for these materials.
- Consult with local or state health departments on plans for a pandemic influenza hotline and/or website for public inquiries.
- Determine how public inquiries will be handled (e.g., refer callers to the health department; provide technical support for handling calls).
- Identify the types of information that will be provided by the hospital and the types of inquiries that will be referred to state or local health departments.

Internal communications

- Determine how to keep administrators, personnel (including infection control staff and intake and triage staff), patients, and visitors informed of the ongoing impact of pandemic influenza on the facility and on the community.
When Communications Team meets, they address the following agenda:

- Review of key messages from state, federal CDC, and colleague agencies.
- Review and evaluation of messages delivered in the prior week.
- Issues and concerns from callers to the flu hotline and others in the public, including rumors and potential for quelling.
- Agreement on key messages for the week.
- Agreement on modes of delivering key messages (public statements, flyers, advertisements, phone/internet, radio, other).
- Release internal statement that all public statements must be routed through the Communications Team or the PIO.

Sample Community Statement may include:

- Expression of empathy with people’s worries and fears
- Confirmation of known facts and action steps Hospital is taking
- Description of what we do not know at this point
- Steps we are taking to address the unknowns and our constant contact with state and federal officials.
- Statement of our commitment to be here for the long term and do all we can
- Where people can get information (the flu hotline) and what they can do to be ready
- Refer callers to appropriate county resources
- Report to Arkansas Department of Emergency Management (ADEM) and the Arkansas Department of Health (DOH) as well as others where resources are needed and where they are unavailable.
Appendix 4
Education Plan

Review current staff education plan included in the hospital’s All Hazards Plan to assure it includes a process for providing:

- Explanation of seasonal vs. pandemic influenza and implications of pandemic influenza
- Difference between upper respiratory infection and influenza
- Prevention and control of influenza
- Review of infection control strategies including; respiratory hygiene/cough etiquette, hand hygiene, standard precautions, droplet precautions, and airborne precautions
- Role of antiviral drugs in preventing disease and reducing rates of severe influenza and its complications
- Information regarding “Quarantine/Home Care” self care (include where informational brochures may be obtained)
- Priority lists for vaccination and anti-viral prophylaxis
- Policies for restricting visitors and mechanisms for enforcing those policies
- Staffing contingency plans, including how the facility will deal with illness in personnel.
- The risk of infection and subsequent complications in high-risk groups
- Policies and procedures for the care of pandemic influenza patients, including how and where pandemic influenza patients will be cohorted
- Reporting to the health department suspected cases of infection caused by novel influenza strains during the Interpandemic and Pandemic Alert Periods
- Measures to protect family and other close contacts from secondary occupational exposure
- A schedule for training/education of clinical staff and a mechanism for documenting participation. Consider using annual infection control updates/meetings, medical Grand Rounds, and other educational venues as opportunities for training on pandemic influenza.
- Cross-training clinical personnel, including outpatient healthcare providers, who can provide support for essential patient-care areas (e.g., emergency department, ICU, medical units).
- Developing a strategy for “just-in-time” training of non-clinical staff who might be asked to assist clinical personnel (e.g., help with triage, distribute food trays, transport patients), students, retired health professionals, and volunteers who might be asked to provide basic nursing care (e.g., bathing, monitoring of vital signs); and other potential in-hospital caregivers (e.g., family members of patients).

Education of patients, family members, and visitors

- Patients and others should know what they can do to prevent disease transmission in the hospital, as well as at home and in community settings.
- Identify language-specific and reading-level appropriate materials for educating patients, family members, and hospital visitors during an influenza pandemic. If language-specific materials are not available for the population(s) being served, arrange for translations.
- Develop a plan for distributing information to all persons who enter the hospital. Identify staff to answer questions about procedures for preventing influenza transmission.
Appendix 5
HHS Supplement 11 Workforce Support:
Psychosocial Considerations and Information Needs

Summary of Public Health Roles and Responsibilities

In Workforce Support

Interpandemic and Pandemic Alert Periods

Healthcare institutions, state and local health agencies, first-responder organizations, and employers of essential service workers:

- Institutionalize psychosocial support services for employees who participate in or provide support for the response to public health emergencies such as influenza pandemics.
- Prepare educational and training materials on psychosocial issues for distribution to employees during an influenza pandemic.

State and local health departments and other groups:

- Lay the groundwork for the development and implementation of workforce resilience programs to maximize responders’ performance and personal resilience during a public health emergency.
- Use behavioral health expertise to develop public health messages, train staff on the use of personal protective equipment (PPE), and conduct other relevant activities.

HHS agencies:

- Create, collect, and provide educational and training materials on psychosocial issues related to pandemic influenza for use by hospital administrators, emergency department staff, safety and security professionals, behavioral health providers, social workers, psychologists, chaplains, and others.
- Provide guidance on the development of self-care strategies and workforce resilience programs.

Pandemic Period

Healthcare institutions, state and local health agencies, first-responder organizations, and employers of essential service workers:

- Provide psychological and social support services for employees and their families.
- Address stigmatization issues that might be associated with participation in such services.
Healthcare institutions:

Provide employees with ongoing access to up-to-date information on healthcare and training issues, as well as on the national and local status of the pandemic.

State and local health departments and other groups:

Implement workforce resilience programs.

HHS agencies:

Provide medical, public health, and community partners with educational and training materials on psychosocial issues related to pandemic influenza.

Provide occupational health guidance on psychosocial issues related to the pandemic, including information on anticipated reactions to restrictive public health measures such as quarantine.

S11-I. Rationale

The response to an influenza pandemic will pose substantial physical, personal, social, and emotional challenges to healthcare providers, public health officials, and other emergency responders and essential service workers (Box 1). Experience with disaster relief efforts suggests that enhanced workforce support activities can help responders remain effective during emergencies (Appendix 1).

During an influenza pandemic, however, the occupational stresses experienced by healthcare providers and other responders are likely to differ from those faced by relief workers in the aftermath of a natural disaster. Globally and nationally, a pandemic might last for more than a year, while disease outbreaks in local communities may last 5 to 10 weeks. Medical and public health responders and their families will be at personal risk for as long as the pandemic continues in their community. Special planning is therefore needed to ensure that hospitals, public health agencies, first-responder organizations, and employers of essential service workers are prepared to help employees maximize personal resilience and professional performance. An essential part of this planning effort involves the creation of alliances with community-based organizations and nongovernmental organizations with expertise in and resources for psychosocial support services or training.
S11-II. Overview

Recommendations for the Interpandemic and Pandemic Alert Periods focus on the establishment of psychosocial support services that will help workers manage emotional stress during the response to an influenza pandemic and resolve related personal, professional, and family issues. The recommendations also address the preparation of informational materials for employees and their families and the development of workforce resilience programs to assist families of deployed workers. Recommendations for the Pandemic Period focus on the delivery of psychosocial support services to response workers, provision of occupational health information to healthcare providers, and implementation of workforce resilience programs.

Supplement 11 addresses the psychological and social ("psychosocial") needs of the occupational groups that will participate in the response to an influenza pandemic. These groups include:

- Healthcare workers who provide medical care to ill persons
- Emergency field workers and other public health personnel who help control the spread of infection
- First-responder and nongovernmental organizations whose employees assist affected groups (e.g., persons in quarantine or isolation)
- Essential service workers whose activities maintain normal functions in the community and minimize social disruption
- Family members of all of these groups

Examples of the psychosocial issues faced by these groups and their families are listed in Boxes 1 and 2. Preparedness planning to address these issues will also be useful in responding to other types of public health emergencies. A checklist outlining key workforce support and resource concerns is provided to assist planners (see Appendix 2).

S11-III. Recommendations for the Interpandemic and Pandemic Alert Periods

A. Institutionalizing psychosocial support services

Healthcare institutions and state and local health agencies should consider incorporating psychosocial support services into occupational health and emergency preparedness planning for an influenza pandemic. First responders and essential service workers employed by companies and local governments (Box 2) might also benefit from these services. Healthcare and public health planners should also contact community-
based organizations and nongovernmental organizations to determine the types of psychological and social support services and training courses available in their jurisdictions.

- Healthcare and public health officials should consider needs for information sharing with emergency planners in schools, law enforcement agencies, and local businesses.
- Planning for the provision of psychosocial support services might include the following activities:
  - Ensuring that administrators, managers, and supervisors are familiar with and actively encourage the use of tools and techniques for supporting staff and their families during times of crisis (see S11-IV.A and Appendix 3)
  - Training staff in hospitals and occupational health clinics (e.g., social workers, psychiatrists, nurses, psychologists, counselors) in behavioral techniques to help employees cope with grief, stress, exhaustion, anger, and fear during an emergency (see S11-IV.A and Appendix 3)
  - If feasible, providing training in psychological support services to persons who are not behavioral health professionals (e.g., primary-care clinicians, emergency department staff, medical/surgical staff, safety and security personnel, behavioral health staff, chaplains, community leaders, staff of cultural and faith-based organizations)
  - Identifying additional resources that can be available to employees and their families during and after a pandemic
  - Developing strategies to assist staff who have child-care or elder-care responsibilities or other special needs that might affect their ability to work during a pandemic

B. **Preparing workforce support materials**

Employers of response workers and providers of essential services should obtain or prepare workforce support materials (in hard copy or electronic format) for distribution during a pandemic. These materials should be designed to do the following:

- Educate and inform employees about emotional responses they might experience or observe in their colleagues and families (including children) during an influenza pandemic and about techniques for coping with these emotions (see Appendix 3).
- Educate employees about the importance of developing "family communication plans" so that family members can maintain contact during an emergency.
- Describe workforce support services that will be available during an emergency, including confidential behavioral health services and employee assistance programs.
- Answer questions about infection control practices to prevent the spread of pandemic influenza in the workplace (see Supplement 4) and employment issues related to illness, sick pay, staff rotation, and family concerns.
Healthcare institutions should be prepared to provide materials that address healthcare and training issues related to pandemic influenza (see S11-IV.B). To support these efforts, CDC, HRSA, NIH, and SAMHSA will collaborate with the Department of Homeland Security, other federal agencies, and nongovernmental organizations to identify or develop educational materials on:

- Stressors related to pandemic influenza
- Signs of distress
- Traumatic grief
- Psychosocial aspects related to management of mass fatalities
- Stress management and coping strategies
- Strategies for building and sustaining personal resilience
- Behavioral and psychological support resources
- Strategies for helping children and families in times of crisis
- Strategies for working with highly agitated patients

C. Developing workforce resilience programs

State and local health agencies should consider establishing workforce resilience programs that will help deployed workers prepare for, cope with, and recover from the social and psychological challenges of emergency field work. CDC has used this approach with staff members who participated in the tsunami relief effort in 2004-2005 and the Marburg hemorrhagic fever outbreak in Angola in 2005.

To prepare for implementation of workforce resilience programs to cope with the special challenges posed by an influenza pandemic, agencies should do the following:

- Plan for a long response (i.e., more than 1 year).
- Identify pre-deployment briefing materials.
- Augment employee assistance programs with social support services for the families of deployed workers (see S11-IV.C).
- Provide program administrators and counselors with information on:
  - Cognitive, physiological, behavioral, and emotional symptoms that might be exhibited by patients and their families (especially children), including symptoms that might indicate severe mental disturbance
  - Self-care in the field (i.e., actions to safeguard physical and emotional health and maintain a sense of control and self-efficacy)
  - Cultural (e.g., professional, educational, geographic, ethnic) differences that can affect communication
  - Potential impact of a pandemic on special populations (e.g., children, ethnic or cultural groups, the elderly).
A. Delivering psychosocial support services

Healthcare facilities and public health agencies—as well as companies and local governments that employ essential service providers—should make full use of public health techniques and communication tools that can help response workers manage emotional stress and family issues and build coping skills and resilience. These tools can include:

- Stress control/resilience teams. These teams can assist and support employees and foster cohesion and morale by:
  - Monitoring employee health and well-being (in collaboration with occupational health clinics, if possible)
  - Staffing “rest and recuperation sites” (see below)
  - Distributing informational materials (see S11-III.B).

  Stress control teams in hospitals should observe recommended infection control precautions.

- Rest and recuperation sites. Sites can be stocked with healthy snacks and relaxation materials (e.g., music, relaxation tapes, movies), as well as pamphlets or notices about workforce support services.

- Confidential telephone support lines staffed by behavioral health professionals

- Services for families. Services to families of employees who work in the field, work long hours, and/or remain in hospitals or other workplaces overnight might include:
  - Help with elder care and child care
  - Help with other issues related to the care or well-being of children
  - Provision of cell phone or wireless communication devices to allow regular communication among family members (see S11-III.B)
  - Provision of information via websites or hotlines
  - Access to expert advice and answers to questions about disease control measures and self care.

- Information for commuters. Workers might need alternative transportation and scheduling (e.g., carpooling, employer-provided private transportation, alternate work schedules during off-peak hours) to avoid exposure to large groups of potentially infected persons.

- Services provided by community- and faith-based organizations. Activities of these organizations can provide relaxation and comfort during trying and stressful times.

A list of additional resources is provided in Appendix 3.

B. Providing information to responders
   1. Healthcare providers
Healthcare providers—especially those who work in hospitals—are likely to be under extreme stress during a pandemic (see Box 3) and will have special needs for open lines of communication with employers and access to up-to-date information. Healthcare facilities should ensure that employees have ongoing access to information on the following:

- International, national, and local progress of the pandemic
- Work issues related to illness, sick pay, staff rotation, shift coverage, overtime pay, use of benefit time, transportation, and use of cell phones
- Family issues, especially availability of child care
- Healthcare issues such as availability of vaccines, antiviral drugs, and personal protective equipment (PPE); actions to address understaffing or depletion of PPE and medical supplies; infection control practices as conditions change; approaches to ensure patients’ adherence to medical and public health measures without causing undue anxiety or alarm; management of agitated or desperate persons; guidance on distinguishing between psychiatric disorders and common reactions to stress and trauma; management of those who fear they may be infected, but are not (so-called “worried well”); and guidance and psychosocial support for persons exposed to large numbers of influenza cases and deaths and to persons with unusual or disturbing disease symptoms.
- Because healthcare workers might be called upon to fill in for sick colleagues and perform unfamiliar tasks, healthcare facilities should consider providing written instructions for “just-in-time” cross training on essential tasks.

2. **Other occupational groups**

Other occupational groups that might participate in the response to pandemic influenza (including police, firefighters, and community outreach workers) should receive training materials that will help them anticipate behavioral reactions to public health measures such as movement restrictions (e.g., quarantine, isolation, closure of national or regional borders), especially if such actions are compounded by an economic crisis or abrupt loss of essential supplies and services.

3. **Stigmatization issues**

Healthcare workers and other emergency responders should be provided with information on what to do if they or their children or other family members experience stigmatization or discrimination because of their role in the pandemic influenza response. Hospital public affairs offices should be prepared to address these issues.
without delay.

C. **Implementing workforce resilience programs**

During an influenza pandemic, state and local health agencies should consider implementing workforce resilience programs that meet the special needs of deployed workers—including workers who do not change job site but whose assignments shift to respond to the pandemic—and the central operations personnel who support them around the clock. First-responder or nongovernmental organizations that send employees or volunteers to assist patients at home or in hospitals might establish similar programs. Workforce resilience programs could provide the following services:

0. **Predeployment/assignment**
   - Conduct briefings and training on behavioral health, resilience, stress management issues, and coping skills.
   - Train supervisors in strategies for maintaining a supportive work environment.

1. **During deployment/assignment**
   - To support responders in the field:
     - Deploy several persons as a team and/or assign “buddies” to maintain frequent contact and provide mutual help in coping with daily stresses.
     - Frequently monitor the occupational safety, health, and psychological well-being of deployed staff.
     - Provide access to activities that help reduce stress (e.g., rest, hot showers, nutritious snacks, light exercise).
     - Provide behavioral health services, as requested.
   - For central operations personnel:
     - Enlist stress control or resilience teams to monitor employees’ occupational safety, health, and psychological well-being (see S11-IV.A).
     - Establish rest and recuperation sites (see S11-IVA), and encourage their use.
     - Provide behavioral health services, as requested.
   - For families of responders:
     - Provide all of the services listed under “Services for Families” in S11-III.A (Note: Services for Families not listed in S11-III.A)
     - Enlist employee assistance programs to provide family members with instrumental support (e.g., assistance obtaining food and medicine) and psychosocial support (e.g., family support groups, bereavement counseling, and courses on resilience, coping skills, and stress management).
     - Provide a suggestion box for input via e-mail or anonymous voice-mail with a toll-free number.
     - Continue to provide outreach to employees’ families to address ongoing psychological and social issues.
Throughout the response, policies on personnel health and safety should be reviewed and revised, as needed.

2. **Post-deployment/assignment**
   - Interview responders and family members (including children) to assess lessons learned that might be applied to future emergency response efforts (see Box 4).
   - Provide ongoing access to post-emergency psychosocial support services for responders and their families (on-site or through partner organizations).
   - Conduct an ongoing evaluation of the after-effects of the pandemic on employees' health, morale, and productivity.

**Box 1. Psychosocial Issues for Response Workers**

Psychosocial issues that response workers might need to address include:

- Illness and death among colleagues and family members
- Fear of contagion and/or of transmitting disease to others
- Shock, numbness, confusion, or disbelief; extreme sadness, grief, anger, or guilt; exhaustion; frustration
- Sense of ineffectiveness and powerlessness
- Difficulty maintaining self-care activities (e.g., getting sufficient rest)
- Prolonged separation from family
- Concern about children and other family members
- Constant stress and pressure to keep performing
- Domestic pressures caused by school closures, disruptions in day care, or family illness
- Stress of working with sick or agitated persons and their families and/or with communities under quarantine restrictions
- Concern about receiving vaccines and/or antiviral drugs before other persons

These issues may be exacerbated by:

- Lack of information
- Rumors, misconceptions, or conspiracy theories
- Loss of faith in health institutions, employers, or government leaders
- Belief that medical resources are not available or fairly distributed
- Death of immediate supervisors or other leaders in the response effort
- Mass casualties and deaths among children
- Economic collapse or acute shortages of food, water, electricity, or other essential services
- Restrictions on civil liberties that are perceived to be inequitable
- Infection control procedures that limit personal contact or hinder communications

Psychosocial issues related to the general public are addressed in **Supplement 10**.
Box 2. Psychosocial Issues for Families of Response Workers

The families of responders will face many challenges in addition to the fears and disruptions that everyone will face during a pandemic. For example:

- Responders might be frustrated, tired, worried, irritable, argumentative, restless, emotional, or distressed.
- Responders might be impatient and less understanding, energetic, optimistic, good natured, or helpful than usual.
- Increased emergency work loads (which might be exacerbated by staffing shortages) can make it difficult for responders to communicate regularly with family members.
- Family members might experience stigmatization or discrimination.

Box 3. Impact of Pandemic Influenza on Healthcare Workers

In addition to the issues faced by all response workers (Box 1), healthcare workers may experience:

- Increased risk of exposure to pandemic influenza
- Constant need to take special precautions to avoid exposure to the pandemic virus
- Illness and death among patients, as well as among colleagues and family members
- Stigmatization and discrimination associated with being perceived as a source of contagion
- Ethical dilemmas, such as conflicts between one’s roles as healthcare provider and parent/spouse, or concern about receiving vaccines or antiviral drugs before other people
- Increased difficulty in performing crucial tasks and functions as the number of severely ill patients increases, the healthcare staff decreases, and medical and infection control resources are depleted
- Frustration regarding the need/expectation to maintain business as usual
- Physical isolation associated with use of infection control measures that limit interpersonal contact

Psychosocial issues related to hospital workers are also addressed in Supplement 3.

Box 4. Lessons Learned during the 2004-2005 Tsunami Relief Effort

- It is difficult to prepare responders for everything they might encounter.
- Even seasoned responders can face situations and issues that cause uneasiness and distress.
- It is not unusual for responders to be asked to work outside their areas of expertise.
- Concerns about family and friends rank high on responders’ lists of priorities.
- Timely, accurate, and candid information should be shared to facilitate decision-making.
- Self-help activities are essential to mission completion.
- Everything possible should be done to safeguard responders’ physical and emotional health.
- Responders do not need to face response challenges alone. They may share their experiences with buddies, teammates, family members, and colleagues.
- It is especially difficult for responders to maintain personal resilience when they
witness the deaths of children. Organizational differences among groups of responders and cultural differences between victims and responders can impede the timely and efficient provision of emergency services.

Appendix 1. Bibliography: Psychosocial Issues Related to Public Health Emergencies


Reissman DB, Klomp RW, Kent AT, Pfefferbaum B. Exploring psychological


Appendix 2. Checklist for Workforce Support Services/Resources

A. Checklist for Interpandemic and Pandemic Alert Periods

Include psychosocial issues in planning

- Incorporate psychosocial support services into emergency preparedness planning for an influenza pandemic.
- Coordinate with business, corporations and other private sector interests in planning for behavioral health response and consequences.
- Develop plans to prepare and support emergency service responders (e.g., police, fire, hospital emergency department staff, mortuary workers) during and following deployment.
o Prepare for a significant surge of individuals who fear they may be infected, but aren't, who may present at emergency departments or other healthcare locations, or contact health information hotlines.

o Develop a demographic picture of the community (e.g., ethnic, racial, and religious groups; most vulnerable; special needs; language minorities) and plan for how they might be reached in a disaster.

o Identify rest and recuperation sites for responders. These sites can be stocked with healthy snacks and relaxation materials (e.g., music, relaxation tapes, movies), as well as pamphlets or notices about workforce support services.

o Develop confidential telephone support lines to be staffed by behavioral health professionals.

o Use behavioral health expertise to develop public health messages, train staff on the psychological impact of the use of personal protective equipment (PPE), and conduct other relevant activities.

### Identify and access existing resources

- Work with community-based organizations and nongovernmental organizations to determine the types of psychological and social support services and training courses available in their jurisdictions.
- Establish public-sector links with private mental health resources such as Red Cross and other national voluntary organizations active in disasters.
- Develop a plan to manage offers of assistance and invited/uninvited volunteers.
- Identify gaps, such as culturally competent and multilingual providers, that might affect disaster services.

### Train behavioral health and related professionals in disaster response strategies

- Train behavioral health staff in hospitals, clinics, and related agencies in techniques to help people cope with grief, stress, exhaustion, anger, and fear during an emergency.
- Train nonbehavioral health professionals (e.g., primary-care clinicians, safety and security personnel, community leaders, and staff of cultural- and faith-based organizations) in basic psychological support services.
- Establish links to health and medical entities for purposes of assisting in screening potential victims for mental disorders and psychogenic symptomatology, functional impairment, substance abuse, etc.

### Develop resources and materials

- Prepare educational and training materials on psychosocial issues for distribution to workers during an influenza pandemic.
B. Checklist for Pandemic Period

**During the first 4 weeks**

- Meet basic needs such as food, shelter, and clothing.
- Provide basic psychological support (psychological first aid).
- Provide needs assessments.
- Monitor the recovery environment (conducting surveillance).
- Provide outreach and information dissemination.
- Provide technical assistance, consultation, and training.
- Foster resilience, coping, and recovery.
- Provide triage.
- Provide treatment.
- Provide psychological and social support services for employees and their families.
- Address stigmatization issues that might be associated with participation in such services.
- Implement workforce resilience programs.
- Work with communications experts to shape messages that reduce the psychological impact of the pandemic.
- Provide medical, public health, and community partners with educational and training materials.

**During subsequent weeks**

- Provide continued outreach, triage, and services.
- Monitor workforce for signs of chronic or severe psychological distress.
- Provide assistance in reintegration for workers who were deployed or isolated from work and family.

**Appendix 3. Psychological First Aid for Emergency Responders**

Along with increased efforts to institutionalize workforce services that support the emotional well-being of responders—both during and after an emergency—a consensus is growing on the usefulness of a set of psychosocial tools and techniques for providing “psychological first aid.” The organizations listed below provide information for those interested in learning more about this topic.

- American Psychiatric Association
- American Psychological Association (APA) Help Center
  [http://www.apahelpcenter.org](http://www.apahelpcenter.org)
- Disaster Epidemiology Emergency Preparedness (DEEP) Center, University of Miami Miller School of Medicine
  [www.deep.med.miami.edu](http://www.deep.med.miami.edu)
- National Center for PTSD, Department of Veterans’ Affairs
  [www.ncptsd.va.gov/](http://www.ncptsd.va.gov/)
- National Child Traumatic Stress Network
Resources from HHS agencies include:

- CDC/American Red Cross. Maintaining a healthy state of mind

- National Institute of Mental Health (NIMH/NIH/HHS)

- Substance Abuse and Mental Health Services Administration (SAMSHA/HHS)
  Disaster Readiness and Response
  [www.samhsa.gov/Matrix/matrix_disaster.aspx](http://www.samhsa.gov/Matrix/matrix_disaster.aspx)

- Disaster Technical Assistance Center. Research listings and fact sheets on self-care
  [www.mentalhealth.samhsa.gov/dtac/Selfcare.asp](http://www.mentalhealth.samhsa.gov/dtac/Selfcare.asp)

- Center for Mental Health Services

Background papers from an International Conference on Stigma and Global Health: Developing a Research Agenda (2001September 5-7; Bethesda, Maryland) are available at [http://www.stigmaconference.nih.gov/papers.html](http://www.stigmaconference.nih.gov/papers.html).

Last revised: November 11, 2005
Appendix 6
HHS Family Planning Guide and Checklist

Click to access:

Pandemic Influenza Planning: A Guide for Individuals and Families

http://www.pandemicflu.gov/plan/individual/familyguide.html
Appendix 7
HHS Medical Office Pandemic Planning Checklist

Click to access:

Medical Offices and Clinics Pandemic Influenza Planning Checklist

http://www.pandemicflu.gov/plan/healthcare/medical.html
Appendix 8
Signs and Locations of Signage and Security Measures for Facility Security and Access Plan

- To direct everyone, including patients and employees, to the ________________ entrance during Pandemic Influenza by ________________ (ex: Community Relations Department). Store signs ________________.

Develop and produce signs instructing all patients to let the Triage Nurse know if they have Influenza-like Illness.

Lock-down and post security at the entrance to the emergency department. Put up sign directing all patients to the ______________________________ Entrance.

Develop and produce signs directing all employees to use ________________Hospital Entrance.

All employees and medical staff: Use the Main Hospital Entrance for entry and exit for all shifts and work
• Coordinate with Communications Team to notify employees via email and intranet to use the Main Hospital Entrance to enter and leave building.
• Lock all entrances as needed. Station Security or other staff to respond to questions and ensure that no one enters through this rear entrance. Put up sign to redirect employees to the ______________ Hospital Entrance.
• Have security and triage personnel screen and record employees with influenza symptoms and send home if present, unless they need further medical attention.
• Distribute dated wristbands for employees who are okay to work after they have been triaged.
• Define essential and non-essential visitors and determine how security personnel may be used to enforce and maintain access controls, if needed.
• Define methods for verifying identification of staff and visitors.
• Define essential and non-essential visitors with regard to the hospital and the population served, including protocols for limiting non-essential visitors.
• Local law enforcement should be provided with information on the hospital security plan.
• Indications and roles for providing assistance should be worked out in advance.
• Hospitals and other health care facilities should anticipate that local law enforcement might be overburdened during a pandemic and therefore will have limited ability to assist with security services.
• Consider plans for having staff act as additional security personnel. This may be required given the increased demand for services, the possibility of long wait times for care, and because triage or treatment decisions may not be in agreement with patient or family expectations (e.g., if antiviral use is limited to those in priority groups).
Appendix 9
Triage Plan

1. Develop a strategy for triage, diagnosis, and isolation of possible pandemic influenza patients. Consider the following triage mechanisms:

   - Use phone triage to identify patients who need emergency care and those who can be referred to a medical office or other non-urgent facility;
   - Assign separate waiting areas for persons with respiratory symptoms;
   - Assign a separate triage evaluation area for persons with respiratory symptoms; and/or
   - Assign a “triage coordinator” to manage patient flow, including deferring or referring patients who do not require emergency care.

2. Review procedures for the clinical evaluation of patients in the emergency department and in outpatient medical offices to facilitate efficient and appropriate disposition of patients. (Use Appendix 7 and Appendix 8 to facilitate this screening.)

3. Review admission procedures and streamline them as needed to limit the number of patient encounters in the hospital (e.g., direct admission to an inpatient bed).

4. Working closely with local public health district, identify a “trigger” point at which screening for signs and symptoms of pandemic influenza in all persons entering the hospital will escalate from passive (e.g., signs at the entrance) to active (e.g., direct questioning). In addition to visual alerts, potential screening measures might include priority triage of persons with respiratory symptoms and telephone screening of patients with appointments.

5. Identify alternate care areas in existing facilities such as main lobby waiting area, outpatient department, etc. (May be called the “alternate care site plan.”)

6. Identify and train staff from other parts of the hospital to assist with triage.

7. Recruit volunteers, retired doctors and nurses, etc and develop training for these volunteers to increase triage staff in the event of a large outbreak, such as pandemic influenza.

8. Incorporate procedures to put into place in the event there is a need to cancel elective admissions and open closed patient care areas.
Footnotes to Figure 1:

1. Further evaluation and diagnostic testing should also be considered for outpatients with strong epidemiological risk factors and mild or moderate illness.

2. Updated information on areas where novel influenza virus transmission is suspected or documented is available on the WHO website.

3. For persons who live in or visit affected areas, close contact includes touching live poultry (well-appearing, sick or dead) or touching or consuming uncooked poultry products, including blood. For animal or market workers, it includes touching surfaces contaminated with bird feces. In recent years, most instances of human infection with a novel influenza A virus having pandemic potential, including influenza A (H5N1), are thought to have occurred through direct transmission from domestic poultry. A small number of cases are also thought to have occurred through limited person-to-person transmission or consumption of uncooked
poultry products. Transmission of novel influenza viruses from other infected animal populations or by contact with fecal contaminated surfaces remains a possibility. These guidelines will be updated as needed if alternate sources of novel influenza viruses are suspected or confirmed.

4. Close contact includes direct physical contact, or approach within 3 feet of a person with suspected or confirmed novel influenza.

5. Standard and Droplet Precautions. 

6. Hospitalization should be based on all clinical factors, including the potential for infectiousness and the ability to practice adequate infection control. If hospitalization is not clinically warranted, and treatment and infection control is feasible in the home, the patient may be managed as an outpatient. The patient and his or her household should be provided with Home Quarantine and Self-Help information. The patient and close contacts should be monitored for illness by local public health department staff.

7. Report suspected cases of novel influenza to the CDC.

8. The general work-up should be guided by clinical indications. Initial diagnostic testing is performed based upon recommendations of health authorities within the state or Centers for Disease Control and Prevention. Depending on the clinical presentation and the patient’s underlying health status, initial diagnostic testing might include:

- Pulse oximetry
- Chest radiograph
- Complete blood count (CBC) with differential
- Blood cultures
- Sputum (in adults), tracheal aspirate, pleural effusion aspirate (if pleural effusion is present) Gram stain and culture
- Antibiotic susceptibility testing (encouraged for all bacterial isolates)
- Multivalent immunofluorescent antibody testing or PCR of nasopharyngeal aspirates or swabs for common viral respiratory pathogens, such as influenza A and B, adenovirus, parainfluenza viruses, and respiratory syncytial virus, particularly in children
- In adults with radiographic evidence of pneumonia, Legionella and pneumococcal urinary antigen testing
- If clinicians have access to rapid and reliable testing (e.g., PCR) for M. pneumoniae and C. pneumoniae, adults and children <5 yrs. with radiographic pneumonia should be tested.
- Comprehensive serum chemistry panel, if metabolic derangement or other end organ involvement, such as liver or renal failure, is suspected.
Appendix 11
Clinical Guidelines for Phase 2, 3, 4, 5, and 6

Footnotes to Figure 2:
1. Antiviral therapy and isolation precautions for pandemic influenza should be discontinued on the basis of an alternative diagnosis only when both the following criteria are met:
   - Alternative diagnosis confirmed using a test with a high positive-predictive value, and
   - Clinical manifestations entirely explained by the alternative diagnosis
2. Standard and Droplet Precautions.
3. See guidance from the state on laboratory testing during the Pandemic Period. Generally, specimens should include respiratory samples (e.g., nasopharyngeal wash/aspirate; nasopharyngeal, nasal or oropharyngeal swabs, or tracheal aspirates) stored at 4°C in viral
transport media. Routine laboratory confirmation of clinical diagnoses will be unnecessary as pandemic activity becomes widespread in a community. CDC will continue to work with state health laboratories to conduct virologic surveillance to monitor antigenic changes and antiviral resistance in the pandemic virus strains throughout the Pandemic Period.

4. The decision to hospitalize should be based on a clinical assessment of the patient and the availability of hospital beds and personnel.

5. Guidelines on cohorting can be found in Facility Access, Triage, and Admission Plan. Laboratory confirmation of influenza infection is recommended when possible before cohorting patients.

6. The general work-up should be guided by clinical indications. Depending on the clinical presentation and the patient’s underlying health status, initial diagnostic testing might include:
   - Pulse oximetry
   - Chest radiograph
   - Complete blood count (CBC) with differential
   - Blood cultures
   - Sputum (in adults) or tracheal aspirate Gram stain and culture
   - Antibiotic susceptibility testing (encouraged for all bacterial isolates)
   - Multivalent immunofluorescent antibody testing of nasopharyngeal aspirates or swabs for common viral respiratory pathogens, such as influenza A and B, adenovirus, parainfluenza viruses, and respiratory syncytial virus, particularly in children
   - In adults with radiographic evidence of pneumonia, Legionella and pneumococcal urinary antigen testing.
   - If clinicians have access to rapid and reliable testing (e.g., PCR) for M. pneumoniae and C. pneumoniae, adults and children <5 yrs. with radiographic pneumonia should be tested.
   - Comprehensive serum chemistry panel, if metabolic derangement or other end-organ involvement, such as liver or renal failure, is suspected.

7. Strategies for the use of antiviral drugs are provided in Pandemic Influenza Medication Plan.

8. Guidance on the reporting of pandemic influenza cases is provided in Surveillance Plan.

9. Patients with mild disease should be provided with FCHN home-care kits, including standardized instructions on home management of fever and dehydration, pain relief, and recognition of deterioration in status. Patients should also receive information on infection control measures to follow at home. Patients cared for at home should be separated from other household members as much as possible. All household members should carefully follow recommendations for hand hygiene, and tissues used by the ill patient should be placed in a bag and disposed of with other household waste. Infection within the household may be minimized if a primary caregiver is designated; ideally, someone who does not have an underlying condition that places them at increased risk of severe influenza disease. Although no studies have assessed the use of masks at home to decrease the spread of infection, using a surgical or procedure mask by the patient or caregiver during interactions may be beneficial.

10. Separation of eating utensils for use by a patient with influenza is not necessary, as long as they are washed with warm water and soap.
Appendix 12
Employee Log

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<th>Draggy</th>
<th>Travel History</th>
<th>Dept./Ext.</th>
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Appendix 13

“Fit For Work” Guidelines

Ideally, health care workers (HCW) are fit to work when one of the following conditions apply:

- They have recovered from pandemic flu, during earlier phases of the pandemic; or
- They have been immunized against the pandemic strain of influenza as outlined in Pandemic Influenza Medication Plan; or
- They are on appropriate antivirals as outlined in the Medication Plan.

1) Such HCWs may work with all patients and may be selected to work in units where there are patients who, if infected with influenza, would be at high risk for complications.

2) Whenever possible, well, unexposed HCWs should work in non-influenza areas.

3) Asymptomatic HCWs may work even if influenza vaccine and antivirals are unavailable.

4) Meticulous attention should be paid to hand hygiene and HCWs should avoid touching mucous membranes of the eye and mouth to prevent exposure to the influenza virus and other infective organisms.

5) Ideally, staff with Influenza-like Illness (ILI) should be considered “unfit for work” and should not work. However, in cases of extremely limited resources, HCWs may be asked to work if they are well enough to do so and must follow these guidelines:
   - Such Health Care Workers must work with non-exposed patients (non-influenza areas) and should be required to wear a mask if they are coughing.
   - They must pay meticulous attention to hand hygiene.
   - They should not be redeployed to intensive care areas, nursery or an area with severely immunocompromised patients, i.e. transplant recipients, hematology/oncology patients, patients with chronic heart or lung disease, or patients with HIV/AIDS and dialysis patients.
Appendix 14
Priority Group

Click to access:

HHS Pandemic Influenza Plan - Appendix D: NVAC/ACIP Recommendations for Prioritization of Pandemic Influenza Vaccine and NVAC Recommendations on Pandemic Antiviral Drug Use

http://www.hhs.gov/pandemicflu/plan/appendixd.html
Appendix 15

STANDING ORDER FOR SEASONAL INFLUENZA VACCINE

Policy:
Patients with no contraindications will be allowed to have the annual Influenza vaccine.

Warnings/Contraindications:
1. History of allergies to egg products or previous Influenza vaccinations.
2. Pregnant patients in their first trimester should consult their doctor first.
3. History of Guillian Barre Syndrome.

Procedure:
1. Patients will be asked about contraindications and those with confirmed contraindications will be referred to their family provider for advice on receiving the Influenza vaccine.
2. Those without contraindications will be given the most current CDC Vaccine Information Sheet (VIS) and asked to sign the consent form.
3. The immunization will be given 0.5ml IM in one of the deltoid regions.
4. Patients will be observed for 15 minutes before leaving.
5. EpiPen 0.3mg auto-injector IM, prn anaphylaxis with immediate provider evaluation.
6. Acetaminophen is recommended for soreness at the site of administration or for a low-grade fever after receiving the vaccine.

As Medical Director (or designee) of _____________________________ Hospital, I hereby authorize the Employee Health Nurse/ designee, to administer the above vaccine according to the above policy and procedure.

__________________________________________________________
Medical Director/Designee Signature Date
Appendix 16
Vaccine Consent Example

Seasonal Influenza Vaccine

Name: ______________________________  Employer: ______________________________

SSN: ______________________________  DOB: ______________________________

HISTORY:

1. Have you ever received an influenza vaccination in the past?  YES  NO
   - If yes, did you have any problems?  YES  NO
   - If yes, what kind of problems? _______________________

2. Do you have an allergy to egg products?  YES  NO

3. Is there a possibility of pregnancy?  YES  NO

4. Are you suffering from any cold or flu symptoms currently?  YES  NO
   - If yes, what symptoms? _______________________

5. Have you ever had Guillain Barre Syndrome?  YES  NO

CONSENT FOR VACCINATION:

I have been provided with the most current CDC Vaccination Information Sheet (VIS) that explains the benefits and risks of receiving influenza vaccination. As with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine, or a mild case of flu-like symptoms. I request that the vaccine be given to me.

SIGNATURE: ______________________________  DATE: _______________________

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<tr>
<th>Date</th>
<th>Manufacturer</th>
<th>Lot #</th>
<th>Exp. Date</th>
<th>Inject Site</th>
<th>Dose 0.5 mL</th>
<th>Provider Signature</th>
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February 20, 2007
Appendix 17
HHS Pandemic Influenza Plan Supplement 3 Healthcare Planning

Click to access:

HHS Pandemic Influenza Plan - Supplement 3 Healthcare Planning

http://www.hhs.gov/pandemicflu/plan/sup3.html
Appendix 18
Arkansas Pandemic Influenza Response Standard Operating Guide

Click to access:
Arkansas Pandemic Influenza Response Standard Operating Guide

http://www.healthyarkansas.com/pandemic_influenza/pandemic_influenza_plan.pdf?cf0A000235=F8F53D8C!QkFQVEITVEhFQUxUSFx1MjY2NTpiYXBoXN0bnRsbTrwejUs6kom7T6ODRcH3x64

(148 page document)
Appendix 19
Additional Resources

World Health Organization Pandemic Flu Information and Updates

HHS Pandemic Flu site and HHS Pandemic Flu Planning


Interim Guidance on Planning for the Use of Surgical Masks and Respirators in Health Care Settings during an Influenza Pandemic

CDC Resources:
Weekly Flu Activity Update
FluSurge Software Estimate the potential impact of a pandemic on resources such as staff beds.

Avian Influenza resources for Health Professionals

Examples of other state/local plans:
Tennessee State Plan

New York City Department of Health and Mental Hygiene. NYC DOHMH Pandemic Influenza Preparedness and Response Plan. July 2006 (includes FAQ about avian flu in Spanish, Chinese and Russian)
Appendix 20  
Key Points of Contact

Local / Regional Offices

County or Local Health Unit ______________________
County Coroner ______________________
Local EMS Provider ______________________
Local Police Department ______________________
Local Fire Department ______________________
County Sheriff ______________________

County / Regional Utilities:
Power (Electricity & Gas) ______________________
Water ______________________
Sanitation ______________________

Municipal / County Public Works ______________________
County Judge ______________________
Local Mayor ______________________
Regional Hospital Leadership ______________________

State Offices

Arkansas Department of Health (DOH) ______________________
Department of Emergency Management (ADEM) ______________________
Department of Environmental Quality (ADEQ) ______________________
National Guard ______________________

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Federal Offices

Centers for Disease Control (CDC) ______________________

Department of Health & Human Services (DHHS) ______________________

Department of Homeland Security / FEMA Region VI Offices (Texas) ______________________

Department of Transportation (DOT) ______________________

FBI ______________________

Nongovernmental Organizations (NGOs)

RACES (Ham Radio Operators) ______________________

American Red Cross ______________________

Salvation Army ______________________

Local Funeral Home Directors ______________________

Local Key suppliers & distributors (Food, hardware, durable goods) ______________________

Local Television, Radio, & Newspapers ______________________

Private Security Firms ______________________

Local PRN Staffing Firms ______________________

Area Schools ______________________
Appendix 21

Questions / issues that came up that should be addressed but NOT part of the hospital template.

Inter-agency Coordination

- Hospitals coordinate efforts through county OEM’s, which in turn, will coordinate with county and state health agencies and ADEM. Special events, such as communicable diseases, would require hospitals to correspond directly with county and Arkansas Department of Health.

- EMS participation within most regions is sporadic.

- Many hospitals are actively meeting with the county Local Emergency Planning Committee (LEPCs). One region requires hospitals within their region to be members of and actively participate in their county LEPC.

- Hospitals need to have access to critical data that is reported “up” to determine real time potential spread of communicable diseases. Hospitals need to develop a standardized protocol for reporting diseases to assure consistent reported data across the state.

- While the HAN messaging system is a good path for information but is not particularly good for emergency messaging after hours, weekends, or holidays. It was suggested that we need several methods of communication which are developed by all stakeholders rather than one group. EMSystems and faxing hospital EDs appeared to meet the needs of the group. Also, how do local health offices report up to the central office and send out notices and alerts.

- Vaccines/antiviral drugs will be picked up by hospitals when notified by the DOH in the event of an epi/pandemic. Hospitals must notify DOH who will pick up the drugs and must bring security personnel. DOH is drafting a plan which will require each hospital to sign a MOU.

EMSystems

- Existing system purchased by DOH for bed tracking and should be used on a frequent (weekly) basis. DOH will be visiting hospitals, beginning January 2007, to assure EMSystems is functioning as well as the Tandberg unit.

- DOH is looking into a patient tracking module to add to the system.
Legal/Authority Questions

- Quarantine
  - Statewide definition and law (see Arkansas Influenza Plan page 107)

- Altered standards of care
  - Good Samaritan coverage
  - Patient staffing ratios increase
  - Different disciplines to do other things (a license person delegates orders to non-licensed persons or student to maintain an altered patient standard of care)
  - Surge increase over the number of licensed beds in a facility with emphasis on cohorting
  - Allowing an increased number of beds in particular rooms

- Regulatory and ethical issues
  - Indemnification of hospitals and healthcare workers during a declared emergency
  - When can a hospital deny care or close down
  - Review and use pending VA Plan with DOH adoption

- Declaration of state of emergency
  - Protection and authority of roadways (who controls and network)
  - Emergency equipment and supplies conveyance
  - Healthcare workers allowed through checkpoints with drivers license and hospital ID badge

- Professional healthcare students/community volunteers (nursing, medical, pharmacy, respiratory)

From the Nursing discipline – Professional Standards

Altered standards of care

- Validation through the state board. What could nursing students do:
  - Dispensing medication
  - Administration of medication

- Develop standardized protocols for antiviral drugs

- Each facility develop a plan how they will assess competencies of students, RN’s, LPN’s, etc.

- Telephone triage with protocols to direct appropriate patient care

Arkansas Department of Health

- Who, what, when, where, how to declare a state of emergency

- EMTALA regulations during an emergency

- Public communication as to self family protection

- Meals Ready to Eat (MRE’s) for patients and staff
Surge capacity
  • Visiting guidelines
  • Non bedside nurses will be doing bedside care
  • Identify all areas for patient care

Action triggers
  • Human to human spread – outside the U.S.
    o Competency plans for students
  • Human to human spread – inside the U.S.
  • Human to human spread – Arkansas

Appendices
  • Checklist for supplies and equipment