CMH

Emerging Infectious Disease Pandemic Plan

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This plan is applicable to the entire hospital, including the skilled nursing floors.

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Original Date	Review	Revision	Name	Signature
8-4-20	8/26/20		Norma Kerling, CEO/CCO	
		9/10/20	N. Kerling	

Purpose Statement and Goals

The purpose of this plan is to reduce the risk of transmission of an emerging or novel infectious disease to health care workers, patients, volunteers and others.

This Emerging Infectious Plan is meant to augment, not replace, the *Pandemic Flu Annex* that the facility has had in place since the 2009 H1N1 Outbreak. This has been developed to effectively mitigate, prepare, respond and recover from novel influenza episodes other biological and special pathogens in the community. Reducing the incidence of transmission of an emerging or novel infectious disease to staff, patients, and the community will depend on early diagnosis, isolation, treatment and transmission prevention measures.

Pandemic planning assumptions have been based on the World Health Organization (WHO) and CDC Pandemic Phases that describe an escalating epidemiologic disease process that correlates to threat and impact levels.

Organization and Responsibility

As a part of our ongoing programs for infection prevention & control, employee health and emergency management, Cuba Memorial Hospital, Inc. conducts a number of mitigation and preparedness activities in readiness for a biological incident. The facility:

- Conducts routine syndromic surveillance activities, including ongoing participation in the NYSDOH Electronic Syndromic Surveillance Program
- Conduct surveillance for influenza-like-illness; monitoring and reporting trends and increases in numbers to their respective Local Health Department (LHD)
- Maintain ongoing communications with, and procedures for collaborating with, local and state public health departments
- Ensure staff implements and communicate appropriate infection prevention precautions in a timely manner
- Utilization and monitoring of personal protective equipment (PPE) following standard and transmission based precautions
- Have a process for safely packaging, identifying and transferring lab specimens to external testing sites, including state and federal labs
- Drills and exercises are conducted periodically to assess the level of staff preparedness for educational and improvement opportunities.

Responsibilities

The CEO has delegated authority through an Incident Command structure to take immediate and appropriate action in the event of an emergency where there is a potential danger, which poses risk or threat to life, personal injury or damage to property.

The Emergency Preparedness RN Manager is designated as the Incident Coordinator for the hospital through the Education/Emergency Preparedness Program:
- Will be responsible for ensuring that the orientation and annual reorientation of employees is consistent with best practice recommendations, current threat assessments, and hospital needs

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- Will coordinate training activities and opportunities with the HR Department and department managers who provide in-service education for staff.

The Education/EP Manager shall identify staff members to attend external training programs on emerging infectious disease topics. This is a key element in expanding the staff knowledge base and developing facility exposure to external "best practices." Infection Preventionist and Employee Health Staff attending educational programs will report out at a Safety Committee, Quality Assurance or other appropriate Committee meeting.

During periods of increased concern about a specific emerging infectious disease, the Facility will implement enhanced surveillance measures. The Education/EP and QA/IP Manager will:

- Assemble and brief the Executive Leadership/Management Team
- Based on information provided by the county or state health department and/or the CDC, review the established case definition
- Establish with all patient reception/entry areas, including direct patient transfers from other facilities//direct admits; their surveillance responsibilities and ensure that they are aware of the heightened concern level
- Implement control measures including those accompanying the patient if needed (i.e.- masks or other PPE)
- Implement hospital surveillance for the case definition with incoming and already admitted patients.
- Test patients and employees and report cases per the criteria established by the county or state health department and/or the CDC.

Incident Management:

Surveillance:

Once an incident has been identified and employees or others have had contact with suspected or actual case patients, surveillance of the potentially exposed people will be conducted. Surveillance will be critical to identifying people that are symptomatic for disease and need to be excluded from work or isolated. Employee Health may use a variety of systems (phone triage, face-to-face temperature screening, etc.) at the discretion of the Infection Prevention Program in accordance with Health Department guidance.

Case Definition of Contact

The definition of a contact will be developed by the Local Health Department (LHD), NYSDOH, and/or CDC, and will be based on available information of the circulating pathogen. Infection Prevention will educate providers on the case definition and risk assess exposure. Infection Prevention in conjunction with employee health, nursing and ancillary department heads will develop a line list of possible exposures. Further mitigation will be based on results of testing and monitoring.

Staff will be required to follow appropriate transmission based precautions to prevent exposure to the pathogen by utilizing appropriate PPE. As directed by the LHD and/or Employee Health. Staff may be removed from work if they are symptomatic or meet exposure case definition.

The primary goal is to identify, isolate and inform followed by treatment of a person(s) with diagnosed or suspected pathogen. The plan will be reviewed and updated based on changes from regulatory agencies and epidemiologic information available. This policy is developed through the Safety Committee. This plan will be implemented through the Incident Commander and the Infection Prevention RN, following the Incident Command structure outlined in the Emergency Management plan.

Case Classification:

1. **Clinical Criteria is based on the pathogen and current case definition:**

   Patient may present with respiratory illness symptoms that can include:
   a. Fever
   b. Cough
   c. Sore Throat
   d. Muscle Aches/Pain
   e. Headache
   f. Rash
   g. Loss of smell and/or taste
   h. Abdominal cramping/diarrheal illness
   i. Nausea/vomiting

2. **Epidemiologic Criteria**

Depending on the world situation, screening patients for travel may be required. Duration of symptoms and potential exposure contacts will need to be evaluated based on epidemiology of international disease and local Health Department guidance. The strain of influenza/respiratory pathogen will dictate the appropriate testing etiology to pursue. Rapid flu tests and specific tests can be utilized if there is suspicion of specific strains. Syndromic surveillance information should be evaluated to determine the extent of respiratory illness and to detect trends of increasing prevalence in the region. The Urgent Care Center participates in NYSDOH syndromic surveillance through reporting data as defined by NYSDOH.

Surveillance and Triage

1. Staff should have a high level of suspicion when approaching a patient with respiratory symptoms and ask the appropriate triage questions.
2. All patients who present with respiratory symptoms should immediately be given procedure mask and be screened for respiratory viral panel.
3. Patient should immediately be placed on transmission-based precautions or cohorted to a designated waiting area in a surge situation.
4. Any person accompanying the patient should also be given a mask and should stay with the patient.
5. Look beyond the patient at contacts who may be infectious as well. Assess whether members of immediate family/close contacts are ill with similar symptoms.
6. The Lock Down policy is implemented to control the entry points of patients, families and visitors when there is a surge of potential patients with respiratory symptoms. The Incident Commander or Infection Prevention RN can decide to implement this control measure. Triage

may be moved to an alternate location on the campus than the Urgent Care Center to prevent contamination of the Urgent Care.

Triage Questions

Screen patients with suspect respiratory symptoms for current case definition or:
- Travel history before illness onset, or close contact with another ill person(s).
- Employment as a healthcare worker with direct patient contact.

OR

- Close contact with person(s) recently diagnosed with a respiratory illness.
    1. If yes to any of these questions, place a procedure mask on the patient.
    2. Arrange for immediate disposition to an isolation room if available or a private room with the door closed and procedure mask on the patient. (In a surge situation cohorting with other patients with the same diagnosis may be necessary. If so, seek approval with the Infection Prevention RN).
    3. Place appropriate transmission-based precaution sign on the door.
    4. If there is any delay in placing the patient in an appropriate room, the patient should not be sent to the waiting room or group areas unless the patient is compliant in wearing a procedure mask continuously.
    5. In a pandemic situation, the surge plan will be implemented with identification of designated waiting areas and patient holding locations to prevent disease transmission. The surge plan is reviewed annually to address facility changes and space allocation.
    6. If there is a large influx of "worried well" the Disaster Mental Health Team will be deployed to assist with management of patients at an alternate location and provide education on the signs and symptoms of the illness and prevention strategies.

The goal must be to process these patients rapidly, while limiting/avoiding contact between ill individuals and other patients. Staff must utilize appropriate PPE for protection.

Control Measures

1. **Airborne Transmission Based Precautions includes:**

    a. Private Room
    b. Respiratory protection: Patients and Visitors should wear procedure mask.
    c. Employees should wear N-95 or Purified Air Powered Respirator (PAPR) or procedure mask based on current CDC guidance.
    d. Eye protection or face shield may be required.
    e. Gowns and gloves are required.
    f. Do not transport the patient, unless it is essential. The patient wears isolation procedure mask based on current CDC guidance. Notify the receiving department of any precautions required.
    g. The transmission-based precaution sign should be placed at the room entrance.
    h. Hand hygiene must be performed before donning and after doffing PPE.
    i. Disposable dedicated equipment should be used if possible.

2. **Droplet Transmission Based Precautions include:**

   a. The use of procedure masks for everyone entering the room.
   b. Disposable dedicated equipment should be used if possible.
   c. Do not transport the patient, unless it is essential.
   d. The transmission-based precautions sign should be placed at the room entrance.
   e. Hand hygiene must be performed before donning and after doffing PPE.

3. **Contact Transmission Based Precautions include:**

   a. The use of gowns and gloves upon entry to the room.
   b. Disposable dedicated equipment should be used if possible.
   c. Do not transport the patient, unless it is essential.
   d. The transmission-based precautions sign will be placed at the room entrance.
   e. Hand hygiene must be performed before donning and after doffing PPE.

4. **Eye protection and N95 respirators** are to be worn while caring for the patient when engaged in any **aerosol generating procedures.**

5. **Standard Precautions always apply.**

6. **Hand Hygiene** is required with every patient encounter and performed in between procedures.

7. **Reusable and shared equipment** must use with hospital approved disinfectant following instruction for use and dwell times.

8. **Psychological Distress**

Staff should recognize that people present with medically unsubstantiated signs and symptoms of disease exposure, or extreme emotional distress from fear of exposure. Clearly, patients exposed to influenza and respiratory pathogens will not be immediately sickened. Therefore, consideration should be given to the need for managing large numbers of "worried well" patients arriving for screening or assessment following a potential exposure.

9. **Recognizing and managing a surge of patients with Respiratory Illness**

The key to rapid intervention and prevention is to maintain a high level of vigilance. The early clinical symptoms of diseases may be mild. The principles of epidemiology should be used to distinguish cases of a disease currently circulating in the community from other diagnoses. Any person with a presentation of symptoms: fever, cough, respiratory distress, a suspected influenza like illness or respiratory pathogen must be considered.

The CEO, LNHA and the Infection Prevention RN should be notified immediately if there is concern of a trend of influenza like illness identified. The Infection Prevention RN will notify

the Local Health Department. The UCC P.A. Manager will review potential cases and assist with reporting to the Local County Health Department and State Health Department.

Patient placement issues will be addressed by the Infection Prevention RN when there is a surge of patients beyond the facility's capacity for isolation rooms. Maintenance Staff will collaborate with the Education/EP Manager to assist with ventilation restriction issues and the Infection Prevention RN can designate specific zones to be delegated as Respiratory Pathogen Surge Zones.

10. Personal Protective Equipment:

When leaving the isolation room, use care when removing the PPE to avoid self-contamination. Remove the PPE in the anteroom, if available. If an anteroom is not available, remove the PPE at the door, away from the patient, just before exiting.

Order of PPE Removal

a. Gloves
b. Gown
c. Goggles or Face Shield Mask or Respirator (N95 or PAPR extended use criteria may be required)
d. Hand Hygiene immediately after removal of PPE. If there is any chance you may have contaminated your hands in the process of any step of PPE removal, please perform hand hygiene prior to the next step.

11. Aerosol-Generating Procedures:

Should be performed with extreme caution and only when proper PPE is worn. Patients who may potentially have a respiratory pathogen should only have medically necessary procedures. Aerosol-generating procedures may facilitate transmission of the respiratory pathogen. Procedures that induce coughing can increase the likelihood of droplet nuclei being expelled into the air. Commonly performed medical procedures that are often considered AGP's, or that create uncontrolled respiratory secretions, include:

- Open suctioning of airways
- Sputum induction
- Cardiopulmonary resuscitation
- Endotracheal intubation and extubation
- Non-invasive ventilation (e.g., BiPAP, CPAP)
- Manual ventilation

Based on limited available data, it is uncertain whether aerosols generated from some procedures May be infectious, such as:
- Nebulizer administration
- High flow O2 delivery

**Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure or due to increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected patients.

For this reason, healthcare personnel should ensure that patients have been evaluated for respiratory pathogens before initiation of aerosol-generating procedures. Evaluation for respiratory pathogens should be based on the most recent case definition available for as defined by CDC or NYSDOH. These procedures should be performed **using airborne precautions**.

When aerosol-generating procedures are performed:

- The number of personnel in the room should be limited to essential staff.
- Standard precautions, (e.g. hand hygiene, gloves, gowns and eye protection) with airborne (e.g. respiratory protective devices with a filter efficiency of greater than or equal to 95%) precautions should be applied.
- Respirator fit check must be assessed each time an N-95 is worn.

12. Cleaning:

Personnel involved in cleaning and disinfection activities should wear appropriate protective attire as is required for transmission-based precautions (gown, gloves and mask etc.). Inpatient rooms should be cleaned and disinfected daily and at the time of patient transfer or discharge.
High touch surfaces must be cleaned daily. Refer to Housekeeping policies.

13. Discontinuing Isolation/Transmission-Based Precautions:

Once a diagnosis has been made the patient will remain in transmission-based precautions based on the CDC recommendations utilizing disease specific criteria. The Infection Prevention RN must be contacted to approve discontinuation of precautions.

14. Transporting The Patient:

Care should be taken when transporting the patient to any room or assigned department. **Notify the department receiving the patient prior to the transfer.** The patient should wear a mask during transport. The patient should be transferred with the minimal number of Staff. Elevators and hallways should be cleared of other people (patients, visitors, employees etc.). The patient should not be placed in waiting rooms or corridors.

<u>Potential Patient Scenario Management Guidelines</u>

A. Patient arrival is anticipated or discovered prior to entry into the Hospital.

The following potential scenarios could provide advance warning if a patient is arriving with influenza like illness or suspected respiratory pathogen:

- Physician, clinic or other medical facility alerts Hospital to patient referral
- Patient self-identifies at initial triage point
- Patient discovered or identified during external pre-triage screening

If the arriving patient is symptomatic, the following steps shall be taken:

- Mask (procedure mask) the patient and escort directly to the private room
- Initiate and follow transmission based precautions with appropriate signage
- Follow procedure to consider implementation of facility lockdown and pre-triage screening if there is a surge of additional patients

B. Patient is discovered following admission to UCC

The following potential scenarios could result from a patient with influenza-like-illness or respiratory pathogen discovered following UCC admission:

- Presenting signs/symptoms were not evident upon arrival
- Patient condition changed post-UCC admission
- Physical examination or diagnostic testing create index of suspicion or diagnosis
- Patient self-identifies or history reveals disease presence post-admission

Once discovery is made, the following steps shall be taken:

- Initiate transmission based precautions.
- Notify the Infection Prevention RN
- When with the patient use transmission-based precautions including utilization of required PPE

Infection Prevention RN will guide implementation of potential exposure measures for incident management:

- Identify all persons present in UCC who may have been exposed to the person under investigation (PUI) and document their location, time(s) of exposure, and activities (See log for all required information)

C. Patient is discovered following admission to a Unit

The following potential scenarios could result from a patient with influenza like illness/respiratory pathogen discovered following admission to a unit:

- Presenting signs/symptoms not identified upon admission
- Patient experiences a change in condition post-admission
- Physical examination or diagnostic testing create suspicion or diagnosis
- Case definition changes and is inclusive for this patient

Once discovery is made the following steps shall be taken:

- Initiate transmission based precautions
- Notify the Infection Prevention RN
- When with the patient use transmission based precautions including utilization of required PPE.

Infection Prevention will guide implementation of potential exposure measures for incident management:
- Work with Employee Health and the area manager to identify all persons who may have been exposed to the person under investigation (PUI) and document their location, time(s) of exposure, and activities (See log for all required information).

Activation Responsibility

It is anticipated that the Infection Prevention RN will be the first point of contact with the local Health Department or NYSDOH reporting a disease detection or outbreak based on surveillance. The Manager on-call or Nurse Manager, upon receipt of notification regarding a potential disease concern, shall confer with Nurse Management/Nursing Supervisor/Administrator and CEO regarding the situation. The QA/IP Manager in collaboration with the LNHA and/or CEO shall define a course of action to implement the emergency plan.
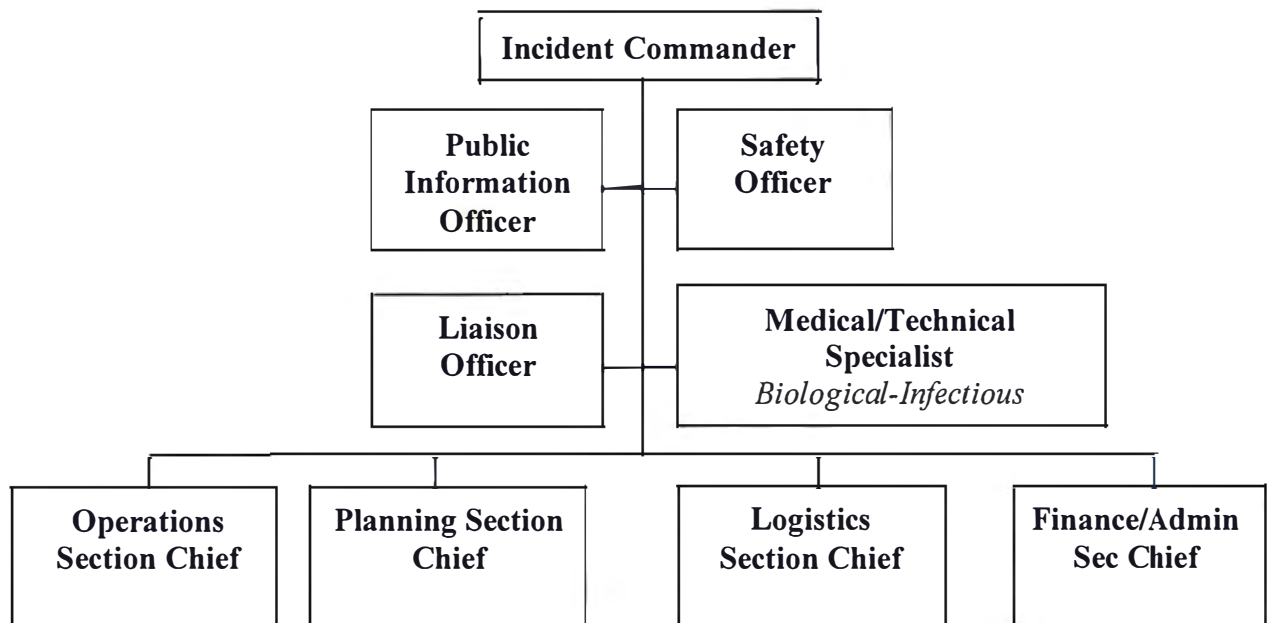
Activation Process

The CEO and/or the LNHA will activate the Hospital Incident Command Center upon identification of any emergency incident.

Hospital Incident command and the Infection Prevention RN

Cuba Memorial Hospital, Inc. uses the Hospital Incident Command System (HICS) for managing all unusual incidents and emergencies. For a pandemic flu/respiratory/emerging pathogen situation, an additional position, the Infectious Disease Medical/Technical Specialist ("ID Specialist"), is activated in the HICS command structure reporting to the Incident Commander. The ID Specialist position is typically filled by the Infection Prevention RN whose primary responsibility is to guide the organization with appropriate strategies and tactics for the evolving situation.

Some of the tasks that would be assigned to the ID Specialist include:

- Provide information to the Local Health Department
- Provide guidance on coordination of hospital admissions of patients who requite transmission-based precautions
- Determine the need for additional personal protective equipment in a surge situation
- Develop communications to disseminate through the command structure to provide information for staff, visitors, current patients, and the media
- Provide guidance on the need to procure antivirals and vaccine if available
- Brief the Incident Commander
- Participate in scheduled meetings

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                    │ Incident Commander  │
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        ┌──────────────────┐      ┌──────────────┐
        │     Public       │      │    Safety    │
        │  Information     │      │   Officer    │
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           │   Liaison    │   │   Medical/Technical      │
           │   Officer    │   │      Specialist          │
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Operations Section Chief	Planning Section Chief	Logistics Section Chief	Finance/Admin Sec Chief

Role of the Infection Prevention RN

The Infection Prevention RN (IP) is responsible for managing the day-to-day activities of the hospital-wide infection surveillance, prevention, and control program. Because the role is highly visible in the hospital and surveillance for infections is a primary function, the IP is in a unique position to detect rapid or subtle increases in patients admitted with unusual presentations.

Ongoing surveillance in Urgent Care (UCC, the Medical Care Unit (MCU) and the skilled nursing units (SNF 2 & SNF 3) is vital to the early recognition of a respiratory pathogen/influenza/emerging pathogen surge event. The IP reviews the electronic medical record (EMR), microbiology reports and admission diagnoses. Communication with the IP is essential when the following events occur:
- Increase in the number of patients with influenza-like or respiratory illness, fever, cough, pneumonia;
- Unexplained deaths occurring in otherwise healthy persons, especially if there is clinical evidence suggestive of an infectious disease process; and
- Increase in the number of persons with sepsis or septic shock.

The IP assumes a leadership role in a hospital's response to an influenza/respiratory/emerging pathogen event. Infection Prevention RN will assume responsibility along with the Medical Director or a designated medical provider.

Maintaining Incident Situational Awareness

The IP plays a key role in maintaining incident situational awareness for the facility. The IP maintains routine contact with the epidemiological source points inside the facility. The IP also interacts with public health and the infectious disease community outside the facility (including the use of Internet-bases resources). The IP or medical provider shall take the lead in ensuring that the Medical staff remains informed, aware, and updated with current information and the evolving situation.

The Incident Commander shall convene the Incident Management Team consisting of, at a minimum, the Command and General Staff (Operations, Planning, Logistics, and Finance Section Chiefs); and the Safety, Public Information, and Liaison Officers; the IP; Medical Care; Infrastructure, Hazmat, and Security Branch Directors, and Human Resource Manager. Other leaders may be brought into the Incident management Team at the discretion of the Incident Commander.

The Incident management Team shall be responsible for assessing the situation initially and on an ongoing basis, and selecting an appropriate incident mobilization strategy and level of activation. At the discretion of the Incident Commander, the Incident Management Team will develop an incident action plan (IAP) addressing the situation, and meet as necessary to plan and prepare the organization for the anticipated impact.

Once the emergency plan is activated, the Infectious Disease Medical/Technical Specialist and Public Information Officer will develop and communicate appropriate information to hospital staff. Such information, developed by the PIO and approved by the Incident Commander, shall include, but not be limited to:
- Nature of the current incident and reason for the emergency plan activation
- Status of routine hospital activities
- Special measures being planned or implemented, and staff's role in carrying them out
- Altered policies or procedures, including resource security and rationing
- Availability of staff support and behavioral health services
- Any other relevant information

Pre-Entry Screening for Staff, Vendors, and Visitors

It may become necessary to implement pre-entry screening for all people entering the hospital building in an effort to interrupt disease transmission. Patients arriving shall be screened using a screening process to identify symptoms. At the discretion of the Incident Commander, a similar process may be instituted for staff, vendors, and visitors. Under these circumstances, no person shall be permitted access to the hospital building without screening clearance.

Screening points shall be established at designated entrances to the building. The screening process will be pathogen-specific, but the following general guidelines could apply:
- All persons arriving to the facility shall be notified in advance, if possible, informed of the situation and the case definition, instructed as to where to report, and given direction regarding what to do if they meet the case definition prior to arrival
- All persons arriving for entry screening will be queued for screening. Separate queues may be set up for staff, vendors, and visitors.
- Screening will be conducted by designated staff following transmission-based precautions. Maintenance staff will be assigned to screening points as needed for security
- All persons who are symptomatic/ill will be referred to a medical provider.
- Vendors and visitors who are medically cleared for access will be identified by a "visitor sticker", which shall be in effect for a limited time.

Patient triage Guidelines

Screening is a process that provides for an initial assessment of patients arriving at the hospital for signs and symptoms of influenza/respiratory/emerging pathogens illness prior to their entry to the hospital building and accessing routine UCC triage. The aim of triage screening is to insure early detection of patients meeting a case definition and interruption of potential transmission to others through targeted screening and adherence to specific precautions form patient management.

Triage screening may be established external to the building in proximity to the UCC. The triage nurse will evaluate each ambulatory patient arriving at the hospital (including non-UCC-related visits) specifically based on the case definition.

For a mass patient influx, sustained incident or where greater environmental controls are needed, a parking lot shall be cleared of vehicles and the hospital triage tent will be erected for an alternate triage site.

Required Communicable Disease Reporting

Reporting of suspected or confirmed communicable diseases is mandated under New York State Sanitary Code (10NYCRR 2.10). Although physicians have primary responsibility for reporting, laboratory directors, Infection Preventionists, and other mandated personnel, as well as health care facilities are required to report communicable diseases.

Reports should be made to the local Health Department and/or NYSDOH and need to be submitted within 24 hours of diagnosis or as directed based on the event.

Specimen Collection, Packaging, Processing, and Transport

The NYSDOH's Wadsworth Center Laboratory (or NYSDOH designated alternate laboratory) is A designated reference laboratory and will conduct definitive diagnostic work on potential specimens. The Wadsworth Center will accept NYSDOH-approved specimens, as well as from other members of the health services system. Laboratory staff is responsible for handling and sending specimens to the health department.

The IP/laboratory personnel shall contact the local health department or NYSDOH before submitting specimens to Wadsworth Center as special sample transportation may be necessary. To contact Wadsworth Center call 518-474-7161 during business hours Monday-Friday 8AM-5PM, or 866-881-2809 for the Public Health Duty Officer at all other hours.

Laboratory Information Specific to Influenza/Respiratory/emerging Pathogen Testing

Diagnostic assays for respiratory pathogens may be helpful in differentiating influenza from other illnesses. Initial testing should include chest radiograph, pulse oximetry, microbiology cultures, and testing for viral respiratory pathogens, as appropriate.

Many respiratory viruses have similar clinical symptoms. A respiratory viral screen by DFA includes testing for influenza A and B, respiratory syncytial virus, parainfluenza virus, human metapneumo virus and adenovirus.

Legionella culture and urinary antigen testing should also be considered if appropriate.

The LDH/NYSDOH epidemiologist must be contacted to determine whether patients meet the case definition before collecting and shipping specimens to the state laboratory. The physician will provide the DOH with the case history and receive approval from the Health Department to send samples to Wadsworth for testing.

Notify the laboratory prior to sending novel respiratory viral specimens. Special collection, packaging, labeling, and downtime requisition may be required. Specimens may require hand delivery to the lab and should not be sent via tube system.

Correct and complete documentation will be sent with all samples. Wadsworth Center History Form must accompany specimens to ensure accurate reporting of results to appropriate parties.

Wadsworth may request specimens to be collected in duplicate in order to provide one set for the facility laboratory and a second for NYSDOH Wadsworth Center Laboratory.

Respiratory Tract Specimens

Respiratory specimens should be collected as soon as possible in the course of the illness. The likelihood of recovering most viruses diminishes markedly >72 hours after symptom onset. Some respiratory pathogens may be isolated after longer periods.

Three types of specimens may be collected for viral or bacterial isolation and PCR. These include:
- Nasopharyngeal wash/aspirate
- Nasopharyngeal swabs; or
- Oropharyngeal swabs. Nasopharyngeal aspirates are the specimen of choice for detection of respiratory viruses and are the preferred collection method for children <2 years old.
- Current guidance will dictate the method of collection and swab/medium required.

Upper Respiratory Tract

Collection of nasopharyngeal wash/aspirate will be done by a physician, nurse practitioner, or physician's assistant.
Have the patient sit with the head tilted slightly backward. Instill 1.0-1.5 ml of non-bacteriostatic saline (pH 7.0) into one nostril. Flush a plastic catheter or tubing with 2-3 ml of saline. Insert the tubing into the nostril parallel to the palate. Aspirate the nasopharyngeal secretions. Repeat this procedure for the other nostril. Collect specimens in sterile vials. Each specimen should be labeled with the proper identification and the date collected.
Collection of nasopharyngeal or oropharyngeal swabs can be obtained by Registered Nurses. Use only sterile Dacron or rayon swabs with plastic shafts. Do NOT use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing.
Nasopharyngeal swabs – insert swab into nostril parallel to the palate and leave in place for a few seconds to absorb secretions. Swab both nostrils.
Oropharyngeal swabs – Swab both posterior and tonsillar areas, avoiding the tongue.

Place the swabs into viral transport media immediately. Break off applicator sticks to permit tightening of the cap. Label each specimen with the proper identification and date of collection.

Lower Respiratory Tract

Collection of broncho-alveolar lavage, tracheal aspirate, pleural tap: If these specimens have been obtained, half should be centrifuged and the cell-pellet fixed in formalin. Remaining unspun fluid should be placed in sterile vials, capped securely, and sealed with parafilm. Each specimen must be properly labeled with identification and date collected.

Blood Components

Collection of Serum – acute serum specimens should be collected (as directed by the local health department/NYSDOH) and submitted as soon as possible. If the patient meets the case definition, convalescent specimens should be collected and submitted if requested. Collect 5-10 ml of whole blood in a serum separator tube. Allow blood to clot, centrifuge briefly and collect all resulting sea in vials, cap and seal with parafilm. A minimum of 200 microliters of serum is preferred for each test (easily obtained from 5 ml of blood). Samples at 4 degrees C.
Contact Microbiology department for specific issues.

Pharmacy Support

The pharmacy maintains a reasonable daily inventory of antivirals currently recommended for the treatment of patients with suspected or diagnosed influenza. Vaccine supplies will be obtained and dispensed by the pharmacy department, if they are available, for patients and staff.

Prevention of Disease Transmission

Infection Prevention Standards are to be followed at all times. Refer to Infection Prevention policy on Standard and Transmission-based Precautions. Standard and transmission-based are the standard of care for all patients and provide employees with protection from disease transmission.

STANDARD PRECAUTIONS	
Component	*Recommendations*
Hand hygiene	After coming in contact with blood, body fluids, secretions, excretions, contaminated items and patient surroundings; immediately after removing gloves; between patient contacts and before donning and after doffing PPE
Personal Protective Equipment (PPE)	
Gloves	For touching blood, body fluids, secretions, exretions, contaminated items;for touching mucous membrane and nonintact skin
Gown	Durning procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions in anticipated.
Mask, eye protection (goggles), face shield*	During patient care masks and eye protection will be utilized.
Soiled patient care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene. Disinfect equipment between patients.
Environmental Control	Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment.
Needles and other sharps	Do not recap, bend, break, or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only; use safety feautres when available; place used sharps in puncture-resistant container.

Staffing

During a pandemic event, it is likely that healthcare staff will be affected by the event in terms of becoming ill or the need to treat sick family members at home. This will place increased demands for staffing on the facility. In addition, pandemic events can cause increased fear/anxiety in staff, which may affect their willingness to report to work.

Human Resources in collaboration with the HICS Labor pool may need to be activated to determine status of staffing needs on a concurrent basis as well as to project extended needs. Human Resources will the Labor Pool will activate a process for rapidly credentialing healthcare professionals.

Communication strategies shall be implemented to provide employees with the knowledge base needed regarding prevention of disease transmission.

During a pandemic/flu/respiratory pathogen situation, staff will self-monitor for flu/respiratory symptoms prior to entering the facility through the designated entrance. Entry stations will be established with a screening process to identify staff with respiratory symptoms. Screening will consist of temperature and review of respiratory symptoms that are deemed significant based on the specific respiratory pathogen/influenza/emerging pathogen situation. Those staff identified with symptoms will be referred to UCC or Employee Health for treatment and restricted from patient care until disease transmission is no longer a risk. Under the Emergency Preparedness Management Plan the Labor Pool Unit may be instituted to handle sick call issues and to distribute staff as appropriate to cover the needs of the hospital. Employee Health will clear staff to return to work after fever is gone and the employee is no longer symptomatic (as directed by the NYSDOH if quarantined). The NYSDOH and CDC guidelines will be consulted to determine disease duration and time frames for staff to be removed from patient care roles.

The surge plan allows for locations for the staff to rest and sleep if they are required to work extended shifts. The Disaster Mental Health Teams will be available to meet with staff to help with stress and issues associated with the pandemic/respiratory pathogen/influenza situation.

Employee Health along with the Labor Pool Unit leader will maintain lists of staff assignments for post exposure follow up concerns in addition to temperature, sign and symptom monitoring for exposed and/or quarantined staff, as necessary.

Surge Capacity measures to manage and enhance bed capacity during a biological incident will be implemented as needed following the Surge Annex to the Comprehensive Emergency Management Plan (CEMP) and the "Surge and Flex Response plan" policy.

Supply management will be the responsibility of the Logistics Section Chief as defined in the CEMP. During a biological event, concern will be focused on the anticipated need for additional antibiotics and/or antivirals and personal protective equipment. Determination through consultation with the NYSDOH on how to access any statewide stockpiles (e.g., Medical Emergency Response Cache (MERC) or the Strategic National Stockpile) during an emergency will be explored.

Requesting External Stockpile Resources

If internal pharmaceutical or other medical supplies will not be sufficient to meet the needs of the hospital staff, the hospital may request resources from an external stockpile. Such resource stockpiles may exist at the county, regional, state, or federal level. Requests for external resources require the approval of the hospital incident commander. In the event that the Office of Emergency Management (OEM) is not activated for the incident, such request shall be forwarded through the Local Health Department.

Risk Communication: Sharing Information with Staff

The Public Information Officer (PIO), Medical Director, and IP RN will be tasked with providing briefings with information on the pandemic event for Incident Commander, nursing leadership, community relations staff, physicians, nurses and department managers.

The PIO maintains current contact information of local community contacts for County Health, media and social service agencies. Maintain communication with local EMS agencies to ensure their inclusion in the pandemic planning and response processes. Notify employees of the facts related to the pandemic status and associated Hospital Incident Command System (HICS) level via internal and external communication systems.

Post additional signs for respiratory hygiene/cough etiquette in public areas, e.g. waiting rooms, UCC, elevators, etc.

Review of key messages from CDC, NYSDOH, LHD, and colleague agencies.

Train assigned staff on messages for community and family inquiries. CEC information on prevent of transmission and management of disease symptoms will be utilized to provide disease facts. Influenza/respiratory pathogen disease sheets are available for staff access via the QA/IP Manager or the Education/EP Manager. The references are maintained by the IP and updated as information changes or updates. There are healthcare worker data sheets and family/patient information sheets that can be utilized related to specific pathogens. Education sheets on transmission based precautions and respiratory etiquette are also available.

Discharging influenza/respiratory pathogen patients in a pandemic situation

The patient with influenza/respiratory pathogen can be discharge if appropriate transmission measures can be put in place at home. Patients should be advised to use disease specific prevention measures for the incubation period specific to the pathogen and health department guidance. NYSDOH may request to be made aware of discharged patients.

Education

Patients and families will be educated on influenza/respiratory/emerging pathogen signs/symptoms and control measures that are required during hospitalization as well as at discharge. During a pandemic outbreak additional information will be provided to visitors in the facility if necessary. Healthcare providers will utilize educational information on influenza/respiratory/emerging pathogen specific to the outbreak through NYSDOH and CDC.

The Infection Prevention RN will provide daily updates to staff on the influenza/respiratory/emerging pathogen situation and educate staff on transmission based precautions and prevention strategies. Infection prevention orientation and annual review is provided to all employees with education on influenza and other emerging or respiratory pathogens. If vaccination or antiviral medications are recommended for the specific situation, education will be provided to employees and patients as appropriate.

Attachments –Social Distancing Protocol

Social Distancing Protocol:

In order to decrease the spread of COVID-19 and lower the impact, **Social Distancing**, will be maintained in the workplace. Social distancing means avoiding large gatherings and maintaining distance (approximately 6 feet) from others when possible (e.g., break rooms, waiting areas, and cafeterias). Strategies include:

1. **Workspaces**
   - Maintain physical space between employees in work areas whenever possible.
   - Maintain physical space between employees and patients/visitors (e. g., partitions, shielding).
   - Implement remote work when possible.
   - Consider flexible work hours (e.g., staggered shifts).
   - Consider flexible lunch and break times.
   - Consider minimizing face-to-face contact between high risk employees, assign tasks that allow them to maintain a distance of 6 feet away from other workers, work remotely if possible.

2. **Clinical Areas:**

   - Maintain physical space between employees and providers at nursing stations, medication rooms, and treatment areas when possible.
   - Minimize the number of individuals during patient visits, procedures, treatments and emergency response events.

3. **Meetings:**
   - Conduct virtual meetings/events when possible through conference call, ZOOM, or WebEx.
   - In-person meetings – ensure physical space between employees.

4. **Public Spaces:**
   - Refers to lobby, waiting rooms, registration areas, hallways, cafeteria, break rooms, restrooms, locker room, etc.
   - Maintain physical space between other employees, patients, and visitors.
   - Follow signage and other space guidance (seating separation, flooring quesques).

5. **Other Strategies:**
   - Deliver healthcare remotely when possible (e. g., telephone visits, video conferences, telehealth, etc).
   - Minimize vendor visits unless essential.

6. **Support respiratory etiquette and hand hygiene for employees, patients and visitors:**
   - Provide tissues and no-touch disposal receptacles.
   - Provide alcohol-based sanitizer in the workplace and public locations.
   - Place posters that encourage hand hygiene and respiratory etiquette at the entrance and other locations where they are likely to be seen.
   - Discourage handshaking – encourage the use of other non-contact methods of greeting.

- **All staff are required to wear masks while working in the facility, even if you work in a non-patient area.**

7. **Perform routine environmental cleaning and disinfection:**
   - Routinely clean and disinfect all frequently touched surfaces in the workspace, such as workstations, keyboards, telephones, handrails, light switches, and door knobs.
   - Discourage workers from using other workers' phones, desks, offices, or other work tools and equipment, when possible. If necessary, clean and disinfect them before and after use.
   - Provide disinfectant wipes so that commonly used surfaces can be wiped down by employees before each use.

CMH will take appropriate actions based on local conditions. Guidelines are subject to change based on the current COVID-19 pandemic information and guidance.