



- UCH/ENTERPRISE
- UCMC
- WCH
- DRAKE - LTCH
- DRAKE - BWP
- DRAKE - SNF
- DRAKE - OUTPATIENT
- AMBULATORY/UCPC
- LEGAL/COMPLIANCE
- MEDICAL STAFF
- MEDICATION MGMT
- OTHER

POLICY

POLICY #	<u>UCH-ICC-007-02</u>		
POLICY NAME	<u>Highly Communicable Respiratory Diseases</u>		
ORIGINATION DATE	<u>03/01/2015</u>		
SPONSORED BY	<u>Laura Schuster, CIC</u>		
	<u>Manager, Infection Prevention</u>		
ADMINISTRATIVE APPROVAL	<u>Dr. George Smulian</u>		
	<u>Medical Director, Infection Control</u>		
LAST REVIEW / REVISION DATE	<u>02/05/2020</u>	NEXT REVIEW DATE	<u>02/05/2023</u>

I. POLICY

- Administrative Interdepartmental Departmental Unit Specific

This plan offers general guidelines for how to prepare and respond to highly communicable respiratory diseases. In cases of specific pathogens, after reviewing recommendations from the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO), Infection Prevention and Control may amend this plan accordingly.

II. PURPOSE

Several pathogenic microbes that are transmitted principally by the droplet or airborne routes may lead to severe respiratory disease including novel viruses (e.g. 2019 novel coronavirus), avian influenza (H5N1), SARS-CoV, and pulmonary plague (etiologic agent, *Yersinia pestis*). Pandemic influenza viruses of novel neuraminidase or hemagglutinin types may in the future emerge as important highly communicable respiratory diseases. This plan is directed to preventing transmission of such highly communicable respiratory diseases within UC Health facilities. For the purpose of this plan, highly communicable respiratory diseases will include novel viruses (e.g. 2019

novel coronavirus), pandemic influenza strains including avian influenza (H5N1), SARS-CoV, *Y. pestis*, agents of hemorrhagic fevers (Ebola, Marburg, Lassa, Congo-Crimean fevers), certain hanta viruses, and certain pox viruses (e.g., smallpox, monkey pox). The Infection Control Medical Director, the Centers for Disease Control and Prevention, or the Ohio Department of Health may designate other agents requiring similar management.

III. DEFINITIONS

- A. **SARS:** Transmission of SARS-CoV in healthcare facilities was a major factor in the spread of SARS-CoV during the 2003 global epidemic. In areas of extensive outbreaks, the virus spread most readily among hospital workers caring for SARS patients, other patients, and visitors. Factors that contributed to the disproportionate rate of transmission in healthcare settings include: 1) a higher virus titer in respiratory secretions during the second week of illness when patients were most likely to be hospitalized, 2) use of ventilators, nebulizers, endotracheal intubation, and other droplet- and aerosol-generating devices and procedures, 3) frequent exposures of workers to patients, their secretions, and potentially contaminated environments, and 4) failure to properly use personal protective equipment (i.e., N95 respirators).
1. The large number of healthcare personnel who contracted SARS demonstrates the importance of early detection and infection control in limiting the spread of disease. In every region in which major outbreaks were reported, a substantial proportion of cases resulted from delays in clinical recognition and isolation of patients. SARS-CoV was also transmitted by infected visitors and by hospitalized patients with other medical conditions that masked the symptoms of SARS. Case recognition and implementation of appropriate precautions greatly reduced the risks of SARS-CoV transmission. However, even with appropriate precautions, there were isolated reports of transmission to healthcare workers in the settings of aerosol-generating procedures and lapses in infection control technique. Experience indicates that early detection and isolation of cases, strict adherence to infection control precautions, and aggressive contact tracing and monitoring can minimize the impact of a SARS outbreak.
- B. **Pandemic Influenza Strains:** Human influenza is caused by a single-stranded, enveloped, RNA virus of the orthomyxoviridae family. Three types infect humans; types A, B, and C. However, type C causes only mild disease. Type B remains relatively stable from year to year. However, the surface proteins of type A (neuraminidase and hemagglutinin) generally vary slightly from year to year (drift). Every 20 to 40 years, the surface proteins change considerably (shift) resulting in a pandemic. Currently circulating strains of type A are classified as H3 and H1 types. An avian strain (H5N1) has been spreading among domestic and wild birds since the late 1990s. More than 100 cases have been described in adults with a mortality of approximately 50%. Avian influenza has generally been acquired from domestic bird-to-human transmission.

However, there are rare reports of human-to-human transmission including patient-to-healthcare worker transmission.

- C. **Novel Virus:** refers to a **virus not seen before**. It can be a virus that is isolated from its reservoir or isolated as the result of spread to an animal or human host where the virus had not been identified before.

IV. PROCEDURE

A. General surveillance and triage

1. In all cases of suspected or known highly communicable respiratory diseases visits or admissions, the Infection Preventionist and receiving location should be notified prior to the patient being triaged. It is the responsibility of the attending physician or his/her designee to notify the Infection Control Professional.
 - a. **In the presence of global highly communicable respiratory disease activity (but no cases in Ohio):**
 - 1) Signs will be placed outside the Emergency Department (ED) and other hospital entrances requesting that persons with respiratory symptoms and epidemiologic exposure identify themselves to the triage nurse or greeter/clinic intake staff.
 - 2) Ideally, a mask should be placed on the patient at the ED or clinic intake/registration desk. Posted visual alerts will recommend “respiratory hygiene precautions.”
 - 3) Clinicians, intake and triage staff will be regularly updated via email, updates posted on the UC Health intranet page, memoranda, and meetings on the status of the highly communicable respiratory disease locally, nationally, and internationally.
 - 4) Intake and triage staff will be trained on how to assess risks for highly communicable respiratory disease and use any applicable tools (thermometers, respiratory signs/symptoms checklists) to screen patients.
 - b. **In the presence of highly communicable respiratory disease activity in Ohio (but no cases in the immediate local area):**
 - 1) The ED should be used for patients who require acute medical evaluations or interventions, or are likely to require hospital admission.
 - 2) The patient may be required to wear a surgical mask upon arrival and will be given the mask by intake staff.
 - c. **In the presence of highly communicable respiratory disease activity in Ohio and cases at local facilities:**
 - 1) Screening of persons (patients and visitors) entering the facility will escalate from passive (e.g., signs at the entrances) to active (e.g., direct questioning, respiratory symptoms, temperature monitoring). Screening may be coordinated with access controls, a triage station outside the facility to screen patients before they enter the facility,

and/or telephone screening of patients with appointments. Separate screening entrances may be established for patients, staff, and visitors (if warranted, visitors may be excluded from entering the healthcare facility).

- 2) A "Highly Communicable Respiratory Disease Evaluation Center" may be used to separate patients with suspected highly communicable respiratory disease from other patients seeking care.

B. Triage and management of cases of highly communicable respiratory diseases

1. To the extent possible (and with help of the local health departments), care for highly communicable respiratory disease cases should remain with their primary physician or local hospital with consultation from the local health department.
2. If a patient contacts their physician via phone, the physician should ascertain the level of illness and then discuss triage with the ED physician (severe disease) or the Infectious Disease physician (mild/moderate disease). The patient will be triaged to the appropriate site for care.
3. If patient has already presented at a UC Health facility, the local physician should ascertain the level of illness and then discuss triage with the ED physician (severe disease) or the Infectious Disease physician (mild/moderate disease).
4. If patient is under consideration for transfer to a UC Health facility either the ED Attending or the Infectious Disease physician should be involved in the triage decision. If possible the patient should be managed at the outside facility or with consultation from the local health department.

C. Notifications

1. The Ohio Dept of Health is notified per Communicable Disease Reporting guidelines. The following may also be notified:
 - a. Infection Preventionist
 - b. Medical Advisor to Infection Prevention and Control
 - c. Nursing House Supervisor
 - d. ED Attending
 - e. Public Safety
 - f. Hospital Administrator on call

D. Clinical evaluation of patients

1. **In the absence of known highly communicable respiratory disease activity worldwide:**
 - a. Perform a routine evaluation of respiratory illnesses and maintain a low index of suspicion for highly communicable respiratory diseases. In the absence of highly communicable respiratory disease transmission anywhere in the world, the overall likelihood that a given patient with fever and respiratory illness has a highly communicable respiratory disease will be exceedingly low unless there are both typical clinical findings and some accompanying

epidemiologic evidence that raises the suspicion of exposure to highly communicable respiratory diseases.

2. **Once highly communicable respiratory disease activity has been documented anywhere in the world:**
 - a. The positive predictive value of even early clinical symptoms (e.g., fever or respiratory symptoms in the absence of pneumonia), while still low, may be more acceptable if used in combination with an epidemiologic link to a setting in which highly communicable respiratory disease has been documented.
 - b. Question all patients with fever or respiratory symptoms about recent close contact with persons suspected to have a highly communicable respiratory disease and about exposure to locations in which recent highly communicable respiratory disease transmission is documented or suspected to have occurred [follow CDC (www.cdc.gov) and WHO (www.who.int/en/) guidance where up to date definitions and algorithms will be posted].
3. Symptoms of patients will vary based on the highly communicable respiratory disease under consideration. WHO and CDC will develop case definitions which will be adopted by UC Health facilities.
4. **Deaths/Human Remains.** Instruct staff to wear appropriate personal protective equipment (PPE).

E. Infection control for highly communicable respiratory diseases

1. Transmission risk of highly communicable respiratory diseases in healthcare facilities depends on the extent of highly communicable respiratory disease activity in the community but also highly communicable respiratory disease activity in the facility. The decision for escalating infection control measures will be based on highly communicable respiratory diseases activity and transmission. For infection control guidance on potential agents of bioterrorism, please refer to hospital Bioterrorism Policy.
2. **Isolation Precautions**
 - a. Staff should be reminded about the importance of strict adherence to and proper use of standard infection control, especially hand hygiene and isolation.
 - b. All patients with suspected highly communicable respiratory diseases seen in the ED should immediately be placed in a private room meeting airborne isolation requirements (i.e., ≥ 6 air exchanges per hour, air exhausted directly to the outside, negative pressure). A surgical mask should be placed on the patient until placement in an AIIR (Airborne Infection Isolation Room).
 - c. Staff should call Public Safety to activate the alarm for an Airborne Infection Isolation Room.
 - d. All patients with suspected highly communicable respiratory disease should be placed on Airborne and Contact Precautions in an AIIR room.
 - e. Protocol for entering Airborne/Contact Precaution room

- 1) N-95 respirator (medical clearance, fit test and training required before use); secure ties or elastic bands at middle of head and neck; fit flexible band to nose bridge; fit snug to face and below chin)
 - 2) Gloves (extend to cover wrist of isolation gown)
 - 3) Gown (fully cover torso from neck to knees, arms to end of wrists, and wrap around the back; fasten in back of neck and waist)
 - 4) Protective eyewear
 - 5) Goggles (for aerosol generating procedures)
- f. Protocol for leaving room (except for respirator, remove PPE at doorway or in anteroom)
- 1) At the door just prior to exit
 - a) Remove gloves by peeling off inside-out. Dispose of gloves in trash.
 - b) Remove goggles or face shield by handling the head band or ear pieces.
 - c) Remove gown by unfastening the back and then remove with inside outward (touching inside of gown only). Dispose of gown in trash.
 - d) Exit room.
 - 2) At the door just outside of room
 - a) Remove N-95 respirator and discard in trash.
 - b) Perform hand hygiene with antiseptic soap and water immediately after removing all PPE.
 - c) Put on clean exam gloves and decontaminate goggles (if reusable) by wiping exterior surface with alcohol or EPA-approved disinfectant.
 - 3) Remove gloves and perform hand hygiene with antiseptic soap or alcohol hand rub.
 - 4) Signs describing the protocol for entering and leaving the room will be placed on the inside and outside of the door.
- g. A log will be maintained of all persons entering the room of patients with a suspect or probable highly communicable respiratory disease.
- h. Aerosol-generating procedures (e.g., sputum induction, airway suctioning, aerosol medication therapy, bronchoscopy, intubation): Special Airborne/Contact Precautions (including eye protection for all patients) must be used for performing all procedures that generate aerosols.
- 1) Limit the use of aerosol-generating procedures on highly communicable respiratory disease patients to those that are deemed medically necessary.
 - 2) Use clinically appropriate sedation during intubation and bronchoscopy to minimize resistance and coughing during the procedure.
 - 3) Use bacterial/viral filters on exhalation valves of mechanical ventilators.

- 4) Eye protection should consist of goggles that fit snugly around the eyes.
 - 5) A face shield may be worn over goggles to protect exposed areas of the face but should not be used as a primary form of eye protection for these procedures.
3. **Transport**
- a. Whenever possible, hospitalized highly communicable respiratory disease patients should have procedures/tests done in their own rooms, rather than transporting to other areas.
 - b. Minimize intra-hospital transport of patients with suspected highly communicable respiratory disease. When patient is being transported for essential diagnostic tests or from clinic/ED to hospital room, have patient wear a surgical mask. Always notify receiving area prior to patient transport. When transporting patients, identify a path segregated from the main traffic routes as much as possible. Ventilators used for patient transport must use bacterial/viral filters on the exhalation valves.
 - c. Transporters should wear N-95 respirator, gloves, gown, and eye protection.
4. **Laboratory**
- a. Laboratory specimens for patients with highly communicable disease patients will be hand carried to the laboratory (i.e., use of the tube system is prohibited).
 - b. Patient specimen management will be handled per laboratory policies.
5. **Visitors**
- a. All visitors (except those identified in b. below) will be excluded from visiting persons with suspect or probable highly communicable respiratory disease.
 - 1) If necessary, an isolation/quarantine order will be sought from the State or County Health Department to enforce this policy.
 - 2) Visitors will be restricted to the guardians of minor children and no more than 2 significant others (e.g., spouse, adult brother/sister), who may visit provided that they do not have fever or respiratory symptoms, and are able to wear appropriate PPE. An exception to the visitation rule can be made by the State Epidemiologist or the Infection Control Medical Advisor.
 - 3) Visitors must undergo daily health screening by a trained professional prior to visitation. Health screening forms will be placed in the patient's medical record.
 - 4) Visitors must receive infection control training and comply with infection control measures.
 - 5) To allow for PPE-free time for the visitor, the maximum time per visit is two hours.
 - 6) Symptomatic visitors exposed to highly communicable respiratory disease patients will be excluded from

visitation and reported to the local health department for follow-up.

F. Patient placement, isolation, and cohorting

1. Patients with suspect or probable highly communicable respiratory diseases should be admitted only if medically indicated (i.e., require hospital care for respiratory distress).
2. Patients requiring hospitalization should be admitted to a room meeting airborne infection isolation criteria. Airborne Infection Isolation Rooms (AIIRs) are available on multiple units. A complete listing of AIIRs can be found in the Isolation Policy (INF-018).
 - a. The number of staff allowed to enter the room should be minimized to only essential personnel. Students should be prohibited from participating in the care of patients with suspect or probable highly communicable respiratory diseases.
 - b. Ideally, a monitor will be placed outside the patient's door to assist with proper use of PPE and maintain the entry log.
3. A lack of AIIRs and/or a need to concentrate infection control efforts and resources may lead to a strategy that includes the following:
 - a. Cohorting patients in individual rooms on the same floor, rather than placing them in AIIRs throughout the hospital; or
 - b. Converting private AIIRs to double rooms to accommodate more patients requiring airborne isolation. This strategy would only be implemented following approval from the Incident Commander, Federal and State authorities, and to the extent that staff could manage the number of patients on the unit.
 - c. A lack of hospital beds may lead to a strategy of utilizing non-licensed inpatient beds for patient management (e.g., PACU, observation beds) following approval from the Incident Commander, Federal and State authorities, and to the extent that staff can manage the number of hospitalized patients.
 - d. In the context of significant highly communicable respiratory disease transmission, high patient volume or frequent unprotected exposures, patients might be divided into the following cohorts for room placement: patients who are exposed and asymptomatic; patients who are exposed and symptomatic but do not meet the highly communicable respiratory disease case definition; patients who meet the highly communicable respiratory disease case definition; non-exposed patients.

G. Engineering and environmental controls

1. Plant Operations will be responsible for ensuring that the AIIRs are functioning properly.
2. If all AIIRs are utilized, investigate whether non-AIIR rooms can be modified to achieve appropriate airflow direction and/or air exchanges for care of highly communicable respiratory disease patients.
3. If the patient must leave the Airborne Precautions room or is discharged, the door must be kept closed for a minimum of 30 minutes prior to

anyone entering without wearing a respiratory protection device. Likewise, the door should remain closed for a minimum of 30 minutes with the isolation sign displayed when a patient is discharged from an Airborne Precautions room. The 30 minute time period will allow the room ventilation system to remove any droplets/droplet nuclei.

4. Environmental disinfection policies should be followed:
 - a. Following discharge, hospital rooms housing highly communicable respiratory disease patients should receive terminal cleaning and disinfection following CDC cleaning guideline for specific disease. Environmental service personnel must wear gloves, gowns, N-95 respirator and eye protection (i.e., goggles or face shield) until cleaning is complete.
 - b. In clinics and procedure areas (e.g., Radiology), all equipment (e.g., stretchers) having direct or close contact with patients with suspected highly communicable respiratory diseases must be disinfected immediately after use following CDC cleaning guideline for specific disease.
 - c. These environmental guidelines may require alteration depending on the pathogen of concern and will be revised at the discretion of the Infection Control Medical Advisor.

H. Exposure reporting and evaluation

1. Occupational exposure consists of:
 - a. providing care or being in the room with a highly communicable respiratory disease patient without wearing proper PPE or
 - b. entering a vacated highly communicable respiratory disease patient's room without wearing a respirator when the patient has not been out of the room for a minimum of 30 minutes.
2. All occupational exposures must be reported to the appropriate occupational health service provider. The occupational health service providers will notify the local health department of all employee exposures.
3. In the setting of human to human transmission in the local geographic area, any employee with respiratory symptoms should report to their occupational health provider for evaluation.
4. Management of asymptomatic healthcare workers exposed to highly communicable respiratory disease.
 - a. Persons who have been exposed to a highly communicable respiratory disease should notify their occupational health service provider. They should also be vigilant for fever or respiratory symptoms following exposure for a period of time that varies depending on the possible respiratory pathogen (influenza = 1-5 days; SARS = 1-10 days). Those who develop fever or respiratory symptoms should limit interactions outside the home and should not go to work, school, out-of-home child care, church, other public areas.
 - b. Exposed unprotected healthcare workers who are asymptomatic, depending upon the disease, may be furloughed at the discretion

of the Medical Advisor to Infection Prevention and Control or the Medical Director of occupational health service during the incubation period of the disease.

- c. Exposed unprotected healthcare workers who are asymptomatic and who are allowed to work must be evaluated prior to work each day at the direction of Employee Health.
- d. Such examinations will be performed for a period of time that varies depending on the possible respiratory pathogen (e.g., influenza = 5 days; SARS = 10 days) following the last unprotected exposure. In addition, exposed asymptomatic healthcare workers should take their own temperature 2x per day and report any elevated temperatures (i.e., ≥ 38.0 °C) to Employee Health.
- e. Afebrile healthcare workers in some or all units with respiratory symptoms may be required to undergo rapid testing for influenza A, influenza B, and RSV depending on the nature of the highly communicable disease pathogen and time of year. Depending on the highly communicable disease pathogen, healthcare workers who test negative may be allowed to continue to work, while wearing a mask and practicing good hand hygiene.

5. **Management of symptomatic healthcare workers exposed to a highly communicable respiratory disease.**

- a. Exposed healthcare workers who develop fever and/or respiratory tract symptoms should not report to work. Rather they should immediately report by phone the development of fever and/or respiratory tract symptoms as follows. An appropriate health provider (e.g., Medical Director Occupational Health, Nurse Practitioner Occupational Health) will evaluate symptomatic persons as medically necessary. Alternatively, symptomatic health care workers could be medically evaluated in alternative locations as directed by the Incident Commander.
- b. If symptoms do not progress to meet the suspect highly communicable respiratory disease definition within the time period to be determined by specific infectious agent, the person may be allowed to return to work (depending on the pathogen), school, out-of-home child-care, church or other public areas, and infection control precautions can be discontinued.

6. **Management of asymptomatic healthcare workers with a high-risk exposure to a highly communicable respiratory disease**

- a. To manage an unprotected high-risk exposure of a worker (i.e., worker in the same room as probable highly communicable respiratory disease patient during a high-risk aerosol-generating procedure and infection control precautions are either absent or breached) with no symptoms of highly communicable respiratory disease, the worker:
 - 1) Should be excluded from duty for a time period that depends on the specific respiratory pathogen (influenza =

5 days; SARS = 10 days) following the date of the last high-risk exposure.

- 2) Need not limit activities outside the health care setting but should be vigilant for development of fever and/or respiratory symptoms.
- 3) Will document active surveillance for the development of fever or respiratory symptoms, and the frequency of recording health status measures will be determined by occupational health service providers.

I. Pre- and post-exposure prophylaxis

1. Pre-exposure antiviral prophylaxis may be made available to selected healthcare workers by the employee health service. Generally, pre-exposure prophylaxis for pandemic influenza would be taken for at least 6 weeks. Guidelines published by CDC, the Ohio Department of Health and professional organizations will be used by Infection Prevention and Employee Health in determining which groups are to be offered prophylaxis.
2. Post-exposure antiviral prophylaxis may be made available to selected healthcare workers by Employee Health. Generally, post-exposure prophylaxis for pandemic influenza would be taken for at least 7 days. Guidelines published by CDC, the Ohio Department of Health and professional organizations will be used by Infection Prevention and Employee Health in determining which groups are to be offered prophylaxis.
3. Vaccine may be made available for healthcare workers as recommended by the Advisory Committee on Immunization Practices, state and federal guidelines. Prioritization may occur based on state and local regulations. All vaccine will be provided to employees with informed consent and at the healthcare system's expense.
4. In the event we are unable to obtain antivirals from usual vendors, a request will be made to local authorities for antivirals from state or federal reserves. Prioritization may occur based on local needs, state and federal regulations.

J. Staffing needs and personnel policies

1. Following appropriate infection control and personal protection equipment training and fit-testing, all healthcare workers are expected to conduct their normal level of job activities in order to provide care for patients with known or suspected highly communicable respiratory diseases
2. During a highly communicable respiratory disease outbreak of any size, existing staffing shortages may be amplified by illness among staff members, fear and concern about the disease, and isolation and quarantine of exposed staff or ill/exposed family members. Staffing shortages are likely to escalate as an outbreak progresses. The strain involved in highly communicable respiratory disease patient care and prolonged use of personal respiratory protection may intensify staffing

challenges. As the number of patients increase and/or staff become ill or are quarantined, a determination will need to be made as to how staffing needs will be met. The staffing needs for highly communicable respiratory disease patient management may be greater than that normally provided for other non-ICU and ICU patients to allow PPE-free time. Use of alternative staffing resources (e.g., retired healthcare workers, volunteers, contract workers, students) may be needed but will require training and support (including malpractice insurance, occupational health services) during the outbreak response.

3. During a highly communicable respiratory disease outbreak of any size, all infection control professionals will be needed to formally monitor and reinforce compliance with PPE measures and policies.
4. Quarantine authority belongs to the health department. If quarantine is used as an exposure management tool, some healthcare workers may be placed on 'home/work restrictions' to ensure sufficient staffing levels. Healthcare workers on home/work restrictions should travel only between home and the healthcare facility for the duration of the restriction. Should quarantine be necessary, the employee will be instructed by the health department regarding details on the restriction.
5. Health care workers have access to mental health professionals to help them cope with the emotional strain of managing a highly communicable respiratory disease outbreak (e.g., Employee Assistance Program).

K. Hospital access controls

1. Consider limiting all hospital visitors and involve police services to enforce access limitations in the event there are a few cases of highly communicable respiratory disease in the facility but no nosocomial transmission. Public Safety will manage all restrictions on movement of visitors, patients, and employees.
2. Consider limiting hospital admissions, transfers, discharges (in accordance with local/state recommendations and regulations) in the event that nosocomial highly communicable respiratory disease transmission occurs.

L. Supplies and equipment

1. Both consumable (e.g., PPE) and durable (e.g., ventilators) supplies will be needed to care for patients.
2. Assess anticipated needs for consumable (e.g., hand hygiene supplies, N-95 respirators, goggles and face shields, gowns, gloves, surgical masks) and durable resources (e.g., ventilators, portable X-ray units, portable HEPA filtration units) that will be necessary to provide care for various numbers of highly communicable respiratory disease patients.
3. The appropriateness and method for reuse of N-95 respirators will be determined by the nature of the highly communicable respiratory disease.
4. If N-95 respirators are not available, alternatively use N-95 respirators from another vendor, followed by N-100 respirators, N-99 respirators, and surgical masks. Any change in the type of respirator used would

require additional fit testing of employees. A PAPR should be used for high-risk procedures. The industrial hygienists in Environmental Health and Safety will be responsible for overseeing appropriate PAPR use.

5. Central Distribution will maintain at least a one to three-month surplus of consumable supplies.
6. In the event of a shortage of resources during a highly communicable respiratory disease outbreak, the Chief of Staff will appoint an ad hoc committee to determine the allocation of scarce resources (e.g., ICU beds, ventilators). Members will be drawn from the ethics committee as well as from medical staff with expertise on the specific situation.

M. Communication and reporting

1. A highly communicable respiratory disease outbreak will generate a need for rapid analysis of the status of patients and transmission in the healthcare facility and reporting of this information to employees, public health officials as well as to the public, the media, and political leaders.
2. On an as needed basis (e.g., two times per day, daily) the health care staff will have a conference call with the state and local health department to report and receive information on highly communicable respiratory disease activity in the healthcare facility and the community. The Hospital Emergency Incident Command System (HEICS) will be activated when there are one or more cases of highly communicable respiratory diseases in the hospital. This call may also discuss discharge planning of highly communicable respiratory disease patients with health department officials to ensure appropriate follow-up and case management in the community.
3. Public Relations will manage all press releases and communications with the general public, news media, and employees. Everbridge or other alert messaging may be used to disseminate these messages to patients and employees.

N. Respiratory hygiene

1. For all patients with febrile and/or respiratory illnesses, perform a routine diagnostic and therapeutic workup and use Droplet Precautions.
2. Emphasize to all visitors/staff/patients, the importance of respiratory hygiene/cough etiquette to help decrease transmission of communicable respiratory pathogens including highly communicable respiratory pathogens.
 - a. Provide surgical masks to all patients with symptoms of a respiratory illness. Provide instructions on the proper use and disposal of mask.
 - b. For patients who cannot wear a surgical mask, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them and the importance of hand hygiene after handling this material.
 - c. Provide hand hygiene materials in waiting room areas and encourage patients with respiratory symptoms to perform hand hygiene.

- d. Designate an area in the waiting room where patients with respiratory symptoms can be segregated (ideally by at least 3 feet) from other patients who do not have respiratory symptoms.
- e. Place patients with respiratory symptoms in a private room (preferred) or cubicle as soon as possible for further evaluation.
- f. Implement use of surgical masks by healthcare personnel during the evaluation of patients with respiratory symptoms.
- g. If no barriers are present, instruct registration and triage staff to remain at least 3 feet from unmasked patients and to consider wearing surgical masks during respiratory infection season and during an outbreak of a highly communicable respiratory disease.
- h. Continue to use Droplet Precautions to manage patients with respiratory symptoms until it is determined that the cause of symptoms is not an infectious agent that requires precautions beyond Standard Precautions.

V. RESPONSIBILITY

Infection Control
Administration
Employee Health

VI. KEY WORDS

Novel
New
MERS
SARS
Influenza
Pandemic
Virus

VII. APPENDIX

None

VIII. RELATED FORMS

None

IX. REFERENCES / CITATIONS

- A. Refer to Center for Disease Control and Prevention (CDC) for latest revisions.
<http://www.cdc.gov/CORONAVIRUS/MERS/INDEX.HTML>
- B. <http://www.cdc.gov/sars/index.html>
- C. www.who.int/csr/disease/coronavirus_infections

- D. <http://www.cdc.gov/ncidod/sars/pdf/clinicalguidance.pdf>
- E. http://www.who.int/csr/disease/coronavirus_infections/InterimRevisedSurveillanceRecommendations_nCoVInfection_18Mar13.pdf
- F. <http://www.ocms.org/NewsEvents/SocietyNews/NewsDetail.aspx?a=1192&ReturnUrl=/NewsEvents/SocietyNews>
- G. <http://www.cdc.gov/flu/avianflu/h7n9-virus.htm>
- H. <http://www.cdc.gov/flu/avianflu/h7n9-case-definitions.htm>