



Pandemic Flu Plan

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Disclaimer:

This plan was developed based on currently available information from the Center for Disease Control (CDC), the United States Department of Health and Human Services, and the World Health Organization (WHO). Ongoing situational developments and research will change these recommendations frequently.

This plan is intended to be used as fluid and flexible guidelines for dealing with the problems associated with a Pandemic Influenza outbreak in our island, and not as strict policy and procedure. Please keep this in mind when applying these recommendations. Any final draft will be forwarded to appropriate departments for review and approval.

Thank You,
Pandemic Flu Planning Committee

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I. INTRODUCTION

An influenza pandemic will create significant challenges for our hospital. The number of children and adults seeking care for febrile and respiratory illnesses will increase substantially; some disease will be severe requiring inpatient care; and many of those infected will have underlying risk factors for adverse outcome including death. Influenza also will occur among health care workers and their family members resulting in shortages of trained staff to care for others. Physical resources, such as hospital beds and respiratory therapy equipment may not be sufficient to meet demand. Shortages of antiviral medications and vaccine will limit the ability to implement these preventive interventions. And large numbers of influenza-infected patients and staff shortages will stress the ability to implement good infection control in the hospital, leading to nosocomial disease; further exacerbating the problem.

Although these stresses on our hospital are inevitable in an influenza pandemic, coordination, planning and exercising preparedness plans can improve the effectiveness of a pandemic response and limit mortality and morbidity. Particularly during the period before vaccine becomes available, quality health care will be the primary intervention to limit adverse health outcomes. Moreover, even when vaccine is available, supplies will be limited, two doses may be required for protection, and effectiveness may be limited in some populations groups such as the very elderly or those who have underlying medical conditions. Thus maintaining quality health care will remain an essential component of a pandemic response.

1. Background

Annual outbreaks of influenza are due to minor changes in the surface proteins of the viruses that enable the viruses to evade the immunity humans have developed after previous infections with the viruses or in response to vaccinations. When a major change in either one or both of their surface proteins occurs spontaneously, no one will have partial or full immunity against infection because it is a completely new virus. If this new virus also has the capacity to spread from person-to-person, then a pandemic will occur.

The surface proteins monitored for change are hemagglutinin (H) and neuraminidase (N). The H surface protein is responsible for cell attachment and entry and is the major antigen of the virus against which antibodies are produced. There are 14 subtypes of H and 9 subtypes of N. Each time a new strain is discovered, the strain subtype of H and N are determined resulting in the **identification of** strain type. Previous influenza pandemics have been associated with changes in H structure. In order for a strain of influenza to be distinguished as pandemic, it must meet the following criteria:

- The virus must have the ability to infect humans and cause high mortality (death);
- Existence of a global human population that is immunologically naïve; and
- Efficient and sustained human-to-human spread.

2. History

Historically, the 20th century saw 3 pandemics of influenza:

- 1918 influenza pandemic caused at least 500,000 U.S. deaths and up to 40 million deaths worldwide
- 1957 influenza pandemic caused at least 70,000 U.S deaths and 1-2 million deaths worldwide
- 1968 influenza pandemic caused about 34,000 U.S deaths and 700,000 deaths worldwide

On Guam, the 1918 influenza pandemic caused the death of approximately 5% of Guam's population (this would be equivalent to 8,400 deaths on Guam today).

3. Assumptions

The Guam Memorial Hospital Plan for **dealing with an** influenza Pandemic is based on the following planning assumptions:

- The influx of patients seeking medical attention will overburden our Emergency Room Department.
- There will be a shortage of rooms available to meet the large influx of patients needing medical attention, both critical and non-critical.
- Supplies, resources and equipment for caring for a large influx of patients will be overwhelmed.
- Staffing will be difficult considering the concern of exposure to communicable disease, the influx of a large number of patients, the likelihood that staff may be sick or caring for a sick family member.
- Visitors, families, and friends of patients will cause an overflow of persons in the Emergency Room Department and other areas of the hospital. They may also act as a means of transmission of pandemic influenza.
- Vaccines and Antivirals may likely not be available until late into the Pandemic Phase. When they do become available to our hospital, it will fall short of the demand.
- Panic will erupt within the community which will cause a secondary effect on the psychosocial stresses of staff and patients.
- **Some** GMHA staff **may** be confused as to when to initiate its Pandemic Influenza Plan.
- The overflow of patients and staff that are being limited to transport in and out of hospital will have a large effect on the resources available through Dietetic Services. Special precautions should be considered to prevent transmission via the Dietetic Services Department.

II. POLICY:

The Guam Memorial Hospital Authority shall use this plan as fluid and flexible guidelines for dealing with the problems associated with a Pandemic Influenza outbreak in our island, and not as strict policy and procedure.

1. Purpose

This plan was designed to ensure that the Guam Memorial Hospital Authority (GMHA) is prepared to implement an effective response before a pandemic arrives, throughout a response if an outbreak occurs, and after the pandemic is over. The overall goal of pandemic preparedness and response is to minimize serious illness and overall deaths. The plan is intended to be dynamic and interactive; it consists of components that are consistent with international, federal, and local guidelines as well as general principles of emergency response.

The GMHA Pandemic Influenza Plan will activate at set phases based on certain trigger points from guidelines provided by:

HHS Pandemic Influenza Plan. Washington, DC: U. S. Department of Health and Human Services; November, 2005.

WHO global influenza preparedness plan: The role of WHO and recommendations for national measures before and during pandemics. Switzerland, World Health Organization, Department of Communicable Disease Surveillance and Response Global Influenza Program: 2005.

Guam Pandemic Influenza Plan (Draft). Division of Public Health, Department of Public Health and Social Services, 2005.

The Phases are as follows:

Phase 1: Interpandemic Period

No indication of any new virus types.

Phase2: Interpandemic Period

New virus type detected in animals but not in man

Phase 3: Pandemic Alert Period

New influenza strain in a human but no (or rare) human-to-human spread.

Phase 4: Pandemic Alert Period

Small cluster(s) with limited human-to-human transmission but spread is highly localized.

Phase 5: Pandemic Alert Period

Larger cluster(s) of human-to-human transmission but still localized to a single country

Phase 6: Pandemic Period

Increased and sustained human-to-human transmission in the general population.

Postpandemic Period

Pandemic transmission over, likely 2-3 years after onset; immunity to new virus type is widespread in

the population.

This plan will identify the following components consistently by Phase:

- 1) Surveillance
- 2) Laboratory
- 3) Antiviral Agents
- 4) Vaccine Delivery
- 5) Employee Health
- 6) Communication
- 7) Clinical Guidelines
- 8) Facility Access
- 9) Surge Capacity

All other components will be addressed by Appendix. See Appendix Table.

2. Objectives

The objective of this plan is to minimize the impact of an influenza pandemic through a set of well established strategies that include:

- Operationalization of the plan through an organizational structure *See Organizational Chart* (See [Appendix 1](#))
- Identification of key personnel related to executing the plan
- Surveillance plans
- Communication plans
- Education and Training Plans
- Triage and Admission Plans
- Prevention and control Plan
- Facility Access Plans
- Occupational Health Plans
- Medication Plan
 - Vaccine and Antiviral Procurement, Storage, and Security Plan
 - Vaccine and Antiviral Use and Distribution Plans
- Surge Capacity/Cohorting Plan
- Staffing Plan (Department Specific)
- Spatial Separation of Patients Plan
- Plan for obtaining anticipated durable and consumable Resources
- Strategy for Handling Increased Number of Deceased persons
- Dietetic Services Plan
- Psychosocial Support Plan

III. INFECTION PREVENTION AND CONTROL PLAN

The guidelines provided in the Infection Prevention and Control Plan shall be implied and practiced in all aspects of practice within the hospital with response to pandemic influenza.

See *Infection Prevention and Control Plan* (See [Appendix 2](#))

IV. PHASE 1: INTERPANDEMIC PERIOD

No indication of any new virus types.

1) Surveillance

- a. Infection Control Nurse will review the weekly summary of syndromic surveillance data from the GMHA-Emergency Department patient log book done by the **Infection Control Committee** Epidemiologist **or designee**.
- b. Microbiology Department will log all routine influenza test results done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse.
- c. Infection Control Nurse will do a weekly review of medical records for patients discharged from the hospital with documentation of pneumonia.
- d. Pandemic Influenza Multidisciplinary Planning Committee will periodically review and revise the *Surveillance Plan* as appropriate

2) Laboratory

- a. Continue with routine laboratory services.
- b. Microbiology Department will log all routine influenza test results done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse.

3) Antiviral Agents

- a. Materials Management will maintain a list of vendor sources of antiviral agents.
- b. Pharmacy will make the planning decisions for acquisition and procurement of antiviral agents.
- c. Pharmacy in conjunction with Employee Health will develop a strategic plan for the management, use, and rapid distribution of antiviral drugs in accordance with CDC Guidelines.
- d. Pharmacy will identify existing storage capabilities and evaluate needs for additional storage space.
- e. Medical Director and Medical Staff in conjunction with Employee Health will assist the GMHA Pandemic Flu Multidisciplinary Planning Committee (GMH PFMPC) with establishing a list of priority populations involved in pandemic response activities and maintenance of critical services and health infrastructure for antiviral prophylaxis.

- f. Pharmacy in conjunction with Planning, Materials Management, and Hospital Administrator will evaluate needs and funding for stockpiling current antivirals.

4) Vaccine Delivery

- a. GMHA PFMPC will develop a plan for management of pandemic strain vaccine delivery, administration during an influenza pandemic and monitoring for adverse reactions
- b. GMHA PFMPC in conjunction with Employee Health will develop a plan for prioritized administration of influenza vaccine in the event of inadequate supplies.
- c. Pharmacy will identify existing securable storage capabilities and evaluate needs for additional storage space.
- d. Director of Medical Staff will encourage physicians to promote increased influenza and pneumococcal vaccine coverage levels in high risk groups.

5) Employee Health

- a. Employee Health Nurse or designee will verify employee seasonal influenza vaccine status and immunize as appropriate.
- b. Employee Health Nurse in conjunction with Administration and Infection Control Committee will consider administrative mandate that all healthcare workers will receive their annual flu shot. This is to be included as a pre-employment requirement.
- c. Employee Health will continue routine services.

6) Communication

- a. Communication Plan will initiate at Phase 6.
- b. Identify current communication capabilities at GMHA.
- c. Identify any existing problems with communication links/capabilities that may affect response during an influenza pandemic.

7) Clinical Guidelines (Triage and Admission)

- a. Clinical Guidelines Plan will initiate at Phase 4
- b. Routine Clinical procedures will be continued at this phase.

8) Facility Access Plan

- a. Continue routine Facility Access practices.

9) Surge Capacity Plan

a. Staffing

- i. Please see *Staffing Breakdown*, See [Appendix 30](#)
- ii. All specific Staffing Plans for departments will be maintained and updated by department managers.

b. Bed Capacity

- i. Bed Capacity Plan will initiate at Phase 6.
- ii. Continually look at options for additional space for patient admissions.

c. Consumable Resources

- i. Encourage department managers to identify current inventory of supplies and equipment for sustaining essential operations for a 6 to 8 week period.

V. **PHASE 2: INTERPANDEMIC PERIOD**

New virus type detected in animals but not in man

1) **Surveillance**

- a. Infection Control Nurse will continue to review the weekly summary of syndromic surveillance data from the GMHA-Emergency Department patient log book done by **Infection Control Committee** Epidemiologist **or designee**.
- b. Microbiology Department will continue to log all routine influenza test results done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse.
- c. Infection Control Nurse will do a weekly review of medical records for patients discharged from the hospital with documentation of pneumonia.
- d. Pandemic Influenza Multidisciplinary Planning Committee will periodically review and revise the *Surveillance Plan* as appropriate

2) **Laboratory**

- a. Continue with routine laboratory services.
- b. Microbiology Department will log all routine influenza test results done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse

3) **Antiviral Agents**

- a. Materials Management will maintain a list of vendor sources of antiviral agents.
- b. Pharmacy will make the planning decisions for acquisition and procurement of antiviral agents.
- c. Pharmacy in conjunction with Employee Health will develop a strategic plan for the management, use, and rapid distribution of antiviral drugs in accordance with CDC Guidelines.
- d. Pharmacy will identify existing storage capabilities and evaluate needs for additional storage space.
- e. Medical Director and Medical Staff in conjunction with Employee Health will assist the GMHA Pandemic Flu Multidisciplinary Planning Committee (GMH PFMPC) with establishing a list of priority populations involved in pandemic response activities and maintenance of critical services and health infrastructure for antiviral prophylaxis.
- f. Pharmacy in conjunction with Planning, Materials Management, and Hospital Administrator will evaluate needs and funding for stockpiling current antivirals

4) **Vaccine Delivery**

- a. GMHA PFMPC will develop a plan for management of pandemic strain vaccine delivery, administration during an influenza pandemic and monitoring for adverse reactions
- b. GMHA PFMPC in conjunction with Employee Health will develop a plan for prioritized administration of influenza vaccine in the event of inadequate supplies.
- c. Pharmacy will identify existing securable storage capabilities and evaluate needs for additional storage space.
- d. Director of Medical Staff will encourage physicians to promote increased influenza and pneumococcal vaccine coverage levels in high risk groups.

5) Employee Health

- a. Employee Health Nurse or designee will verify employee seasonal influenza vaccine status and immunize as appropriate.
- b. Employee Health Nurse in conjunction with Administration and Infection Control Committee will consider administrative mandate that all healthcare workers will receive their annual flu shot. This is to be included as a pre-employment requirement.
- c. Employee Health will continue routine services.

6) Communication

- a. Communication Plan will initiate at Phase 6.
- b. Identify current communication capabilities at GMHA.
- c. Identify any existing problems with communication links/capabilities that may affect response during an influenza pandemic.

7) Clinical Guidelines (Triage and Admission)

- a. Clinical Guidelines Plan will initiate at Phase 4
- b. Routine Clinical procedures will be ongoing at this phase

8) Facility Access Plan

- a. Pandemic Flu Multidisciplinary Planning Committee will identify current facility access problems and concerns that may affect response in an influenza pandemic and identify options and plans for controlling hospital access.
- b. Continue routine Facility Access practices.

9) Surge Capacity Plan

- a. **Staffing**
 - i. Please see *Staffing Breakdown*, See [Appendix 30](#)
 - ii. All specific Staffing Plans for departments will be maintained and updated by department managers.
- b. **Bed Capacity**
 - i. Bed Capacity Plan will initiate at Phase 6.
 - ii. Continually look at options for additional space for patient admissions.
- c. **Consumable Resources**

- i. Encourage department managers to identify current inventory of supplies and equipment for sustaining essential operations for a 6 to 8 week period.

VI. PHASE 3: PANDEMIC ALERT PERIOD

New influenza strain in a human but no (or rare) human-to-human spread.

1. Surveillance

- a. Infection Control Nurse will continue to review the weekly summary of syndromic surveillance data from the GMHA-Emergency Department patient log book done by **Infection Control Committee** Epidemiologist **or designee**.
- b. Microbiology Department will continue to log all routine influenza test results done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse.
- c. Infection Control Nurse will continue weekly review of patients discharged from hospital with medical records documentation of pneumonia.
- d. Pandemic Influenza Multidisciplinary Planning Committee will periodically review and revise the *Surveillance Plan* as appropriate.

2. Laboratory

- a. Laboratory Administrator or designee will evaluate the supply and usage of Rapid Influenza A & B tests (i.e Directigen Flu A & B kits) to determine supply needs during a 6-8 week period.
- b. Laboratory Director, Laboratory Administrator and Microbiology Supervisor will work with Department of Public Health and Social Services (DPHSS) Laboratory to address surge capacity issues during an influenza pandemic.
- c. Laboratory Administrator or designee will assess current routine lab supplies and resources needs to last for a 6-8 week period in preparation for a pending influenza pandemic. See *Laboratory Collection, Processing, and Referral of Specimens to DPHSS*, See [Appendix 4](#)
- d. Microbiology Department will continue surveillance of all routine influenza tests done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse. The surveillance log will specifically identify the following:
 - i. Total number of respiratory specimens tested
 - ii. Number testing positive for influenza by type (or subtype if known) and age group
- e. Laboratory personnel will continue to conduct routine testing.
- f. Laboratory Administrator will start planning with DPHSS the specimen requirements and transport flow in the event that GMH is directed to refer specimens. See *Laboratory Collection, Processing, and Referral of Specimens to DPHSS*, See [Appendix 4](#)
- g. Laboratory Director shall update Laboratory Plan as needed.

3. Antiviral Agents

- a. Pharmacy in conjunction with Planning, Materials Management, and Hospital Administrator will evaluate needs and funding for stockpiling antivirals for the upcoming pandemic flu strain.
- b. Pharmacy Director or designee in conjunction with Materials Management will identify an adequate quantity of antivirals and procure that amount based on funding availability.
- c. If antivirals are available then the following actions will take place:
 - 1) Pharmacy will store the antivirals in the identified storage space.
 - i. *Pharmacy Antiviral/Vaccine Control and Management Plan*, See [Appendix 18](#)
 - 2) Employee Health will implement *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#)
 - 3) Security Department will patrol storage areas and Administration areas.
 - 4) GMH PFMPC will update the *Pharmacy Antiviral/Vaccine Control and Management Plan* as needed.

4. Vaccine Delivery

- a. GMHA PFMPC will develop a plan for management of pandemic strain vaccine delivery, administration during an influenza pandemic and monitoring for adverse reactions.
- b. GMHA PFMPC in conjunction with Employee Health will develop a plan for prioritized administration of influenza vaccine in the event of inadequate supplies.
- c. Pharmacy will identify existing securable storage capabilities and evaluate needs for additional storage space.
- d. Director of Medical Staff will encourage physicians to promote increased influenza and pneumococcal vaccine coverage levels in high risk groups.

5. Employee Health

- a. Employee Health Nurse or designee will verify employee seasonal influenza vaccine status and immunize as appropriate.
- b. Employee Health Nurse in conjunction with Administration and Infection Control Committee will consider administrative mandate that all healthcare workers will receive their annual flu shot. This is to be included as a pre-employment requirement.
- c. Employee Health will continue routine services.
- d. Employee Health Nurse will communicate daily with Infection Control and monitor CDC recommendations and requirements as the virus is identified.
- e. Employee Health will implement *GMHA Antiviral/Vaccine Administration Plan* (See [Appendix 23](#)) if antivirals/vaccines are available.
- f. Employee Health will work with Departmental Managers to identify essential versus non-essential workers in order to facilitate a priority list for antiviral/vaccine administration to employees.

6. Communication

- a. Communication Plan will initiate at Phase 6.

- b. Identify current communication capabilities at GMHA.
- c. Identify any existing problems with communication links/capabilities that may affect response during an influenza pandemic.

7. Clinical Guidelines (Triage and Admission)

- a. Clinical Guidelines Plan will initiate at Phase 4
- b. Education Department in conjunction with Staff Nurse Training Officer will train staff on Clinical Guidelines Plan as indicated in *GMHA Clinical Guidelines Flow Chart for Avian Influenza/Novel Influenza Without Local Transmission*, See [Appendix 14](#).
- c. Update Clinical Guidelines Plan as needed.

8. Facility Access Plan

- a. Security Department will identify systems available for securing multiple entrances to the hospital (manual and physical means for securing).
- b. Pandemic Flu Multidisciplinary Planning Committee will make a plan for control of an influx of patients through the Emergency Room during an influenza pandemic. Plans should ensure segregation of Influenza-Like-Illness (ILI) from routine ER patient inflow. See *Facility Access Flow Chart (ER Patients)*, See [Appendix 8](#).
- c. Facilities Maintenance will make Traffic Control Signs to direct patients to the External Triage screening area. Facilities Maintenance will store the signs until needed. See *Traffic Control Signs*, See [Appendix 10](#)
- d. Security and Facilities Maintenance will continually update this plan as needed.
- e. Pandemic Flu Multidisciplinary Planning Committee will execute an exercise of the Facility Access Plan and make changes as needed.

9. Surge Capacity Plan

a. Staffing

- i. Please see *Staffing Breakdown*, See [Appendix 30](#). All specific Staffing Plans for departments will be maintained and updated by department managers.
- ii. Incorporate *Governor's Executive Order*, See [Appendix 31](#), into Staffing Plan.

b. Bed Capacity

- i. Bed Capacity Plan will initiate at Phase 6.
- ii. Continually look at options for additional space for patient admissions.

c. Consumable Resources

- i. Encourage department managers to identify current inventory of supplies and equipment for sustaining essential operations for a 6 to 8 week period.

VII. PHASE 4: PANDEMIC ALERT PERIOD

Small cluster(s) with limited human-to-human transmission anywhere.

1. Surveillance

- a. Infection Control Nurse will continue weekly review of patients discharged from the hospital with a medical records documentation of pneumonia.
- b. Microbiology Department will log all routine influenza test results done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse.
- c. Infection Control Nurse will review log kept by Microbiology of patients meeting the criteria for avian influenza A testing. See *Criteria for Testing for Avian Influenza A (H5N1)*, See [Appendix 5](#)
 - i. Cases meeting the case definition for testing shall be reported by the clinician as a suspect Class I Disease within 24 hours. See *Reporting to DPHSS of Suspected / Actual Cases*, See [Appendix 16](#)
- d. Infection Control Nurse will review Emergency Room log on Influenza-Like - Illness that is initiated at this phase under the *Clinical Guidelines Plan*. Total number of cases will be reported by Infection Control to the Territorial Epidemiologist for Surveillance purposes.
- e. Infection Control Nurse will work with Territorial Epidemiologist to be added to the Health Alert Network (HAN). The notification system shall take place as follows:
 - i. When a HAN fax arrives during regular hours, the IC Department immediately notifies the Medical Director's office and confirms that he or she has received it.
 - ii. When a HAN fax arrives during off-hours, the Communication Center shall immediately notify the Medical Director and confirms that he or she has received it. The Medical Director contacts the Administrator to alert him when appropriate.
- f. MIS shall send out an automatic alert in the sign-in set up to inform all departments regarding heightened surveillance levels encouraging consistent reporting of cases to Hospital Infection Control will also be encouraged.
- g. Infection Control will review Employee Health log of employees screened for Epidemiological Criteria (see *Employee Health Plan*.)
- h. Pandemic Influenza Multidisciplinary Planning Committee will periodically review and revise the *Surveillance Plan* as needed.

2. Laboratory

- a. Laboratory Administrator or designee will continue to evaluate the supply and usage of Rapid Influenza A & B tests (i.e Directigen Flu A & B kits) to determine supply needs during a 6-8 week period.
- b. Laboratory Director, Laboratory Administrator and Microbiology Supervisor will continue to work with Department of Public Health and Social Services (DPHSS) Laboratory to address surge capacity issues during an influenza pandemic.
- c. Laboratory Administrator or designee will continue to monitor supply and equipment needs.

- d. Microbiology Department will continue surveillance of all routine influenza tests done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse. The surveillance log will specifically identify the following:
 - i. Total number of respiratory specimens tested
 - ii. Number testing positive for influenza by type (or subtype if known) and age group
- e. Laboratory personnel will continue to conduct routine testing.
- f. If a specimen is sent to laboratory that is referenced as meeting the criteria for testing as a novel influenza strain, then the following actions need to be taken:
 - i. Microbiology will implement processes for processing and referral of specimens to DPHSS. See *Laboratory Collection, Processing, and Referral of Specimens to DPHSS*, See [Appendix 4](#).
 - ii. Microbiology will contact the **Public Health Supervisor** or alternative for additional instructions or updates for specimen referral.
 - iii. Microbiology staff will log the case in the Influenza Log book and report the case to Infection Control.
- g. Laboratory Director in conjunction with Laboratory Administrator will update *Laboratory Plan* as needed.

3. Antiviral Agents

- a. Pharmacy Director or designee in conjunction with Materials Management will continue to procure more antivirals.
- b. GMH PFMPC will update the *Pharmacy Antiviral/Vaccine Control and Management Plan* Antiviral Management and Administration Plan and Antiviral Priority Listing as needed.
- c. As antivirals are continually received the following actions will take place:
 - i. Pharmacy will store the antivirals in the identified storage space.
 - 1.) See *Pharmacy Antiviral/Vaccine Control and Management Plan*, See [Appendix 18](#)
 - ii. Employee Health will implement *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#), in compliance with *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#)
 - iii. Security Department will patrol storage areas and Administration areas.

4. Vaccine Delivery

- a. Employee Health will conduct a drill on GMHA Antiviral/Vaccine Administration Plan (See [Appendix 23](#)) and make changes as needed.
- b. Update *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#).
- c. Continually encourage Medical Staff to promote increased influenza and pneumococcal vaccine coverage levels in high risk groups.

5. Employee Health

- a. Employee Health Nurse or designee will verify employee seasonal influenza vaccine status and immunize as appropriate.
- b. Employee Health Nurse in conjunction with Administration and Infection Control Committee will consider administrative mandate that all healthcare workers will receive their annual flu shot. This is to be included as a pre-employment requirement.
- c. Employee Health will continue routine services.
- d. Employee Health Nurse will communicate daily with Infection Control and monitor CDC recommendations and requirements as the virus is identified.
- e. Employee Health will implement *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#), in compliance with *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#), if antiviral/vaccines are available.
- f. Department Managers will refer employees meeting the Epidemiological Criteria to Employee Health. Referred employees are mandated to *clear* with Employee Health prior to returning to work. See *Employee Health Pandemic Flu Screening Questionnaire*, See [Appendix 21](#). Employees identified as a potential influenza case will be treated in accordance with *GMHA Clinical Guidelines Flow Chart for Avian Influenza/Novel Influenza Without Local Transmission* (See [Appendix 14](#)). Employee Health will maintain a log of personnel who are screened. Employee Health will report cases and/or suspect cases to Infection Control.

6. Communication

- a. Communication Plan will initiate at Phase 6.
- b. Identify current communication capabilities at GMHA.
- c. Identify any existing problems with communication links/capabilities that may affect response during an influenza pandemic.
- d. Communication Center will conduct training and testing of *Phone Screening Guidelines Plan*, See [Appendix 27B](#), and make changes as needed.

7. Clinical Guidelines (Triage and Admission)

- a. Implement Clinical Guidelines Plan. See *GMHA Clinical Guidelines Flow Chart for Avian Influenza/Novel Influenza Without Local Transmission*, See [Appendix 14](#).
- b. Update the Clinical Guidelines Plan as needed.

8. Facility Access Plan

- a. Security Department will identify systems available for securing multiple entrances to the hospital (manual and physical means for securing).
- b. Pandemic Flu Multidisciplinary Planning Committee will make a plan for control of an influx of patients through the Emergency Room during an influenza pandemic. Plans should ensure segregation of Influenza-Like-Illness (ILI) from routine ER patient inflow. See *Facility Access Flow Chart (ER Patients)*, See [Appendix 8](#).

- c. Facilities Maintenance will make Traffic Control Signs to direct patients to the External Triage screening area. Facilities Maintenance will store the signs until needed. See *Traffic Control Signs*, See [Appendix 10](#)
- d. Security and Facilities Maintenance will continually update this plan as needed.
- e. Pandemic Flu Multidisciplinary Planning Committee will execute an exercise of the Facility Access Plan and make changes as needed.

9. Surge Capacity Plan

a. Staffing

- i. Please see *Staffing Breakdown*, See [Appendix 30](#)
- ii. All specific Staffing Plans for departments will be maintained and updated by department managers.
- iii. Incorporate *Governor's Executive Order*, See [Appendix 31](#), into Staffing Plan.

b. Bed Capacity

- i. Bed Capacity Plan will initiate at Phase 6.
- ii. Continually look at options for additional space for patient admissions.

c. Consumable Resources

- i. Department Managers shall re-examine current inventory of supplies and equipment for sustaining essential operations for a 6 to 8 week period.

VIII. PHASE 5: PANDEMIC ALERT PERIOD

Larger cluster(s) of human-to-human transmission but still localized to a single country/region.

1. Surveillance

- a. Infection Control Nurse will continue weekly review of patients discharged from the hospital with a medical records documentation of pneumonia.
- b. Microbiology Department will log all routine influenza test results done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse.
- c. Infection Control Nurse will review log kept by Microbiology of patients meeting the criteria for avian influenza A testing. See *Criteria for Testing for Avian Influenza A (H5N1)*, See [Appendix 5](#).
 - i. Cases meeting the case definition for testing shall be reported by the clinician as a suspect Class I Disease within 24 hours. See *Reporting to DPHSS of Suspected / Actual Cases*, See [Appendix 16](#)
- d. Infection Control Nurse will continue to review the Emergency Room log on Influenza-Like-Illness. Total number of cases will be reported by Infection Control to the Territorial Epidemiologist for Surveillance purposes.
- e. MIS will continue daily electronic monitoring of the following areas:
 - i. Numbers of individuals treated for influenza.

- ii. Numbers of employees treated for influenza.
 - iii. Numbers of all hospitalized admissions for influenza.
- f. MIS shall send out an automatic alert in the sign-in set up to inform all departments regarding heightened surveillance levels encouraging consistent reporting of cases to Hospital Infection Control will also be encouraged.
- g. Infection Control will review Employee Health log of employees screened for Epidemiological Criteria (see *Employee Health Plan.*). Infection Control will report cases to Territorial Epidemiologist.
- h. Infection Control Nurse will continue to monitor the Health Alert Network (HAN). The notification system shall take place as follows:
 - i. When a HAN fax arrives during regular hours, the IC Department immediately notifies the Medical Director's office and confirms that he or she has received it.
 - ii. When a HAN fax arrives during off-hours, the Communication Center shall immediately notify the Medical Director and confirms that he or she has received it. The Medical Director contacts the Administrator to alert him when appropriate.
 - iii. Infection Control will update this notification system as needed.
- i. Pandemic Influenza Multidisciplinary Planning Committee will periodically review and revise the *Surveillance Plan* as needed

2. Laboratory

- a. Laboratory Administrator or designee will ensure the continuous availability of Rapid Influenza A & B tests based on determined supply needs for a 6-8 week period.
- b. Laboratory Director, Laboratory Administrator and Microbiology Supervisor will continue to work with Department of Public Health and Social Services (DPHSS) Laboratory to address surge capacity issues and referral of lab specimens during an influenza pandemic.
- c. Laboratory Administrator or designee will continue to monitor supply and equipment needs.
- d. Microbiology Department will continue surveillance of all routine influenza tests done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse. The surveillance log will specifically identify the following:
 - i. Total number of respiratory specimens tested
 - ii. Number testing positive for influenza by type (or subtype if known) and age group
- e. Laboratory personnel will continue to conduct routine testing.
- f. If a specimen is sent to laboratory that is referenced as meeting the criteria for testing as a novel influenza strain, then the following actions need to be taken:
 - i. Microbiology will implement processes for processing and referral of specimens to DPHSS. See *Laboratory Collection, Processing, and Referral of Specimens to DPHSS*, See [Appendix 4](#).

- ii. Microbiology will contact the **Public Health Supervisor** or alternative for additional instructions or updates for specimen referral.
- iii. Microbiology staff will log the case in the Influenza Log book and report the case to Infection Control.
- g. Laboratory Director in conjunction with Laboratory Administrator will update *Laboratory Plan* as needed

3. Antiviral Agents

- a. Pharmacy Director or designee in conjunction with Materials Management will continue to procure more antivirals.
- b. As antivirals are continually received the following actions will take place:
 - i. Pharmacy will store the antivirals in the identified storage space.
 - 1.) *Pharmacy Antiviral/Vaccine Control and Management Plan*, See [Appendix 18](#)
 - ii. Employee Health will implement *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#), in compliance with *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#).
 - iii. Security Department will patrol storage areas and Administration areas.
- c. GMH PFMPC will update the Antiviral Management and Administration Plan and Antiviral Priority Listing as needed.

4. Vaccine Delivery

- a. Continue to monitor for availability of vaccine for pandemic influenza.
- b. If vaccines are available:
 - i. Initiate *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#).
 - ii. Distribute based on priority, See *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#).
 - iii. Place vaccines in the designated secured storage area identified by Pharmacy (to be inserted upon completion)
 - iv. Documentation, monitoring, and surveillance of adverse events shall be implemented. See *Pandemic Influenza Post Vaccination Worksheet and Adverse Events Monitoring*, See [Appendix 24](#).
 - v. follow contingent priority listing if the supply is inadequate
- c. Update Priority Listing for Vaccine Distribution and contingent plan as needed.
- d. Encourage Medical Staff to promote increased influenza and pneumococcal vaccine coverage levels in high risk groups.

5. Employee Health

- a. Employee Health Nurse or designee will continue to verify employee seasonal influenza vaccine status and immunize as appropriate.
- b. Implement administrative mandate that all healthcare workers will receive their annual flu shot. This is to be included as a pre-employment requirement that will include additional staff/volunteers.
- c. Employee Health will continue routine services.

- d. Employee Health Nurse will communicate daily with Infection Control and monitor CDC recommendations and requirements as the virus is identified.
- e. Employee Health will implement *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#), in compliance with *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#).
- f. Implement early detection and treatment plan for healthcare personnel who meet the *Epidemiological Criteria* section of the *GMHA Clinical Guidelines Flow Chart for Avian Influenza/Novel Influenza Without Local Transmission* (See [Appendix 14](#)).
- g. Department Managers will refer employees meeting the Epidemiological Criteria to Employee Health. Referred employees are mandated to *clear* with Employee Health prior to returning to work. See *Employee Health Pandemic Flu Screening Questionnaire*, See [Appendix 21](#). Employees identified as a potential influenza case will be treated in Accordance with *GMHA Clinical Guidelines Flow Chart for Avian Influenza/Novel Influenza Without Local Transmission*. Employee Health will maintain a log of personnel who are screened. Employee Health will report cases to Infection Control.

6. Communication

- a. Communication Plan will initiate at Phase 6.
- b. Identify current communication capabilities at GMHA.
- c. Identify any existing problems with communication links/capabilities that may affect response during an influenza pandemic.
- d. Communication Center will conduct training and testing of *Phone Screening Guidelines Plan*, See [Appendix 27B](#), and make changes as needed.

7. Clinical Guidelines (Triage and Admission)

- a. Implement Clinical Guidelines Plan. See *GMHA Clinical Guidelines Flow Chart for Avian Influenza/Novel Influenza Without Local Transmission*, See [Appendix 14](#).
- b. Update the Clinical Guidelines Plan as needed.

8. Facility Access Plan

- a. Continue implementation of the Facility Access Plan, See *Facility Access Flow Chart (ER Patients)*, See [Appendix 8](#).
- b. Director of Security will ensure compliance with the *Facility Access Plan*, See [Appendix 8](#).
- c. Director of Security will work with Nursing personnel to restrict visitation to watchers only.
- d. Security and Facilities Maintenance will continually update this plan as needed.
- e. Pandemic Flu Multidisciplinary Planning Committee will work with Security and Facilities Maintenance to continue to address facility access problems and concerns.

9. Surge Capacity Plan

a. Staffing

- i. Please see *Staffing Breakdown*, See [Appendix 30](#)
- ii. All specific Staffing Plans for departments will be maintained and updated by department managers.
- iii. Incorporate *Governor's Executive Order*, See [Appendix 31](#), into Staffing Plan.

b. Bed Capacity

- i. Refer to *Surge Capacity Table*, See [Appendix 11](#)
- ii. Refer to *Bed Capacity Table*, See [Appendix 12](#), and *Airborne Infection Isolation Capacity*, See [Appendix 13](#)
- iii. Continually look at options for additional space for patient admissions.

c. Consumable Resources

- i. All department specific plans for maintaining and ensuring adequate consumable resources for a 6 to 8 week period shall be managed and updated as needed by department managers.

IX. Phase 6: Pandemic Period

Cases of novel flu virus occurring on Guam.

1. Surveillance

- a. Infection Control Nurse will continue weekly review of patients discharged from the hospital with a medical records documentation of pneumonia.
- b. Microbiology Department will log all routine influenza test results done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse.

NOTE: Routine laboratory confirmation of clinical diagnosis will be unnecessary as pandemic activity becomes widespread in the community. Therefore surveillance activities related to positive influenza tests may be stopped.

- c. Infection Control Nurse will review log kept by Microbiology of patients meeting the criteria for avian influenza A testing. See *Criteria for Testing for Avian Influenza A (H5N1)*, See [Appendix 5](#).
 - i. Cases meeting the case definition for testing shall be reported by the clinician as a suspect Class I Disease within 24 hours. See *Reporting to DPHSS of Suspected / Actual Cases*, See [Appendix 16](#).
- d. Infection Control Nurse will continue to review the Emergency Room log on Influenza-Like-Illness. Total number of cases will be reported by Infection Control to the Territorial Epidemiologist for Surveillance purposes.
- e. MIS will continue daily electronic monitoring of the following areas:
 - i. Numbers of individuals treated for influenza.
 - ii. Numbers of employees treated for influenza.

- iii. Numbers of all hospitalized admissions for influenza.
- f. MIS shall send out an automatic alert in the sign-in set up to inform all departments regarding heightened surveillance levels encouraging consistent reporting of cases to Hospital Infection Control will also be encouraged.
- g. Infection Control will review Employee Health log of employees screened for Epidemiological Criteria (see *Employee Health Plan.*). Infection Control will report cases to Territorial Epidemiologist.
- h. Infection Control Nurse will continue to monitor the Health Alert Network (HAN) for significant changes.
- i. Pandemic Influenza Multidisciplinary Planning Committee will periodically review and revise the *Surveillance Plan* as needed
- j. Infection Control Nurse will continue hospital surveillance for pandemic influenza in incoming and already admitted patients.

2. Laboratory

- a. Laboratory Administrator or designee will ensure the continuous availability of Rapid Influenza A & B tests based on determined supply needs for a 6-8 week period.
- b. Laboratory Director, Laboratory Administrator and Microbiology Supervisor will continue to work with Department of Public Health and Social Services (DPHSS) Laboratory to address surge capacity issues and referral of lab specimens during an influenza pandemic.
- c. Laboratory Administrator or designee will continue to monitor supply and equipment needs.
- d. Microbiology Department will continue surveillance of all routine influenza tests done per normal lab protocol and monitor for any significant increase in cases. The microbiologist on duty will report significant changes to the Infection Control Nurse. The surveillance log will specifically identify the following:
 - i. Total number of respiratory specimens tested
 - ii. Number testing positive for influenza by type (or subtype if known) and age group.
- e. Laboratory personnel will continue to conduct routine testing.
- f. If a specimen is sent to laboratory that is referenced as meeting the criteria for testing as a novel influenza strain, then the following actions need to be taken:
 - i. Microbiology will implement processes for processing and referral of specimens to DPHSS. See *Laboratory Collection, Processing, and Referral of Specimens to DPHSS*, See [Appendix 4](#).
 - ii. Microbiology will contact Claire Baradi or alternative for additional instructions or updates for specimen referral.
 - iii. Microbiology staff will log the case in the Influenza Log book and report the case to Infection Control.
 - iv. **NOTE:** Laboratory Administrator will continually check for updates in recommendations from DPHSS for routine laboratory confirmation of clinical diagnoses. **Routine laboratory confirmation of clinical diagnosis of pandemic flu will be unnecessary as pandemic activity**

becomes widespread in the community. CDC will continue to work with the DPHSS laboratory to conduct virologic surveillance to monitor antigenic changes and antiviral resistance in the pandemic virus strains throughout the Pandemic Period

- g. Laboratory Director in conjunction with Laboratory Administrator will update *Laboratory Plan* as needed.

3. Antiviral Agents

- a. GMHA PFMPC will collaborate with DPHSS with updates on availability of antivirals.
- b. If DPHSS has antivirals available:
 - i. DPHSS will supply secured mobilization of antivirals to GMHA Pharmacy Department
- c. As antivirals are continually received the following actions will take place:
 - i. Pharmacy will store the antivirals in the identified storage space.
 - 1) See *Pharmacy Antiviral/Vaccine Control and Management Plan*, See [Appendix 18](#).
 - ii. Employee Health will implement *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#), in compliance with *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#).
 - iii. If the stock of antivirals allows, nursing staff shall implement *Pharmacy Antiviral/Vaccine Control and Management Plan*, See [Appendix 18](#).
- d. GMH PFMPC will update the Antiviral Management and Administration Plan and Antiviral Priority Listing as needed.

4. Vaccine Delivery

- a. Pharmacy will collaborate with DPHSS for availability of pandemic strain vaccine.
- b. When vaccines are available:
 - i. Employee Health will coordinate the initiation of the *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#).
 - ii. Employee Health Nurse will ensure distribution based on priority, See *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#).
 - iii. Place vaccines in the designated secured storage area identified by Pharmacy (to be inserted upon completion)
 - iv. Nurses assigned to the vaccine distribution site will ensure documentation, monitoring, and surveillance of adverse events based on *Pandemic Influenza Post Vaccination Worksheet and Adverse Events Monitoring*, See [Appendix 24](#).
- c. PFMPC will update Priority Listing for Vaccine Distribution and contingent plan as needed.

5. Employee Health

- a. Employee Health will continue routine services.

- b. Employee Health Nurse or designee will continue to verify employee seasonal influenza vaccine status and immunize as appropriate.
- c. Employee Health Nurse will communicate daily with Infection Control and monitor CDC recommendations and requirements as the virus is identified
- d. Implement administrative mandate that all healthcare workers will receive their annual flu shot. This is to be included as a pre-employment requirement that will include additional staff/volunteers.
- e. Employee Health will implement *GMHA Antiviral/Vaccine Administration Plan*, See [Appendix 23](#), in compliance with *Prioritization Listing for Antiviral and Vaccine Delivery*, See [Appendix 19](#). Verify employee seasonal influenza vaccine status and immunize as appropriate.
- f. Employee Health Nurse will implement early detection and treatment plan for healthcare personnel who meet the *Epidemiological Criteria* section of the *GMHA Clinical Guidelines Flow Chart for Avian Influenza/Novel Influenza Without Local Transmission* (See [Appendix 14](#)).
- g. All non-ill employees will report to their workstation after screening.
- h. Employees with Flu like Symptoms will proceed with the following:
 - i. Any employee who develops flu-like symptoms during their workday will report to the Front Main Entrance for evaluation and disposition.
 - ii. Employee Health Nurse will Test employees with flu symptoms for influenza per CDC protocol if they meet both clinical and epidemiological criteria for testing. (See *Clinical Guidelines*)
 - iii. Employees at home that are concerned regarding questionable symptoms are to call phone triage for screening.
 - iv. If the employees meet clinical and epidemiological criteria, cases should be reported to DPHSS. See *Reporting to DPHSS or Suspected / Actual Cases*, See [Appendix 16](#).
 - v. *Employee Health Fit to Work Status* (See [Appendix 20](#)) will be determined by a physician.
 - vi. 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:
 - 1) Such Health Care Workers should be required to wear a mask if they are coughing.
 - 2) They must pay meticulous attention to hand hygiene.
 - 3) They should not be floated to intensive care areas, nursery or an area with severely immunocompromised patients, i.e. chronic heart or lung disease, or patients with HIV/AIDS and dialysis patients.
- i. Employee Health Nurse will collaborate with Nursing Supervisor to identify personnel at high risk of complications (e.g. pregnant, immunocompromised persons). Those identified will 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).

- j. Refer to *Psychosocial Support Plan* for employees who need counseling to maximize professional performance and personal resilience by addressing management of grief, exhaustion, anger, fear, self and family physical needs, and ethical dilemmas.

6. Communication

- a. Communication Center will identify any existing problems with communication links/capabilities that may be affecting response.
- b. Communication Center in conjunction with MIS will notify employees of the current pandemic level.
- c. Hospital Administrator will implement the *Plan Activation Procedures*, See [Appendix 27A](#).
- d. Communication Center will implement *Phone Screening Guidelines Plan*, See [Appendix 27B](#), based on activation by Command Post.
- e. Command Post will monitor CDC, Health Alert Network (HAN) as well as international news media to assist with updates in this Communication Plan.
- f. Communication Center will update the Communication Plan as needed.
- g. Communication Center in conjunction with MIS will release internal statements indicating that all public statements must be routed through the Hospital Administrator or designee.

7. Clinical Guidelines (Triage and Admission)

- a. Implement Clinical Guidelines Plan. See *GMHA Clinical Guidelines Flow Chart for Avian Influenza/Novel Influenza With Local Transmission*, See [Appendix 15](#).
- b. Update the Clinical Guidelines Plan as needed.

8. Emergency Operations

- a. Emergency Operations Plan will initiate at Phase 4

9. Facility Access Plan

- a. Continue implementation of the Facility Access Plan, See *Facility Access Flow Chart (ER Patients)*, See [Appendix 8](#).
- b. Facilities Maintenance will erect signs at all entrances directing all employees to the Main Hospital Entrance and directing all patients to the ER Temporary Triage Site. See *Traffic Control Signs*, See [Appendix 10](#).
- c. Director of Security will assign security personnel to all hospital entrances to assist in limiting employee access to the Main Hospital Entrance.
- d. Visitor restrictions will be implemented. See *Visitor Restrictions Plan*, See [Appendix 3](#).
- e. Nursing Supervisor will ensure appropriate nursing personnel coverage at the triage areas (Front Main Entrance and ER Temporary Triage Site).
- f. Facilities Maintenance will erect signs at the ER Temporary Triage Site directing patients with flu like symptoms to report symptoms to a nurse for appropriate instructions and directions.

- g. Lock other facility entrances other than the Front Main Entrance and the ER Entrance. Station Security to respond to questions and ensure that no one enters through other entrance areas. Put up signs in all entrance areas indicating the appropriate place of exit and entrance.
- h. Director of Security will ensure compliance with the *Facility Access Plan*.
- i. Security and Facilities Maintenance will continually update this plan as needed.
- j. Pandemic Flu Multidisciplinary Planning Committee will work with Security and Facilities Maintenance to continue to address facility access problems and concerns.

10. Surge Capacity Plan

a. **Staffing Plan:** See *Staffing Breakdown Plan*, See [Appendix 30](#).

b. Bed Capacity

- i. Refer to *Surge Capacity Table*, See [Appendix 11](#)
- ii. Refer to *Total Bed Capacity Table*, See [Appendix 12](#), and *Airborne Infection Isolation Capacity*, See [Appendix 13](#).
- iii. Command Post will determine threshold when to cancel elective admissions and surgery.
- iv. Command Post will determine threshold for implementation of Rapid discharge policies and procedures to expedite transfer of patients out of the hospital (See *Patient Rapid Discharge Plan*, See [Appendix 17](#)).
- v. Social Services will arrange referrals to home healthcare agencies for at-home follow-up care of early discharged and deferred admission patients.
- vi. Command Post will implement *GMHA Overflow Plan* as needed, See [Appendix 40](#).

*** Please refer to Island wide Community Plan for further Procedures.**

X. POSTPANDEMIC PERIOD

Pandemic transmission over, likely 2-3 years after onset; immunity to new virus type is widespread in the population.

1. Surveillance

- a. Infection Control Nurse will continue surveillance activity (as outlined in Phase 6(B) in anticipation of a second-wave of influenza cases.
- b. MIS will gather electronic numbers and reports to the Infection Control Nurse and Territorial Epidemiologist for the following:
 - i. Total number of patients treated for influenza.
 - ii. Total number of employees treated for influenza.
 - iii. Total numbers of all mortality cases from influenza and/or complications of influenza.
 - iv. Total numbers for all hospitalized admissions for influenza.
- c. Pandemic Influenza Multidisciplinary Committee in conjunction with the Executive Management Council shall conduct an evaluation of how the surveillance plan worked.

- d. GMHA Pandemic Influenza Multidisciplinary Committee in conjunction with an Ethics Committee shall review the ethical distribution cases to determine needs or plan changes.
- e. Repeat Phases 4-6 as appropriate.

2. Laboratory

- a. Resume routine laboratory services.
- b. Laboratory Administrator and staff will inventory supplies and restock all supplies expended.
- c. Review effectiveness of Laboratory Plan and integrate needed changes.

3. Antiviral Agents

- a. Evaluate of Antiviral Agent Plan and make necessary changes for future reference.

4. Vaccine Delivery

- a. Evaluate of Vaccine Delivery Plan and make necessary changes for future reference.

5. Employee Health

- a. Resume pre-pandemic Employee Health practices.

6. Communication

- a. Resume pre-pandemic communication systems.

7. Clinical Guidelines

- a. Resume pre-pandemic Clinical (hospital) care.

8. Facility Access Plan

- a. Resume pre-pandemic facility access

9. Surge Capacity Plan

- a. Resume pre-pandemic practices.

XI. Psychosocial Support Plan

See *Psychosocial Support Plan*, See [Appendix 28](#)

XII. Mass Fatality Plan

See *Mass Fatality Plan*, See [Appendix 29](#)

XIII. Department Specific Plans

Medical Services Staffing Plan, See [Appendix 32](#)

Nursing Services Staffing Plan, See [Appendix 33](#)

Respiratory Services Pandemic Flu Plan, See [Appendix 34](#)

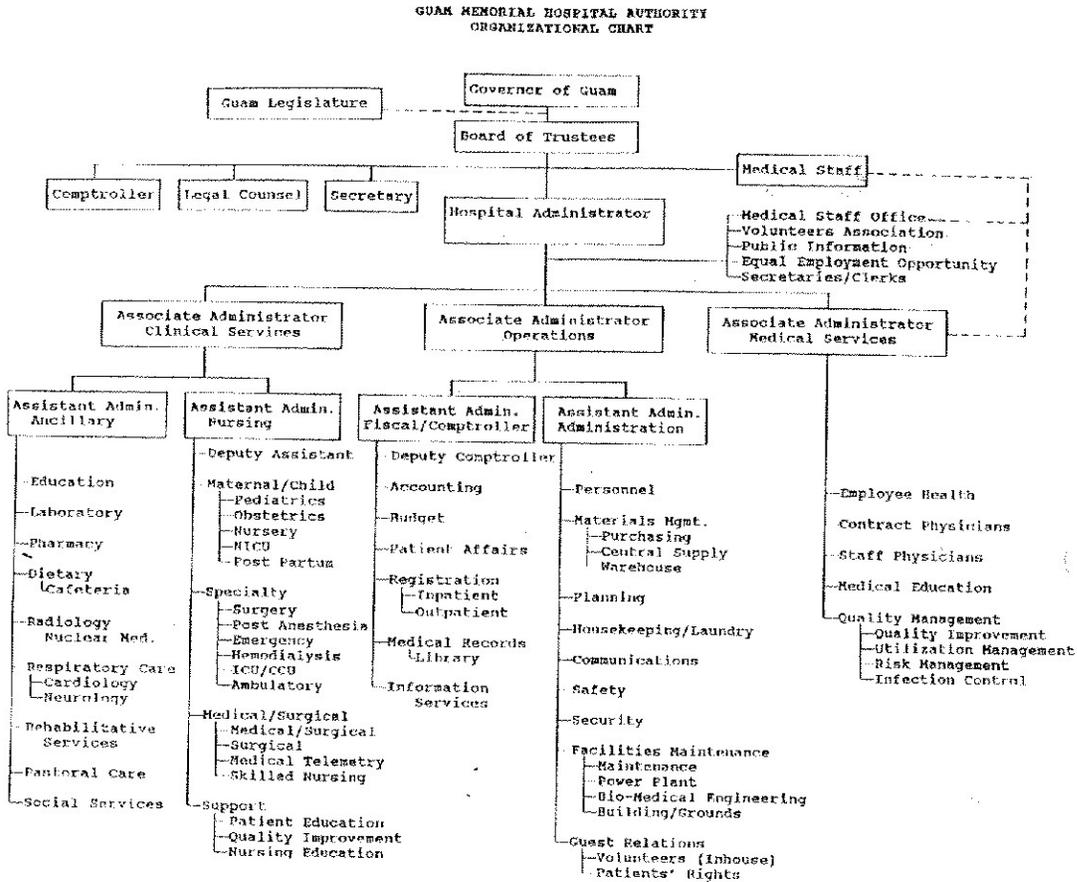
Security Pandemic Flu Plan, See [Appendix 35](#)

Environmental Services Pandemic Flu Plan, See [Appendix 36](#)

Spiritual Care Services Pandemic Flu Plan, See [Appendix 37](#)
Dietary Services Pandemic Flu Plan, See [Appendix 38](#)
Patient Registration Pandemic Flu Plan, See [Appendix 40](#)

APPENDIX 1: GMHA ORGANIZATIONAL CHART

Policy 6100-14
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 Hospital Administrator
 Date: June 19, 1992

Approved: Rosie R. Tainongong
 Rosie R. Tainongong, Chairperson
 Board of Trustees
 Date: June 23, 1992

APPENDIX 2: INFECTION PREVENTION AND CONTROL PLAN

PURPOSE: The purpose of this plan is to guide GMHA's preparedness and response activities to mitigate the impact of flu pandemic. It will assist with control of transmission.

Outbreaks of influenza have been prevented or controlled through a set of well established strategies that include:

- 1) vaccination of patients and healthcare personnel (See *Medication and Employee Health Plan*);
- 2) early detection of influenza cases in a facility;
- 3) use of antivirals to treat ill persons and, if recommended, as prophylaxis (See *Medication and Employee Health Plan*).
- 4) isolation of infectious patients in private rooms or cohort units;
- 5) use of appropriate barrier precautions during patient care, as recommended for Standard and Droplet Precautions (See Box 1); and
- 6) administrative measures, such as restricting visitors, educating patients and staff, and cohorting healthcare workers assigned to an outbreak unit.

These are the primary infection control measures recommended in this plan. They will be updated, as necessary, based on the observed characteristics of the pandemic influenza virus.

A. Basic infection control principles for preventing the spread of pandemic influenza in the hospital are as follows:

- Limit contact between infected and non-infected persons (*2)
- Isolate infected persons (i.e., confine patients to a defined area as appropriate for the healthcare setting).
- Limit contact between nonessential personnel and other persons (e.g., social visitors) and patients who are ill with pandemic influenza.
- Promote spatial separation in common areas (i.e., sit or stand as far away as possible—at least 3 feet—from potentially infectious persons) to limit contact between symptomatic and non-symptomatic persons.
- Protect persons caring for influenza patients in healthcare settings from contact with the pandemic influenza virus.

Persons who must be in contact should:

- Wear a surgical or procedure mask (*3) for close contact with infectious patients.
- Use contact and airborne precautions, including the use of N95 respirators, when appropriate.
- Wear gloves (gown if necessary) for contact with respiratory secretions.
- Perform hand hygiene after contact with infectious patients.
- Contain infectious respiratory secretions:
- Instruct persons who have “flu-like” symptoms (see below) to use respiratory hygiene/cough etiquette (See Box 2). Post Visual Alert signs as reminders of Respiratory Hygiene/Cough Etiquette (See Exhibit VII)

- Promote use of masks (*4) by symptomatic persons in common areas (e.g., waiting rooms in physician offices or emergency departments) or when being transported (e.g., in emergency vehicles).

2 During the early stages of a pandemic, laboratory-confirmation of influenza infection is recommended when possible.

3 Surgical masks come in two basic types: one type is affixed to the head with two ties, conforms to the face with the aid of a flexible adjustment for the nose bridge, and may be flat/pleated or duck-billed in shape; the second type of surgical mask is pre-molded, adheres to the head with a single elastic and has a flexible adjustment for the nose bridge. Procedure masks are flat/pleated and affix to the head with ear loops. All masks have some degree of fluid resistance but those approved as surgical masks must meet specified standards for protection from penetration of blood and body fluids.

4 Coughing persons may wear either a surgical or procedure mask. However, only procedure masks come in both adult and pediatric sizes.

B. Symptoms of influenza include fever, headache, myalgia, prostration, coryza, sore throat, and cough. Otitis media, nausea, and vomiting are also commonly reported among children. Typical influenza (or “flu-like”) symptoms, such as fever, may not always be present in elderly patients, young children, patients in long-term care facilities, or persons with underlying chronic illnesses.

C. Management of infectious patients

1. Respiratory hygiene/cough etiquette

Respiratory hygiene/cough etiquette has been promoted as a strategy to contain respiratory viruses at the source and to limit their spread in areas where infectious patients might be awaiting medical care (e.g., emergency department) (See Box 2)

The impact of covering sneezes and coughs and/or placing a mask on a coughing patient on the containment of respiratory secretions or on the transmission of respiratory infections has not been systematically studied. In theory, however, any measure that limits the dispersal of respiratory droplets should reduce the opportunity for transmission. Masking may be difficult in some settings, e.g., pediatrics, in which case the emphasis will be on cough hygiene.

The elements of respiratory hygiene/cough etiquette include:

- Education of healthcare facility staff, patients, and visitors on the importance of containing respiratory secretions to help prevent the transmission of influenza and other respiratory viruses
- Posted signs in languages appropriate to the populations served with instructions to patients and accompanying family members or friends to immediately report symptoms of a respiratory infection as directed
- Source control measures (e.g., covering the mouth/nose with a tissue when coughing and disposing of used tissues; using masks on the coughing person when they can be tolerated and are appropriate)
- Hand hygiene after contact with respiratory secretions, and
- Spatial separation, ideally >3 feet, of persons with respiratory infections in common waiting areas when possible.

2. Droplet precautions and patient placement

Patients with known or suspected pandemic influenza should be placed on droplet precautions for a minimum of 5 days from the onset of symptoms. Because immunocompromised patients may shed virus for longer periods, they may be placed on droplet precautions for the duration

of their illness. Healthcare personnel should wear appropriate PPE (See Box 1). If the pandemic virus is associated with diarrhea, contact precautions (i.e., gowns and gloves for all patient contact) should be added.

D. Infection control practices for healthcare personnel

Infection control practices for pandemic influenza are the same as for other human influenza viruses and primarily involve the application of standard and droplet precautions (See Box 1) during patient care. During a pandemic, conditions that could affect infection control may include shortages of antiviral drugs, decreased efficacy of the vaccine, increased virulence of the influenza strain, shortages of single-patient rooms, and shortages of personal protective equipment. These issues may necessitate changes in the standard recommended infection control practices for influenza. CDC will provide updated infection control guidance as circumstances dictate.

1. Personal protective equipment

a) PPE for standard and droplet precautions

PPE is used to prevent direct contact with the pandemic influenza virus. PPE that may be used to provide care includes surgical or procedure masks, as recommended for droplet precautions, and gloves and gowns, as recommended for standard precautions (See Box 1). Additional precautions may be indicated during the performance of aerosol-generating procedures (see below).

Information on the selection and use of PPE is provided at www.cdc.gov/ncidod/hip/isolat/isolat.htm/.

- Masks (surgical or procedure)
 - Wear a mask when entering a patient's room. A mask should be worn once and then discarded. If pandemic influenza patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.
 - Change masks when they become moist.
 - Do not leave masks dangling around the neck.
 - Upon touching or discarding a used mask, perform hand hygiene.
- **Gloves**
 - A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of latex, vinyl, nitrile, or other synthetic materials are appropriate for this purpose; if possible, latex-free gloves should be available for healthcare workers who have latex allergy.
 - Gloves should fit comfortably on the wearer's hands.
 - Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.
 - Perform hand hygiene after glove removal.
 - If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance,

reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids, including during suctioning.

- Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.

- **Gowns**

- Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. Most patient interactions do not necessitate the use of gowns. However, procedures such as intubation and activities that involve holding the patient close (e.g., in pediatric settings) are examples of when a gown may be needed when caring for pandemic influenza patients.

- A disposable gown made of synthetic fiber or a washable cloth gown may be used.

- Ensure that gowns are of the appropriate size to fully cover the area to be protected.

- Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.

- If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used. It is doubtful that disposable aprons would provide the desired protection in the circumstances where gowns are needed to prevent contact with influenza virus, and therefore should be avoided. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.

- **Goggles or face shield**

In general, wearing goggles or a face shield for routine contact with patients with pandemic influenza is not necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for standard precautions. Additional information related to the use of eye protection for infection control can be found at <http://www.cdc.gov/niosh/topics/eye/eye-infectious.html>.

b) PPE for special circumstances

- **PPE for aerosol-generating procedures**

During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a N95 respirator or other appropriate particulate respirator. Respirators should be used within the context of a respiratory protection program that includes fit-testing, medical clearance, and training. If possible, and when practical, use of an airborne isolation room may be considered when conducting aerosol-generating procedures.

- **PPE for managing pandemic influenza with increased transmissibility**

The addition of airborne precautions, including respiratory protection (an N95 filtering face piece respirator or other appropriate particulate respirator), may be considered for strains of influenza exhibiting increased transmissibility, during initial stages of an

outbreak of an emerging or novel strain of influenza, and as determined by other factors such as vaccination/immune status of personnel and availability of antivirals. As the epidemiologic characteristics of the pandemic virus are more clearly defined, CDC will provide updated infection control guidance, as needed.

• **Precautions for early stages of a pandemic**

Early in a pandemic, it may not be clear that a patient with severe respiratory illness has pandemic influenza. Therefore precautions consistent with all possible etiologies, including a newly emerging infectious agent, should be implemented. This may involve the combined use of airborne and contact precautions, in addition to standard precautions, until a diagnosis is established.

c) Caring for patients with pandemic influenza

Healthcare personnel should be particularly vigilant to avoid:

- Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.

(See also: <http://www.cdc.gov/ncidod/hip/ppe/default.htm>.)

- Contaminating environmental surfaces that are not directly related to patient care (e.g., door knobs, light switches)

2. Hand Hygiene

Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings (see <http://www.cdc.gov/handhygiene/pressrelease.htm>) and is an essential element of standard precautions. The term “hand hygiene” includes both hand washing with either plain or antimicrobial soap and water and use of alcohol-based products (gels, rinses, foams) containing an emollient that do not require the use of water.

- If hands are visibly soiled or contaminated with respiratory secretions, wash hands 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.
- Always perform hand hygiene between patient contacts and after removing PPE.
- Ensure that resources to facilitate hand washing (i.e., sinks with warm and cold running water, plain or antimicrobial soap, disposable paper towels) and hand disinfection (i.e., alcohol-based products) are readily accessible in areas in which patient care is provided. For additional guidance on hand hygiene See <http://www.cdc.gov/handhygiene/>.

3. Disposal of solid waste.

Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with a pandemic influenza virus:

- Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps, and non-medical waste.

- Discard as routine waste used patient-care supplies that are not likely to be contaminated (e.g., paper wrappers).
- Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

4. Linen and laundry

Standard precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from patients with pandemic influenza:

- Place soiled linen directly into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.
- Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
- Wear gloves for transporting bagged linen and laundry.
- Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
- Wash and dry linen according to routine standards and procedures (www.cdc.gov/ncidod/hip/enviro/guide.htm).

5. Dishes and eating utensils

Standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic influenza:

- Wash reusable dishes and utensils in a dishwasher with recommended water temperature (www.cdc.gov/ncidod/hip/enviro/guide.htm).
- Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of patients) should be discarded with other general waste.
- Wear gloves when handling patient trays, dishes, and utensils.

6. Patient-care equipment

Follow standard practices for handling and reprocessing used patient-care equipment, including medical devices:

- Wear gloves when handling and transporting used patient-care equipment.
- Wipe heavily soiled equipment with an EPA-approved hospital disinfectant before removing it from the patient's room.

Follow current recommendations for cleaning and disinfection or sterilization of reusable patient-care equipment.

- Wipe external surfaces of portable equipment for performing x-rays and other procedures in the patient's room with an EPA-approved hospital disinfectant upon removal from the patient's room.

7. Environmental cleaning and disinfection

Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic influenza follow the same general principles used in healthcare settings.

a) Cleaning and disinfection of patient-occupied rooms

(See: www.cdc.gov/ncidod/hip/enviro/Enviro_guide_03.pdf)

- Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are not necessary for routine cleaning of an influenza patient's room.
- Keep areas around the patient free of unnecessary supplies and equipment to facilitate daily cleaning.
- Use any EPA-registered hospital detergent-disinfectant. Follow manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling.
- Follow facility procedures for regular cleaning of patient-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes, ventilator surfaces) in addition to floors and other horizontal surfaces.
- Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Standard Precautions.

b) Cleaning and disinfection after patient discharge or transfer

- Follow standard facility procedures for post-discharge cleaning of an isolation room.
- Clean and disinfect all surfaces that were in contact with the patient or might have become contaminated during patient care. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.
- Do not spray (i.e., fog) occupied or unoccupied rooms with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

8. Postmortem care

Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids.

9. Laboratory specimens and practices

Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

Detection of persons entering the facility who may have pandemic influenza

* Post visual alerts (in appropriate languages) at the entrance to hospital outpatient facilities (e.g., emergency department) instructing persons with respiratory symptoms (e.g., patients, persons who accompany them) to:

- Inform reception and healthcare personnel when they first register for care, and
- Practice respiratory hygiene/cough etiquette

* Triage patients for influenza symptoms:

* Discourage unnecessary visits.

* Instruct symptomatic patients on infection control measures to limit

* As the scope of the pandemic escalates locally, consider setting up a separate triage area for persons presenting with symptoms of respiratory infection. Because not every patient

presenting with symptoms will have pandemic influenza, infection control measures will be important in preventing further spread.

* During the peak of a pandemic, emergency departments and outpatient offices may be overwhelmed with patients seeking care. Identify a “triage officer” may be useful for managing patient flow, including deferral of patients who do not require emergency care.

* Designate separate waiting areas for patients with influenza-like symptoms. If this is not feasible, the waiting area should be set up to enable patients with respiratory symptoms to sit as far away as possible (at least 3 feet) from other patients.

“Source control” measures to limit dissemination of influenza virus from respiratory secretions

- Post signs that promote respiratory hygiene/cough etiquette in common areas (e.g., elevators, waiting areas, cafeterias, lavatories) where they can serve as reminders to all persons in the healthcare facility. See Box 2 and Exhibit VIII for *Visual Alert Signs*

Signs should instruct persons to:

1. Cover the nose/mouth when coughing or sneezing.
2. Use tissues to contain respiratory secretions.
3. Dispose of tissues in the nearest waste receptacle after use.
4. Perform hand hygiene after contact with respiratory secretions.

- Facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability of materials in waiting areas for patients and visitors.
- Provide tissues and no-touch receptacles (e.g., waste containers with pedal-operated lid or uncovered waste container) 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.
- Promote the use of masks and spatial separation by persons with symptoms of influenza.
- Offer and encourage the use of either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties or elastic) by symptomatic persons to limit dispersal of respiratory droplets.
- Encourage coughing persons to sit as far away as possible (at least 3 feet) from other persons in common waiting areas.

c) Hospitalization of pandemic influenza patients

• Patient placement

- Limit admission of influenza patients to those with severe complications of influenza who cannot be cared for outside the hospital setting.
- Admit patients to either a single-patient room or an area designated for cohorting of patients with influenza.

• Cohorting

- Designated units or areas of a facility should be used for cohorting patients with pandemic influenza. During a pandemic, other respiratory viruses (e.g., non-pandemic influenza, respiratory syncytial virus, parainfluenza virus) may be circulating concurrently in a community. Therefore, to prevent cross-transmission of respiratory viruses, whenever possible assign only patients with confirmed pandemic influenza to the same room. At the height of a pandemic, laboratory testing to confirm pandemic

influenza is likely to be limited, in which case cohorting should be based on having symptoms consistent with pandemic influenza.

- Personnel (clinical and non-clinical) assigned to cohorted patient care units for pandemic influenza patients should not “float” or otherwise be assigned to other patient care areas. The number of personnel entering the cohorted area should be limited to those necessary for patient care and support.
- Personnel assigned to cohorted patient care units should be aware that patients with pandemic influenza may be concurrently infected or colonized with other pathogenic organisms (e.g., *Staphylococcus aureus*, *Clostridium difficile*) and should adhere to infection control practices (e.g., hand hygiene, changing gloves between patient contact) used routinely, and as part of standard precautions, to prevent nosocomial transmission.
- Because of the high patient volume anticipated during a pandemic, cohorting should be implemented early in the course of a local outbreak.

• **Patient transport**

- Limit patient movement and transport outside the isolation area to medically necessary purposes.
- Consider having portable x-ray equipment available in areas designated for cohorting influenza patients.
- If transport or movement is necessary, ensure that the patient wears a surgical or procedure mask. If a mask cannot be tolerated (e.g., due to the patient’s age or deteriorating respiratory status), apply the most practical measures to contain respiratory secretions. Patients should perform hand hygiene before leaving the room.

• **Visitors**

- Screen visitors for signs and symptoms of influenza before entry into the facility and exclude persons who are symptomatic.
- Family members who accompany patients with influenza-like illness to the hospital are assumed to have been exposed to influenza and should wear masks.
- Limit visitors to persons who are necessary for the patient’s emotional well-being and care.
- Instruct visitors to wear surgical or procedure masks while in the patient’s room.
- Instruct visitors on hand-hygiene practices.

d) Control of nosocomial pandemic influenza transmission

- Once patients with pandemic influenza are admitted to the hospital, nosocomial surveillance should be heightened for evidence of transmission to other patients and healthcare personnel. (Once pandemic influenza is firmly established in a community this may not be feasible or necessary.)
- If limited nosocomial transmission is detected (e.g., has occurred on one or two patient care units), appropriate control measures should be implemented. These may include:
 - Cohorting of patients and staff on affected units
 - Restriction of new admissions (except for other pandemic influenza patients) to the affected unit(s)

- Restriction of visitors to the affected unit(s) to those who are essential for patient care and support
- If widespread nosocomial transmission occurs, controls may need to be implemented hospital wide and might include:
 - Restricting all nonessential persons
 - Stopping admissions not related to pandemic influenza and stopping elective surgeries

e) Monitoring patients for pandemic influenza and instituting appropriate control measures

Despite aggressive efforts to prevent the introduction of pandemic influenza virus, persons in the early stages of pandemic influenza could introduce it to the facility. Early detection of the presence of pandemic influenza is critical for ensuring timely implementation of infection control measures.

- Early in the progress of a pandemic in the region, increase resident surveillance for influenza-like symptoms. Notify state or local health department officials if a case(s) is suspected.
- If symptoms of pandemic influenza are apparent, implement droplet precautions for the patient, pending confirmation of pandemic influenza virus infection. Patients and roommates should not be separated or moved out of their rooms unless medically necessary. Once a patient has been diagnosed with pandemic influenza, roommates should be treated as exposed cohorts.
- Cohort residents and staff on units with known or suspected cases of pandemic influenza.
- Limit movement within the facility (e.g., temporarily close the dining room and serve meals on nursing units, cancel social and recreational activities).

BOX 1: RECOMMENDATIONS FOR APPLICATION OF STANDARD PRECAUTIONS FOR THE CARE OF ALL PATIENTS IN ALL HEALTHCARE SETTINGS

Component	Recommendations
STANDARD PRECAUTIONS	
Hand hygiene	<p>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. 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.</p>
Personal protective equipment (PPE) <ul style="list-style-type: none"> • Gloves • Gown • Face/eye protection (e.g., surgical or procedure mask and goggles or a face shield) 	<ul style="list-style-type: none"> • For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and nonintact skin • During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated • During procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, excretions
Safe Work Practices	<p>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).</p>

Patient Resuscitation	Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.
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 after handling equipment.
Soiled Linen and Laundry	Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.
Needles and Other Sharps	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.
Environmental cleaning and disinfection	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, door knobs, lavatory surfaces)
Disposal of Solid Waste	Contain and dispose of solid waste (medical and non-medical) in accordance with facility procedures and/or state regulations; wear gloves when handling waste containers; perform hand hygiene.
Respiratory hygiene/cough etiquette Source control measures for persons with symptoms of a respiratory infection; implement at first point of encounter (e.g., triage/reception areas) within a healthcare setting.	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.

DROPLET PRECAUTIONS	
Patient Placement	<p>Place patients with influenza in a private room or cohort with other patients with influenza/ *Keep door closed or slightly ajar; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet precautions to all persons in the room.</p> <p>*During the early stages of a pandemic, infection with influenza should be laboratory-confirmed, if possible.</p>
Personal protective Equipment	<p>Wear a surgical or procedure mask for entry into patient room; wear other PPE as recommended for standard precautions.</p>
Patient transport	<p>Limit patient movement outside of room o medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.</p>
Other	<p>Follow standard precautions and facility procedures for handling linen and laundry and dishes and eating utensils, and for cleaning/disinfection of environmental surfaces and patient care equipment, disposal of solid waste, and postmortem care.</p>
AEROSOL-GENERATING PROCEDURES	
	<p>During procedures that may generate small particles of respiratory secretions (e.g., endotracheal intubation, bronchoscopy, nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator or other appropriate particulate respirator.</p>

BOX 2. 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.**

See *Visual Alert Posters* (See Appendix 26) for signage that will be erected in all areas of the hospital.

Environmental Services 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 handwashing where sinks are available.

Masking and separation of persons with symptoms of respiratory infection during periods of increased respiratory infection in the community should be pursued.

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.

GMHA may wish to institute this recommendation year-round.

APPENDIX 3: VISITOR RESTRICTIONS PLAN

1. During the initial phases of the pandemic period, there should be no restrictions (other than the routine restrictions for visitation) for asymptomatic visitors who have recovered from pandemic influenza or have been immunized against the pandemic strain of influenza. This rule can be changed as events arise that may require greater restrictions.
2. Visitors with ILI should not visit until they are asymptomatic. Close relatives of terminally ill patients can be exempt, but should put a mask on upon entry into the facility and their visit shall be restricted to that patient only.
3. Visitors should be informed when the hospital has influenza activity. Those who have not yet had the pandemic strain of influenza or who have not been immunized against the pandemic strain, should be discouraged from visiting. Close relatives of terminally ill patients can be exempt, but they should restrict their visit to that individual only and they should wash their hands on exit from the patient's room. Wearing a mask upon entry to the facility is only useful if there is no influenza in the community.

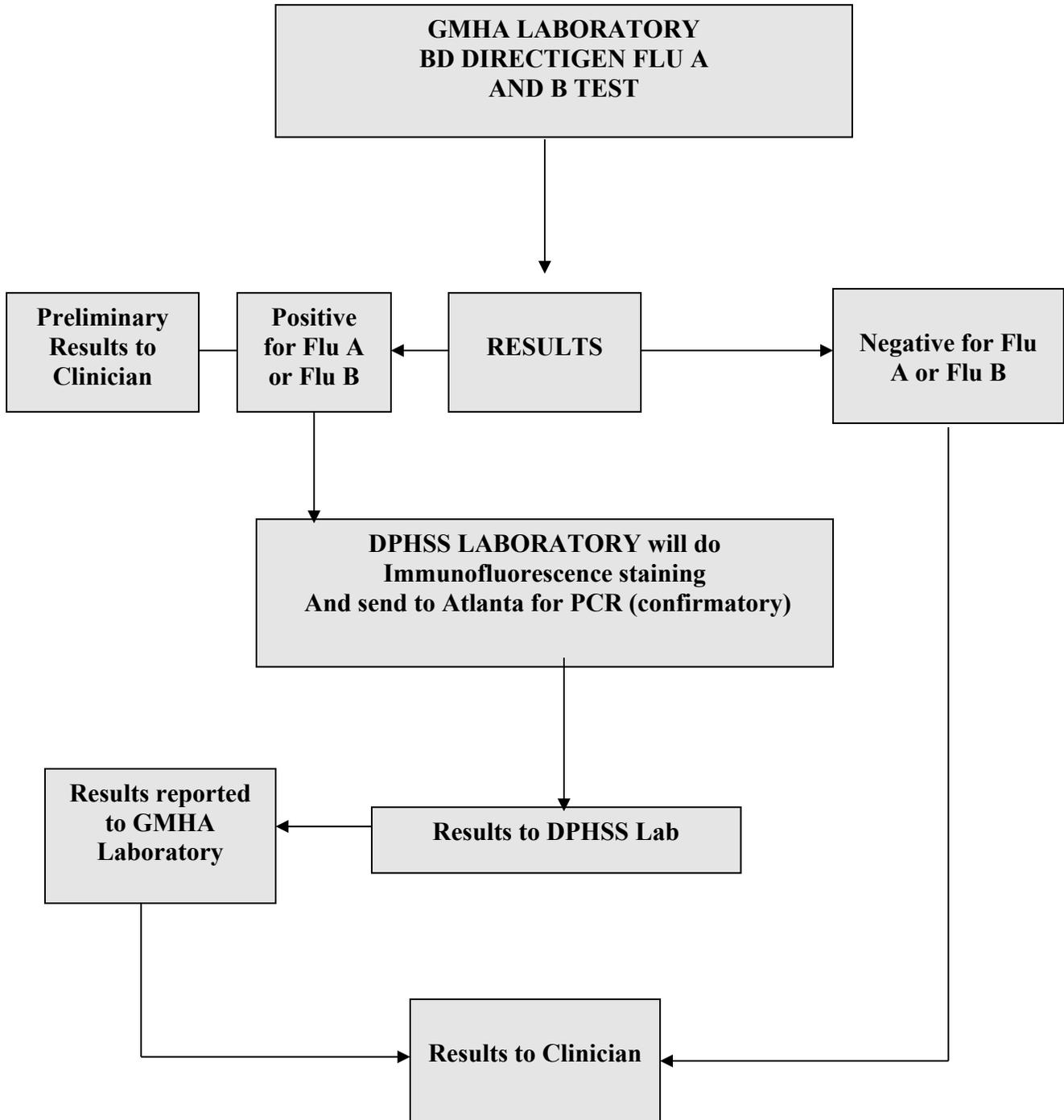
APPENDIX 5: CRITERIA FOR TESTING FOR AVIAN INFLUENZA A (H5N1)

Test patients and employees and report cases per the following criteria:

- i. Testing for avian influenza A (H5N1) is indicated for **hospitalized** patients with
 - a) Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, AND
 - b) History of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans
- ii. Testing for avian influenza A (H5N1) should be considered on a case-by-case basis in consultation with CDC guidelines for **hospitalized or ambulatory** patients with:
 - a) Documented temperature of $>100.4^{\circ}\text{F}$ with one or more of the following: cough, sore throat, shortness of breath, AND
 - b) 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 influenza A (**H5N1**) in an H5N1-affected country within 10 days of symptom onset.

If the above criteria are met, call the Guam CDC Disease Reporting and Consultation line at 735-7143 (working hours) or 888-9276 (24 hours a day) as quickly as possible.

APPENDIX 6: ALGORITHM FOR LABORATORY SCREENING AND CONFIRMATION OF PANDEMIC INFLUENZA IN HUMANS



APPENDIX 7: WHO GUIDELINES FOR THE COLLECTION OF HUMAN SPECIMENS FOR LABORATORY DIAGNOSIS OF AVIAN INFLUENZA INFECTIONS (12 January 2005)

1. General information

Respiratory virus diagnosis depends on the collection of high-quality specimens, their rapid transport to the laboratory and appropriate storage before laboratory testing. Virus is best detected in specimens containing infected cells and secretions. Specimens for the direct detection of viral antigens or nucleic acids and virus isolation in cell cultures should be taken preferably during the first 3 days after onset of clinical symptoms.

2. Type of specimens

A variety of specimens are suitable for the diagnosis of virus infection of the **upper respiratory tract**.

- Nasal swab
- Nasopharyngeal swab
- Nasopharyngeal aspirate
- Nasal wash
- Throat swab

In addition to swabs from the upper respiratory tract, invasive procedures can be performed for the diagnosis of virus infections of the lower respiratory tract where clinically indicate:

- Transtracheal aspirate
- Bronchoalveolar lavage
- Lung biopsy
- Post-mortem lung or tracheal tissue.

Specimens for the laboratory diagnosis of avian influenza A should be collected in the following order of priority.

- Nasopharyngeal aspirate
- Acute serum
- Convalescent serum.

Specimens for direct detection of viral antigens by immunofluorescence staining of infected cells should be refrigerated and processed within 1-2 hours. Specimens for use with commercial near-patient tests should be stored in accordance with the manufacturer's instructions. Specimens for virus isolation should be refrigerated immediately after

collection and inoculated into susceptible cell cultures as soon as possible. If specimens cannot be processed within 48-72 hours, they should be kept frozen at or below -70 ° C. Respiratory specimens should be collected and transported in virus transport media. A number of media that are satisfactory for the recovery of a wide variety of viruses are commercially available.

3. Procedures for specimen collection

a. Material required

- Sputum/mucus trap
- Polyester fiber-tipped applicator (**NO** calcium alginate, cotton tipped or wooden stick)
- Plastic vials
- Tongue depressor
- 15-ml conical centrifuge tubes
- Specimen collection cup or Petri dishes
- Transfer pipettes

b. Virus transport Medium

(1) Virus transportation medium for use in collecting throat and nasal swabs.

- Add 10 g veal infusion broth and 2 g bovine albumin fraction V to sterile distilled water (to 400 ml).
- Add 0.8 gentamicin sulfate solution (50 mg/ml) and 3.2 ml amphotericin B (250ug/ml)
- Sterilize by filtration

(2) Nasal wash medium

- Sterile saline (0.85% NaCl)

c. Preparing to collect specimens

Clinical specimens should be collected as described below and added to transport medium. Nasal or nasopharyngeal swabs can be combined in the same vial of virus transport medium. When possible, the following information should be recorded on the Field Data Collection Form: general patient information, type of specimens, date of collection, and contact information of person completing the form, etc.

Standard precautions should always be followed, and barrier protections applied whenever samples are obtained from patients.

Nasal swab

A dry polyester swab is inserted into the nostril, parallel to the palate, and left in place for a few seconds. It is then slowly withdrawn with a rotating motion. Specimens from both

nostrils are obtained with the same swab. The tip of the swab is put into a plastic vial containing 2-3 ml of virus transport medium and the applicator stick is broken off.

Nasopharyngeal swab

A flexible, fine-shafted polyester swab is inserted into the nostril and back to the nasopharynx and left in place for a few seconds. It is slowly withdrawn with a rotating motion. A second swab should be used for the second nostril. The tip of the swab is put into a vial containing 2-3 ml of virus transport medium and the shaft cut.

Nasopharyngeal aspirate

Nasopharyngeal secretions are aspirated through a catheter connected to a mucus trap and fitted to a vacuum source. The catheter is inserted into the nostril parallel to the palate. The vacuum is applied and the catheter is slowly withdrawn with a rotating motion. Mucus from the other nostril is collected with the same catheter in a similar manner. After mucus has been collected from both nostrils, the catheter is flushed with 3 ml of transport medium.

The patient sits in a comfortable position with the head slightly tilted backward and is advised to keep the pharynx closed by saying “K” while the washing fluid (usually physiological saline) is applied to the nostril. With a transfer pipette, 1-1.5 ml of washing fluid is instilled into one nostril at a time. The patient then tilts the head forward and lets the washing fluid flow into a specimen cup or a Petri dish. The process is repeated with alternate nostrils until a total of 10-15 ml of washing fluid has been used. Dilute approximately 3 ml of washing fluid 1:2 in transport medium.

Throat swab

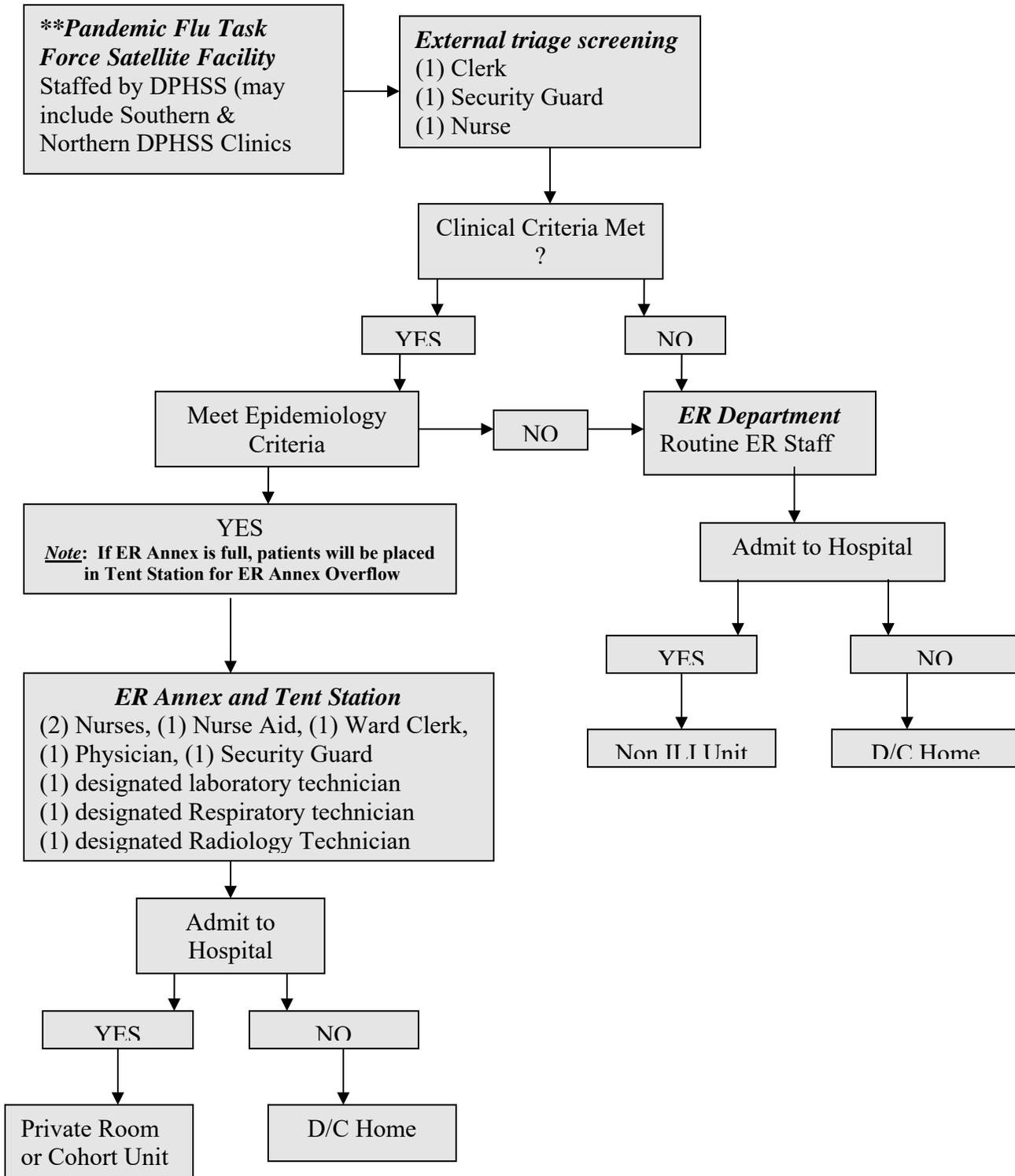
Both tonsils and the posterior pharynx are swabbed vigorously, and the swab is placed in transport medium as described above.

4. Sera collection for influenza diagnosis

An acute-phase serum specimen (3-5 ml of whole blood) should be taken soon after onset of clinical symptoms and not later than 7 days after onset. A convalescent-phase serum specimen should be collected 14 days after the onset of symptoms. Where patients are near death, a second ante-mortem specimen should be collected.

Although single serum specimens may not provide conclusive evidence in support of an individual diagnosis, when taken more than 2 weeks after the onset of symptoms they can be useful for detecting antibodies against avian influenza viruses in a neutralization test.

APPENDIX 8: FACILITY ACCESS FLOW CHART, ER PATIENTS



****Pandemic Flu Task Force will identify satellite sites for patients to seek outpatient care (non-critical care). Only patients requiring critical care will be referred from these sites to GMHA or GMHA’s overflow facility. The processes for referral of these patients shall include adequate endorsement.**

Station 1: ER External Triage Site (This external site will be necessary until we have a barrier set up in the internal ER Registration area (i.e. plexi-glass))

Staff Needs:

- 1) One (1) nurse
- 2) One (1) registration clerk
- 3) one (1) security guard

Equipment and Supply Needs:

- 1) Mobile desk and chairs
- 2) Computer with Patient Registration Capabilities and access to AS400
- 3) Pens, clip boards
- 4) Case Definition Screening Forms
- 5) Thermometer
- 6) Alcohol hand rub
- 7) Communication Link such as radio or cellular phone.

Work-Practice:

- 1) Staff assigned to this area should wear a mask and should follow standard precautions.
- 2) Visitors should be restricted. Visitors accompanying the sick individual should be screened for avian/novel influenza. Their contact information should be obtained for reporting to DPHSS.
- 3) Hand hygiene should be practiced regularly.
- 4) Supplies used for obtaining patient information should be disinfected using an EPA approved disinfectant.
- 5) Patients being admitted to the ER Annex should be referred or transported using a mask.
- 6) See *Infection Control Plan*.

ER Annex and Tent Station:

Staff Needs:

- 1) One (1) physician
- 2) Two (2) Nurses
- 3) one (1) nurse aide
- 4) one (1) ward Clerk
- 5) one (1) designated laboratory technician
- 6) one (1) designated Respiratory technician
- 7) one (1) designated Radiology Technician

Equipment and Supply Needs:

- 1) Computer and printer with AS400 access (Order Communication)
- 2) Pharmaceuticals
- 3) Crash Cart with medications and supplies
- 4) Medical Supplies

- 5) Communication Link such as telephone, radio, or cellular phone.

Work Practice:

- 1) Staff should initiate Standard and Droplet Precautions
- 2) Hand Hygiene should be practiced regularly
- 3) Avoid procedures that generate aerosols if possible (nebulized medications, intubation, bronchoscopy, non-invasive ventilation, ventilation using high-frequency oscillation).
- 4) Visitors should be restricted
- 5) Avoid transportation as much as possible. Transporter is to follow standard and droplet precautions. If transportation is necessary, patient should be masked appropriately.
- 6) See *Infection Control Plan*.

Current Situation:

2 canopies are available for use for the external triage site during an influenza pandemic to be situated outside the Emergency Room. In the event that additional tents or other resources are needed, Command Post shall be informed to make collaborative efforts with Incident Command as needed.

APPENDIX 9: ER ANNEX OVERFLOW, TENT STATION

1. Facilities Maintenance will erect tent stations once Nursing Supervisors have indicated that it would be necessary to handle ER Annex Overflow.
2. Security department will ensure compliance with the traffic flow in these areas.
3. Additional signage will be erected by Facilities department to assist with traffic flow.
4. Nursing Supervisors in conjunction with Command Post will assist with identifying the pulling of staff (as indicated below) for each station.

Tent Station Staff Needs:

- 1) One (1) physician
- 2) Two (2) Nurses
- 3) one (1) nurse aide
- 4) one (1) ward Clerk
- 5) one (1) designated laboratory technician
- 6) one (1) designated Respiratory technician
- 7) one (1) designated Radiology Technician

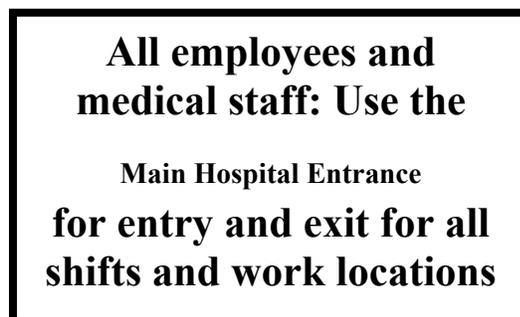
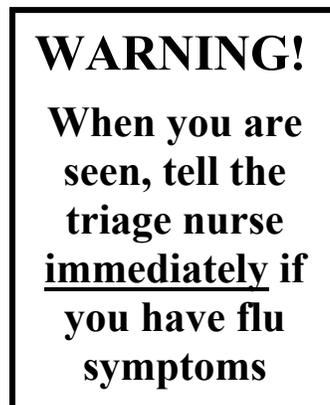
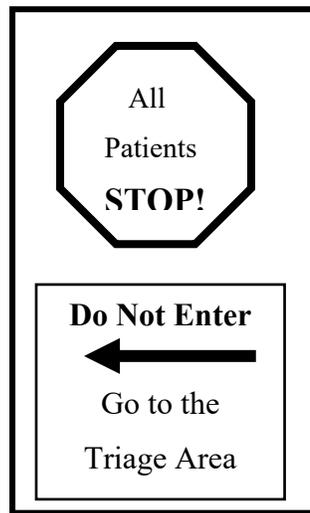
Equipment and Supply Needs:

- 1) two (2) 20x20 canopies
- 2) two (2) to three (3) folding tables
- 3) Computer with AS400 access for Order Communication and Printer
- 4) 20 cots (more or less)
- 5) Communication Link (radio, cellular, or telephone extension)
- 6) Light set-up
- 7) Tarps for privacy, wind/rain break
- 8) Weights and ties for holding down canopies
- 9) Trailer for mobilization of needed supplies and equipment.
- 10) Equipped Crash cart
- 11) Pharmaceuticals
- 12) Medical Supplies
- 13) Alcohol hand rub
- 14) Portable sink

Work Practice:

- 1) Staff should initiate Standard and Droplet Precautions
- 2) Hand Hygiene should be practiced regularly
- 3) Avoid procedures that generate aerosols if possible (e.g., nebulized medications, intubation, bronchoscopy, ventilation using high-frequency oscillation).
- 4) Visitors should be restricted
- 5) Avoid transportation as much as possible. Transporter is to follow standard and droplet precautions. If transportation is necessary, patient should be masked appropriately.
- 6) See *Infection Control Plan*.

APPENDIX 10: TRAFFIC CONTROL SIGNS



APPENDIX 11: SURGE CAPACITY TABLE

Resource	Bed Capacity	Daily Staffed Beds	Surge Bed
Acute Care (adult & pediatrics)	158	80% occupancy rate	16
ER Annex			8
Inpatient Hemodialysis			6
Rehab Treatment			4
L&D Observation			3
Skilled Nursing	60	50% occupancy rate	30
		Existing Surge	67
Renovate shell space behind ICU		Additional Surge	18
		TOTAL	85

APPENDIX 12: BED CAPACITY TABLE

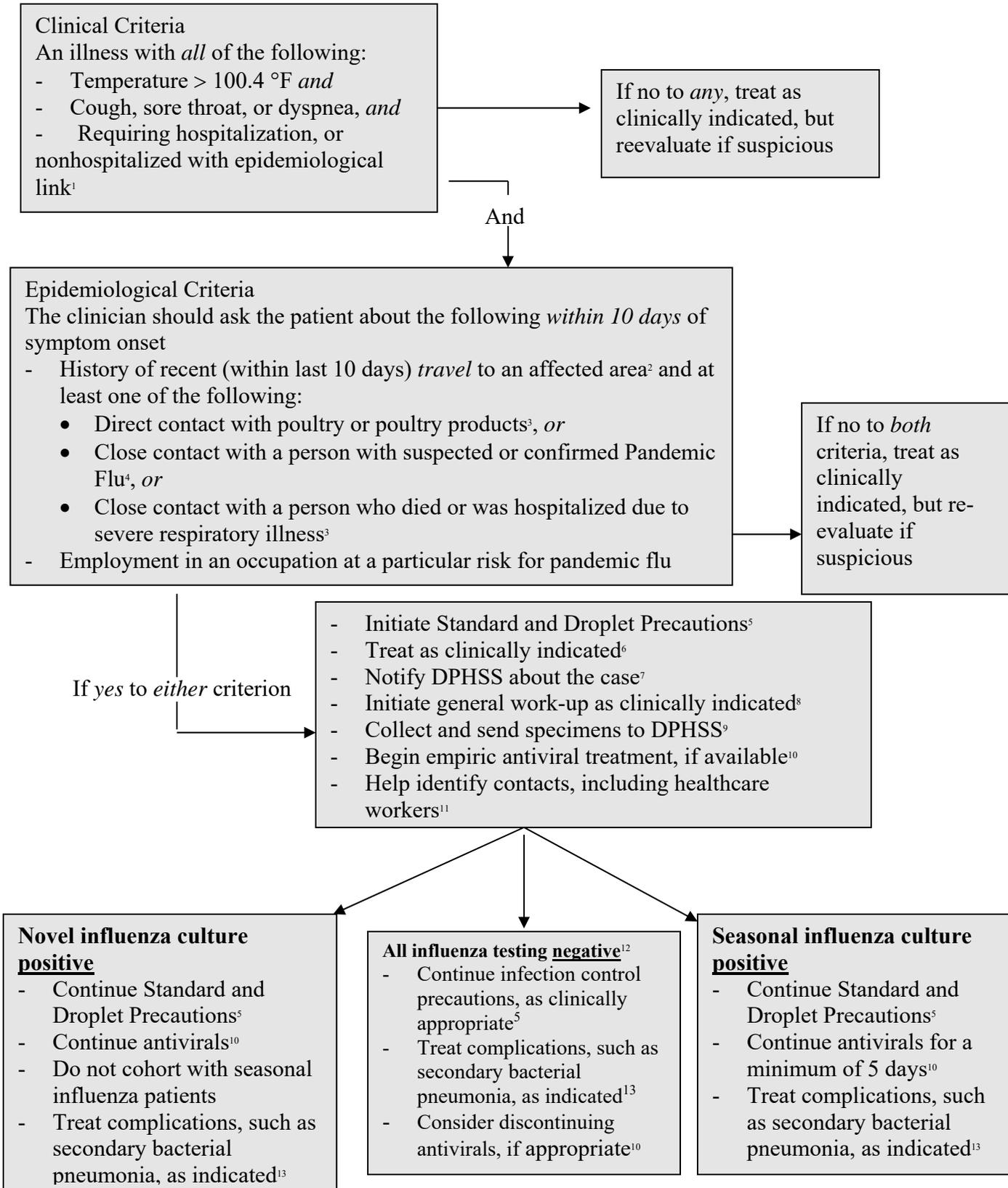
UNIT/DEPARTMENT	TOTAL BED CAPACITY
Surgical (4 th floor)	33
Medical Surge Annex (3 rd floor)	16
Medical Surgical	28
Medical Telemetry	20
PCU	6
ICU/CCU	10
Pediatrics	22
PICU	3
OB	20
TOTAL	158

APPENDIX 13: AIRBORNE INFECTION ISOLATION CAPACITY

Department	Rooms	Beds
Emergency Room	1	1
ER Annex	8	8
OR Recovery	1	1
OB Nursery	2	2
Outpatient Hemodialysis	1	1
Inpatient Hemodialysis	4	4
Medical Surgical	4(2 with anterooms)	3
Medical Telemetry	1 private, 5 semi	11
Surgical	2	2
Pediatrics	22	22
Skilled Nursing	4	4
ICU/CCU	1	1

APPENDIX 14: GMHA CLINICAL GUIDELINES FLOW CHART FOR AVIAN INFLUENZA/NOVEL INFLUENZA *WITHOUT* LOCAL TRANSMISSION

Initiate at Phase 4 through Phase 5



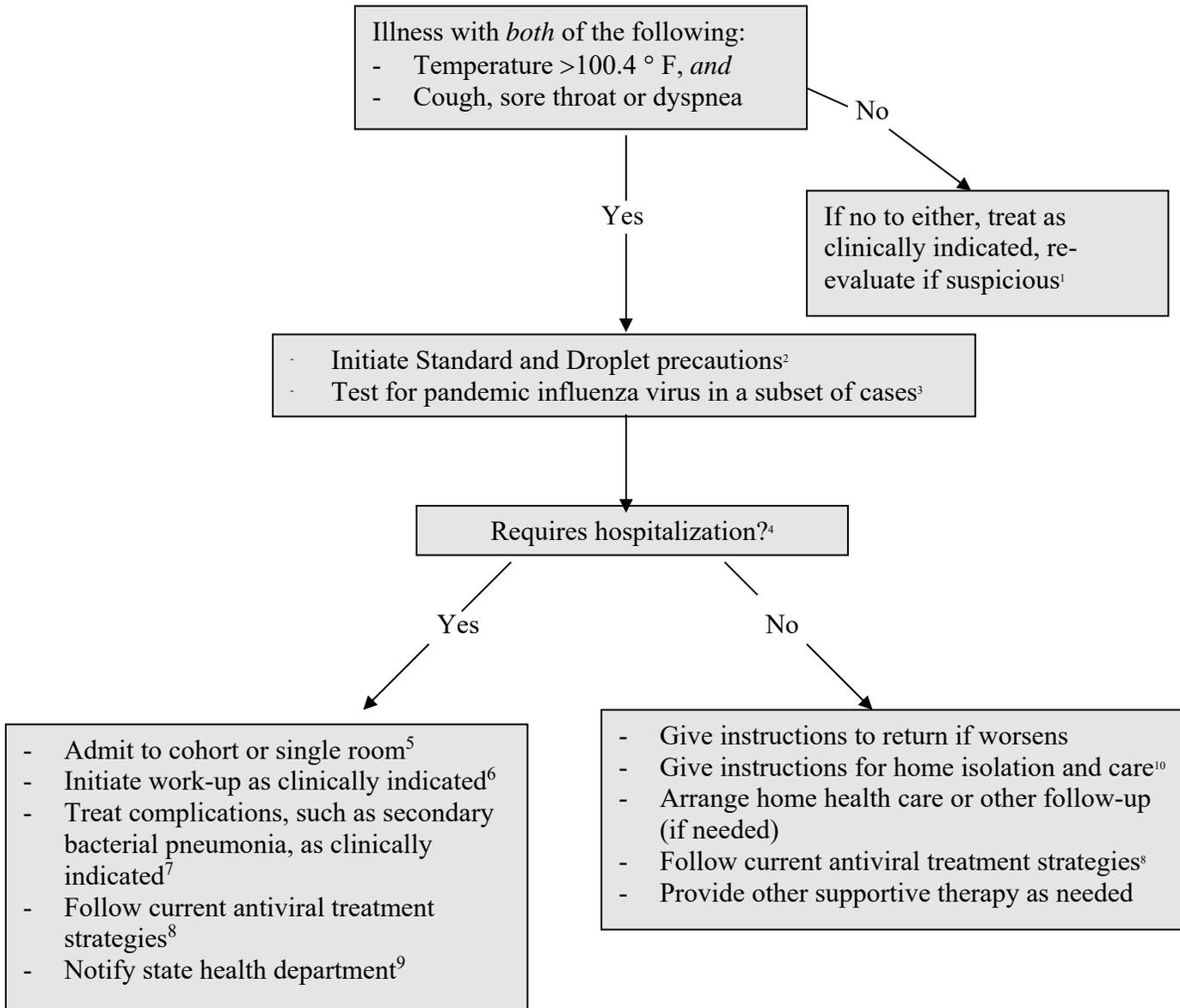
Footnotes to Appendix 14:

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 (http://www.who.int/csr/disease/avian_influenza/country/en/index.html).
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 (see *Infection Control Plan*, See [Appendix 2](#))
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*, See [Appendix 43](#). The patient and close contacts should be monitored for illness by local public health department staff.
7. **Guidance on how to report suspected cases of novel influenza:** See *Reporting to DPHSS of Suspected / Actual Cases*, See [Appendix 16](#).
8. 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), 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.
9. Guidelines for novel influenza virus testing as per DPHSS / CDC. All of the following respiratory specimens should be collected for novel influenza A virus testing: nasopharyngeal swab; nasal swab, wash, or aspirate; throat swab; and tracheal aspirate (for intubated patients), stored at 4° C (39°F) in viral transport media; and acute and convalescent serum samples. See *WHO Guidelines for the Collection of Human Specimens for Laboratory Diagnosis of Avian Influenza Infections*, See [Appendix 7](#).
 10. Strategies for the use of antiviral drugs are provided in the *Antiviral Agents Plan*.
 11. Guidelines for the management of employee exposures are provided in the *Employee Health Plan*.
 12. Given the unknown sensitivity of tests for novel influenza viruses, interpretation of negative results should be tailored to the individual patient in consultation with the state health department. Novel influenza directed management might need to be continued, depending on the strength of clinical and epidemiological suspicion. Antiviral therapy and isolation precautions for novel influenza may be discontinued on the basis of an alternative diagnosis. The following criteria may be considered for this evaluation:
 - Absence of strong epidemiological link to known cases of novel influenza
 - Alternative diagnosis confirmed using a test with a high positive-predictive value
 - Clinical manifestations explained by the alternative diagnosis

APPENDIX 15: GMHA CLINICAL GUIDELINES FLOW CHART FOR AVIAN INFLUENZA/NOVEL INFLUENZA *WITH* LOCAL TRANSMISSION

Initiate at Phase 6



Footnotes to Appendix 15:

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:
 - a. Alternative diagnosis confirmed using a test with a high positive-predictive value, AND
 - b. Clinical manifestations entirely explained by the alternative diagnosis
2. Standard and Droplet Precautions (See *Infection Control Plan*, See [Appendix 2](#)).
3. Update plans and guidance from the DPHSS 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. See *WHO Guidelines for the Collection of Human Specimens for Laboratory Diagnosis of Avian Influenza Infections*, See [Appendix 7](#).

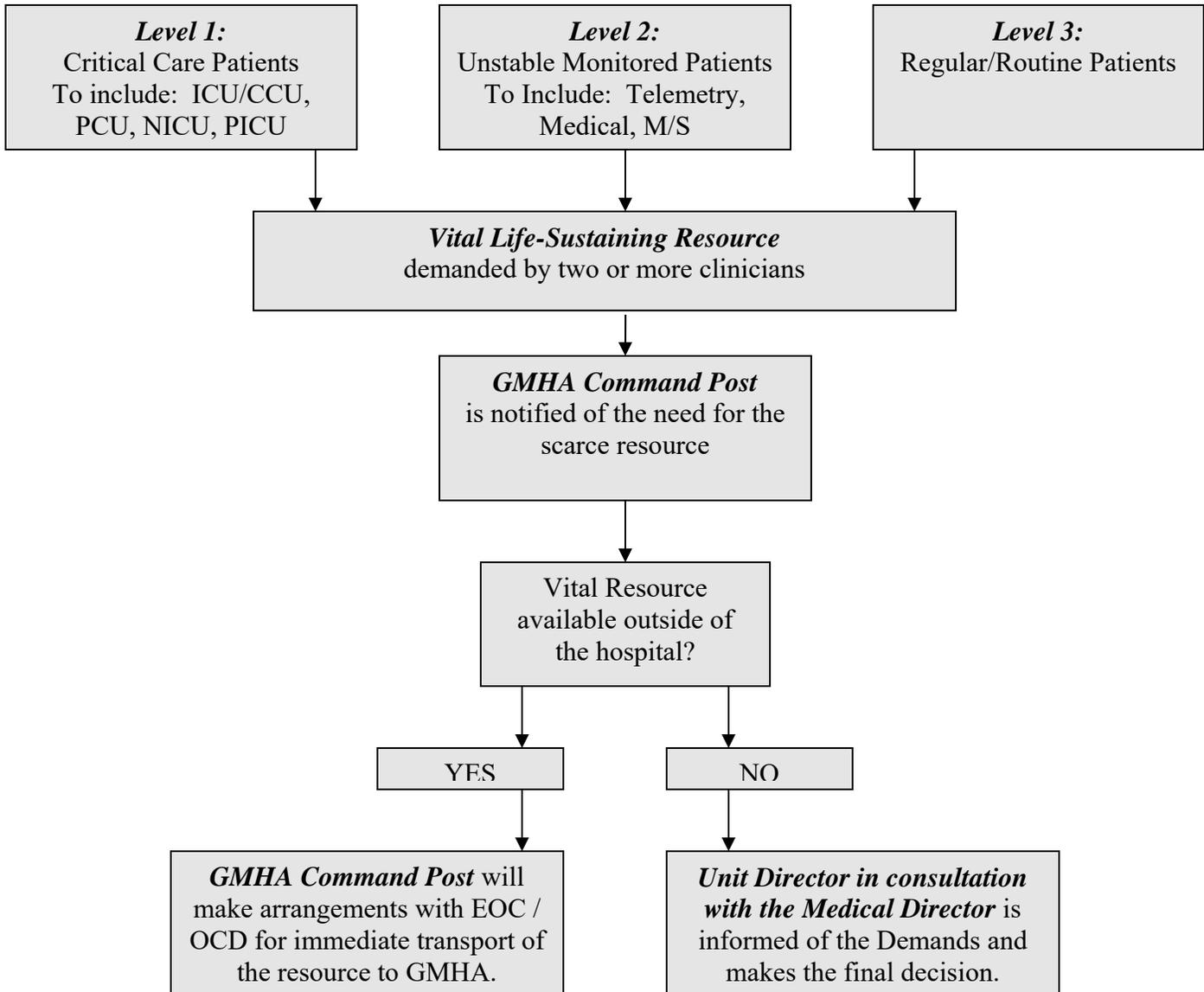
Routine laboratory confirmation of clinical diagnoses will be unnecessary as pandemic activity becomes widespread in the community. CDC will continue to work with the DPHSS laboratory to conduct virologic surveillance to monitor antigenic changes and antiviral resistance in the pandemic virus strains 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 the *Infection Control Plan and Surge Capacity 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 *Antiviral Agents Plan*.
8. Guidance on the reporting of pandemic influenza cases is provided in See *Reporting to DPHSS of Suspected / Actual Cases*, See [Appendix 16](#).

9. Patients with mild disease should be provided with 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, See *Home Quarantine and Self-Help Information*, See Appendix 43. 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. 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 15 A: GMHA ETHICAL DISTRIBUTION (SCARCE RESOURCES)

In all areas of care there will be demands for resources that may be considered life-sustaining. At any given point the demand may exceed the availability of the resource (for example ventilators, oxygen supply). As such, there may be a point in time when there is only one critical resource that is being demanded by two or more physicians to sustain the life of their patients. In an event such as this, the following chain of demand shall be followed:



APPENDIX 15B: VENTILATOR ALLOCATION GUIDELINE

A powerful strain of avian influenza has generated concern about a possible pandemic, though scientists do not know with certainty whether or when a pandemic will occur. However, the better-prepared Guam is, the greater its chances of reducing morbidity, mortality and economic consequences. In a pandemic, many more patients could require the use of mechanical ventilators than can be accommodated with current supplies. A federal ventilator stockpile exists, and GMH has afforded additional ventilators (and may purchase more) that would meet the needs of patients in a moderately severe pandemic.

An ethical framework must guide recommendations for allocating ventilators in a pandemic. Key ethical concepts are the duty to care for patients and the duty to use scarce resources wisely. Maintaining a balance between these two sometimes competing ethical obligations represents the core challenge in designing a just system for allocating ventilators.

- 1) Pre-triage requirements: Facilities must reduce the need for ventilators and expand resources before instituting ventilator triage procedures.
- 2) Patient categories of triage for facilities: All patients in acute care facilities will be equally subject to triage guidelines, regardless of their disease category or role in the community.
- 3) Implications of triage for facilities: State-wide consistency will prevent inequities; chronic care facilities will maintain different standards from acute care facilities.
- 4) Clinical evaluation: Clinicians will evaluate patients based on universally applied objective criteria, and offer time-based trials of ventilator support.
- 5) Triage decision-makers: Supervising physicians will take responsibility in triage decisions. Primary care clinicians will care for patients and will not determine ventilator allocation.
- 6) Palliative care: Palliative care will play a crucial role in providing comfort to patients, including those who do not receive ventilator treatment
- 7) Appeals process: Physicians and patients require a means of requesting review for triage decisions; ethics committee members and others should be prepared to assist in the appeals process.
- 8) Communication about triage: Government and clinicians need to provide clear, accurate and consistent communication about triage guidelines. Data gathering and public comment can help improve the triage system.

Associated Assumptions for Ventilator Allocation for Guam:

- 15% of the admitted patients with pandemic influenza will require intensive care,
- 7.5% of the admitted patients with pandemic influenza will require ventilators,
- At any given time, 85% of the ventilators in acute care settings are in use, and
- 70% of deaths related to pandemic influenza are projected to occur in the hospital.

The GMHA moderate scenario with a 35% attack rate (percentage of population infected) and 6-week outbreak duration. Using GMH figures, there could be more than _____ total

influenza patients requiring intensive care unit (ICU) beds. More than ____ cumulative influenza patients would require ventilator support during at least part of outbreak's duration, with over ____ patients needing them simultaneously during peak weeks.

TECHNICAL CONSIDERATIONS FOR PURCHASING ADDITIONAL VENTILATORS

A number of technical considerations will guide the purchase and use of these supplemented ventilators. Since a pandemic supposes excess numbers of patients requiring critical care, the extra ventilators should be portable so that they can be used outside of the typical settings. Ventilators should have settings that adjust for volume and pressure, important in caring for patients with the severe respiratory symptoms of patients with H5N1-related pneumonia. Supplemental oxygen may be in short supply, so ventilators that are relatively oxygen sparing is preferable. Staffing will be severely limited; ventilators should therefore be easy to use, since less experienced staff may need to manage patients on ventilators. This type of ventilators should be introduced as soon as possible in to regular use in hospitals, for instance when transporting patients, so that many workers will be competent in their use.

Triage Protocols

guidelines would 1) provides liability protections for providers and institutions; and 2) provide tiers so that as patients increase, and resources are depleted the criteria become more stringent.

Three tiers of criteria:

FIRST tier would eliminate access to ventilators for patients with the highest probability of mortality, including ventilator- dependent patients with persistent hypotension, and/or failure of greater than four organ systems. If resources continue to fall short, a second tier;

SECOND tier would deny access to ventilators for patients with respiratory failure as well as high use of additional resources. This tier includes patients who have a pre- existing illness with a poor prognosis, including: severe congestive heart failure; acute renal failure requiring hemodialysis; severe chronic lung disease; AIDS with a low CD4 count; active malignancy with a poor potential for survival; cirrhosis with ascites; hepatic failure; and irreversible neurologic impairment, including persistent vegetative state. In sum, tier includes patients with respiratory failure and other chronic or potentially fatal conditions.

THIRD tier is intentionally vague. A guideline development committee must examine survival data in real time, and add categories of patients who would not have access to ventilators in an overwhelming disaster.

PROPOSAL: the extubation of any patient “who might be stable, or even improving, but whose objective assessment indicates a worse prognosis than other patients who require the same resource. Thus, patient A’s continued use of the ventilator appears to depend not only on the estimated survival probability of patient A, but also upon that of newly arriving patient B, whose better health status leads to extubation and probable death of A, and the intubation of B (at least until C arrives).

Critical Care Triage tool based in part of the Sepsis-related Organ Failure Assessment (SOFA)

The sofa score adds points based on objective measures of function in six key organs and systems: lungs, liver, brain, kidneys, blood clotting, and blood pressure. A perfect SOFA score, indicating normal function in all six categories, is 0; the worst possible score is 24 and indicates life- threatening abnormalities in all six systems. The components of SOFA scoring are listed in Appendix15B, Table 1.

This triage protocol is based on *three evaluative components: inclusion criteria, exclusion criteria, and minimum qualifications for survival (MQS)*. Inclusion criteria focus on respiratory failure and refractory hypotension, and identify patients who benefit from admission to critical care. Exclusion criteria include a list of severe ailments. These exclusion criteria focus on all illnesses that draw extensively upon resources. MQS, a term taken from military triage, refers to limits placed on resources used for any individual patient.

Patients are initially assessed for inclusion and exclusion criteria; if inclusion criteria are present and exclusion criteria are absent, patients are then evaluated with a SOFA score. Patients are reevaluated at 48 and 120 hours and either continue with similar levels of care or are re- assigned to a different category, based on sofa scores and other objective criteria. In the OHPIP protocol, patients may lose access to ventilators and other critical care resources if their SOFA score increases. They may also lose access to ventilators and other critical care resources if their SOFA scores increases. They may also lose access if SOFA scores fail to improve within the allocated period. The idea is based on an argument that failure to improve during the designated during the designated interval is associated with a high probability of mortality and thus these patients should assigned to a different treatment category. Tables describing the protocol are presented in Appendix 15B, Table 2.

Appeals: a central triage Committee should be formed to perform ongoing modifications of the triage protocol as the pandemic progresses, and to consider appeals and/or exemptions requested by clinicians. For example, the committee could be consulted if a triage officer or clinician thinks a patient is inappropriately designated “blue” under the protocol.

The following components should be incorporated into the process for ventilator allocation:

- 1) Pre- triage requirements
- 2) Clinical evaluation
- 3) Palliative care
- 4) Appeals process
- 5) Communication about triage.

- 1) Pre- triage Requirements:

- a. Limiting Need: As the pandemic spreads, hospitals should limit the non- critical use of ventilators. Elective procedures should be canceled and/or postponed

during the period of emergency. As a pandemic stretches from days to weeks, facilities will require a review system for procedures that decrease morbidity or mortality, but are not of an emergency nature.

- b. **Securing Resources:** Before rationing procedures are implemented, facilities should institute all available means of creating “surge capacity.” Staffing issues are critical, for personnel are the most valuable resource in any healthcare facility. Staff members will fall ill, will leave work to care for family, or may decline to serve from fear of contagion, while the number of infected patients reaches unprecedented levels. The stockpiling of protective equipment, including masks and gloves, is a critical planning responsibility for facilities. Without adequate protective measures, facilities may undermine their capacity to provide adequate staffing during a public health disaster. Alternate levels of staffing should be permitted during the pandemic emergency, and systems for extending the skills of available staff must be utilized.

Facility, state, and federal ventilator stockpiles should be assessed and additional ventilators should be brought into the system as rapidly as possible. Systems for sharing information about the number and severity of cases, equipment availability, and staffing shortages could be activated throughout hospital systems and regional networks. For instance, not all facilities may be equipped to care for infants who need ventilatory support; clinicians and families need rapid access to information about where such support is available.

2) Clinical evaluation

A clinical evaluation system based on the OHPIP protocol and on the SOFA score is adapted for use in this guidelines. Incoming patients who meet the inclusion criterion of pulmonary failure will be assessed for exclusion criteria and will then be placed in categories based on variation of the OHPIP system (see Appendix II). Patients on ventilators when triage begins will also be assessed whether they meet criteria for continued use. Candidates for extubation during a pandemic would include patients with the highest probability of mortality. When a ventilator becomes available, and many potential patients are waiting, clinicians may choose the patient with pulmonary failure who has the best chance of survival with ventilatory support, based on objective clinical criteria.

Emergency Services: Some patients arrive in the emergency department with endotracheal tubes already inserted. EMS personnel should continue to intubate patients before arrival at the hospital. Emergency department staff may reassess patients upon arrival and extubate as necessary those patients who do not meet criteria for ICU admission and ventilator use.

Time Trials: Continued use of the ventilator will be reviewed and reassessed at intervals of 48 and 120 hours. Patients who continue to meet criteria for benefit or improvement would continue until the next assessment, while those who no longer met these criteria would lose access to mechanical ventilation.

Time trials for ventilator use should reflect the expected duration of beneficial treatment for acute respiratory distress syndrome (ARDS) or other likely complications of severe influenza. Too brief a trial, for instance of only a few hours, might not provide any significant benefit to patients including those who might survive with a limited but longer trial. Excessively brief trials might permit the use of ventilators by more patients, but without decreasing overall mortality. Moreover, very short trials would raise the option of terminal extubation for large numbers of patients, a circumstance that the guidelines should attempt to minimize if possible.

Exclusion criteria: Clinicians will assess patients for exclusion criteria both to determine the appropriateness of the initiation and continuation of ventilator use. Selecting and defining exclusion criteria are a challenging aspect of designing a triage system. A model set of exclusion criteria would objectively define those patients with a high risk of mortality even with ventilator support, but would not rely on subjective judgments of quality of life. Exclusion criteria should focus primarily on current organ function, rather than on specific disease entities. A revised set of exclusion criteria, drawing upon the work of OHPIP and incorporating suggestions from workgroup members and additional critical care experts, is presented below.

EXCLUSION CRITERIA FOR VENTILATOR ACCESS*

- Cardiac arrest: unwitnessed arrest, recurrent arrest, arrest unresponsive to standard measures; Trauma- related arrest
 - Metastatic malignancy with poor prognosis
 - Severe burn: body surface area >40%, severe inhalation injury
 - End- stage organ failure:
 - Cardiac: NY Heart Association class III or IV
 - Pulmonary: severe chronic lung disease with FEV1** <25%
 - Hepatic: MELD***score >20
 - Renal: dialysis dependent
 - Neurologic: severe irreversible neurologic event/ condition with high expected mortality. The primary clinicians treating a patient would have neither the main nor the sole responsibility for deciding to remove a ventilator from the patient. Clinicians directly caring for the patient would assess the patient's condition and note the emergence of any exclusion criteria; a triage review officer, the supervising clinician in charge of intensive care patients (either in the unit or in its overflow areas), would make triage decisions based on the allocation protocol.
- 3) Palliative care: Patients who fail to meet rationing criteria have poor prognoses and will be taken off ventilators. Clinicians should then endeavor to follow existing facility protocols for withdrawing and withholding life sustaining care. Palliative care should be offered to patients who fail to meet rationing standards for continued ventilator support. Typically, terminal weaning in response to patient to patient preferences can include sedation, so that the patient need not suffer from air hunger. Patients who are extubated against their wishes may be offered sedation, but may choose to decline.

Clinicians should clearly document the rationale and decision regarding sedation with extubation; Transparency is a crucial element in adhering to ethical standards. Facility protocols for terminal extubation may offer guidance for appropriate dosing and procedures. In addition, facilities should prepare for a significant increase in demand for palliative care expertise extubated patients could receive nasal cannula oxygen if available or other supplements to breathing. Facilities will need to address whether family or community members will be allowed to supplement ventilation, perhaps after transfer out of the ICU, with hand held- devices such as ambu- bags.

- 4) Appeals process: Triage decisions will engender controversy and objections. Some review process is needed to assure consistency and justice in the application of the criteria. Ideally, even under conditions of limited staffing, personnel involved in the appeals process would differ from those who made the initial triage determination, and if possible, the review should be made by several persons rather than an individual. These persons should also be experienced in conflict mediation and have clinical expertise; drawing upon members of the ethics committee, the patient representative service, retired clinicians, and the chaplaincy may be ways to provide an appeals process even during the period of limited staffing. This system offers the benefit of review for individual cases, but also creates potentially unworkable delays in implementing triage decision during the public health emergency.
 - a. Some argue that a real- time appeals process could invite explosive debate during a time of scarce manpower and other resources. An alternate to a real time appeals process could involve daily retrospective review of all triage decisions. The review would assure that standards are followed consistently and correctly, and would present an opportunity for correcting the guidelines or their implementation as needed. Such retrospective review would provide oversight and accountability for triage decisions, but would not permit intervention for individual decisions regarding access to ventilators.

5) Communication about triage

Initiation of each phase of treatment, but especially for ventilator support, will require clear communication about goals and options. Even before a patient comes to the hospital, political leaders and health officials will have to emphasize publicly that pandemic flu is potentially fatal, that clinicians are doing all they can with the available resources, and that everyone will need to adjust to a different way of providing and receiving health care than is customary. Patients and families must be informed immediately that ventilator support represents a trial of therapy that may not improve the patients' condition sufficiently, and that the ventilator will be removed if this approach does not enable the patient to meet specific criteria. Training of staff for pandemic readiness should include guidance on how to discuss such time trials. Communication should be clear upon hospital admission and ICU admission, as well as upon initiation of ventilator treatment.

LEGAL ISSUES: In devising a rationing scheme for ventilators, Guam law (with combined ethical and clinical recommendations) should examine various current health laws, regulations and policies. The best resolution for the challenging issue of liability and/or indemnification

for providers and facilities during a public health emergency are as yet unclear; various options, including new legislation, merit consideration.

Emergency Powers: A pandemic could meet the criteria of a “disaster” needed to trigger the emergency powers of the Governor and local officials enumerated in Guam Law. In a disaster, the Governor may temporarily suspend “any statute, local law, ordinance, or orders, rules or regulations.” Suspensions are subject to “local constitution, the federal constitution and statutes and regulations,” and “no suspension shall be made which does not safeguard the health and welfare of the public and which is not reasonably necessary to the disaster effort.” Suspensions are limited to 30 days, but can be renewed. Prudence compels consideration of which laws should be suspended by the Governor in a pandemic.

DNR Orders: Ventilator triage in a public health emergency will change the context in which decisions are made to attempt resuscitation. If pandemic triage guidelines endorse the removal of ventilators from patients in certain circumstances, physicians cannot then resuscitate such patient by reintubation. Article 29-B of the Public Health Law presumes that a patient consents to cardiopulmonary resuscitation and require consent to issuance of a DNR order.

- As noted above, any suspension of law by the Governor in an emergency is subject to the requirements of the federal and state constitutions, as well as federal law. Whether the emergency suspension of the DNR law (or portions thereof) to support emergency ventilator allocation would be viewed as running afoul of these requirements cannot be predicted with certainty.
- DNR orders in other contexts, for instance for hospice patients and others for whom ventilator use is not an issue, should continue to rely upon consent from patients or surrogates, even during the public health emergency.

Brain Death: Evaluations of brain death in Guam follow voluntary guidelines that can be revised or amended before or during an emergency without invocation of the Governor’s emergency powers. These guidelines call for two separate assessments of stem reflexes separated by a six- hour interval. Revised guidelines for brain death evaluations for use during a public health emergency should be reviewed as part of pandemic planning, so that they may be promulgated quickly if an emergency is declared. Criteria for removal of ventilator support during a pandemic might include an abbreviated assessment for brain death, relying upon only one assessment of brain stem reflexes and the elimination of various confounding factors such as substance overdose.

Liability: Among the most challenging legal questions related to the pandemic is the issue of liability protection for clinicians and facilities that adhere to rationing criteria in a public health crisis. Patient consent, the mainstay of ordinary medical care, will not be the determining factor in allocating ventilators. These emergency allocation guidelines represent a significant departure from standard non-emergency practice and will generate distress for clinicians and patients. Threatened and actual legal actions are reasonable concerns in response to any emergency rationing scheme.

- Voluntary guidelines for ventilator allocation would provide strong evidence for an acceptable standard of care during the dire circumstances of a pandemic. But while the guidelines offer the prospect of liability protection for providers and facilities, it cannot promise in advance that a court would accept its view. Further Guam law does not clearly empower the Governor to offer legal immunity to providers, even in a state of emergency.
- In regard to potential lawsuits related to ventilator allocation, legislation is the only avenue certain to provide robust protection for providers who adhere to the guidelines. Protections should extend to facilities and a wide range of clinicians, including doctors, nurses, respiratory technicians, emergency medical personnel and others. Such legislation could offer immunity to health care providers engaged in ventilator allocation, alternatively, could guarantee defense and/or indemnification to providers. One statute that may prove useful in this regard is section 17 of the Public Officers Law, which provides for indemnification and defense of state employees. “Employee” is given broad meaning in the statute by numerous subsections of section 17(1). It may be appropriate to recommend legislation adding to this list of indemnified “employees” those persons who engage in conduct pursuant to ventilator allocation guidelines.
- Another indemnification option worth exploring is the “volunteer” provision of section 17, which includes among indemnified persons “volunteers(s) expressly authorized to participate in a state-sponsored volunteer program.” It may be possible to design a state-sponsored volunteer program including those providers who participate in a ventilator allocation triage process, thereby offering them defense and indemnification by statute, even if the ventilator guidelines could be offered defense and indemnification by statute, even if the ventilator guidelines themselves remained voluntary and non-statutory. Such a statute would need to clarify that “volunteers” defined for this purpose include paid health care providers who comply with ventilator allocation guidelines.

Appendix 15B, Table 1. Sequential Organ Failure Assessment (SOFA) score

Variable	0	1	2	3	4
PaO ₂ /FiO ₂ mmHg	<400	≤400	≤300	≤200	≤100
Platelets, x 10 ³ /μL	.150	≤150	≤100	≤5	≤20
Bilirubin, mg/dL (μmol/L)	<1.2 (<20)	1.2-1.9 (20-32)	2.0-5.9 (33-100)	6.0-11.9 (101-203)	>12 (>203)
Hypotension	None	MABP<70mmHg	Dop≤5	Dop>5, Epi≤0.1, Norepi≤0.1	Dop>15, Api>0.1, Norepi>0.1
Glasgow Coma Score	15	13-13	10-12	6-9	<6
Creatinine, mg/dL (μmol/L)	<1.2 (<106)	1.2-1.9 (106-168)	2.0-3.4 (169- 300)	3.5-4.9 (301-433)	>5 (>434)

Dopamine (Dop), epinephrine (Epi), norepinephrine (Norepi) doses in μg/kg/min SI in brackets

Explanation of variables:

PaO₂/ FiO₂ = indicate the level of oxygen in the patients' blood.

Platelets = are critical component of blood clotting.

Bilirubin = is measured by a blood test and indicates liver function.

Hypotension = indicates low blood pressure; scores of 2, 3, and 4 indicate that blood pressure must be maintained by the use of powerful medications that require ICU monitoring, including dopamine, epinephrine, and norepinephrine.

The Glasgow coma score = is a standardized measure that indicates neurologic function; low score indicates poorer function.

Creatinine = is measured by a blood test and indicates kidney function.

Appendix 15B, Table 2: Triage Tool, Initial Assessment, 48 Hour Assessment, 120 hour Assessment

The overview of the protocol is as follows, with colors corresponding to triage categories:

BLUE	High probability of mortality; should be discharged from critical care and should receive medical management and palliative care as appropriate
	<ul style="list-style-type: none"> Initial: Exclusion criteria or SOFA > 11 48 hours: Exclusion criteria or SOFA >11 or SOFA 8-11 unchanged 120 hours: Exclusion criteria or SOFA > 11 or SOFA < 8 unchanged
RED	Highest priority for critical care
	<ul style="list-style-type: none"> Initial SOFA ≤ 7 or single organ failure 48 hours: SOFA < 11 and decreasing 120 hours: SOFA < 11 and decreasing progressively
YELLOW	Intermediate priority for critical care
	<ul style="list-style-type: none"> Initial :SOFA 8-11 48 hours: SOFA < 8 unchanged 120 hours: SOFA < 8 with minimal decrease (<3 point decrease in 72 hours)
GREEN	Low probability of mortality; defer admission/ discharge from critical care
	<ul style="list-style-type: none"> Initial: no significant organ failure 48 hours: no longer ventilator dependent 120 hours: no longer ventilator dependent

Critical Care Triage Tool		
Initial Assessment		
Color Code	Criteria	Priority/Action
Blue	Exclusion Criteria* Or SOFA >11*	Medical mgmt +/-Palliate & d/c
Red	SOFA ≤ Or Single Organ Failure	Highest
Yellow	SOFA 8-11	Intermediate
Green	No significant organ failure	Defer or d/c, reassess as needed

*If exclusion criteria or SOFA > 11 occurs at any time from the initial assessment to 48 hours change triage code to Blue and palliate.

d/c = discharge

Critical Care Triage Tool		
48 Hour Assessment		
Color Code	Criteria	Priority/Action
Blue	Exclusion Criteria <u>Or</u> SOFA >11 <u>Or</u> SOFA 8-11 no Δ	Medical mgmt +/-Palliate & d/c
Red	SOFA <11 and decreasing	Highest
Yellow	SOFA <8 no Δ	Intermediate
Green	No longer ventilator dependent	d/c from CC

Δ = change
CC = critical care
d/c = discharge

Critical Care Triage Tool		
120 Hour Assessment		
Color Code	Criteria	Priority/Action
Blue	Exclusion Criteria* <u>Or</u> SOFA >11* <u>Or</u> SOFA <8 no Δ	Palliate & d/c from CC
Red	SOFA score <11 and decreasing progressively	Highest
Yellow	SOFA <8 minimal decreas (<3 point decrease in past 72h)	Intermediate
Green	No longer ventilator dependent	d/c from CC

*If exclusion criteria or SOFA >11 occurs at anytime from 48 – 120 hours
change triage code to Blue and palliate.

Δ = change
CC = critical care
d/c = discharge

APPENDIX 16: REPORTING TO DPHSS OF SUSPECTED / ACTUAL CASES

For Suspected Novel Cases of Pandemic Influenza, reporting should be done by telephone call within 24 hours of identification. This will apply to those cases that are identified prior to local transmission (transmission of pandemic influenza throughout the community of Guam). Therefore, the disease reporting is classified as a Class I Disease based on the Official Guam Reportable Disease List, Chapter 3, Title X, Guam Code Annotated.

Telephone reports: Weekdays 8:00am to 5:00pm

735-7299 or 735-7143

After hours / Weekends: Emergency telephone

888-WARN (9276)

Fax reports (24hours):

Fax number: 734-1475 or 734-2066

Fax Reports shall be made using the DPHSS Morbidity Report Card as seen below:

Morbidity Report Card

Disease: _____ Date: _____
Specimen: _____
Name: _____
Occupation: _____
 Civilian Tourist Military Military Dependent
Ethnicity: _____ Patient No. _____
Age: _____ DOB: _____ Sex: _____
Physical Address: _____
Village: _____ Phone: _____
Clinic: GMHA Doctor: _____

To be completed by the laboratory and then transmitted to DPH&SS

Lab investigation: IFA direct examination Other test.....

Lab conclusion (circle result): **NEGATIVE** **FLU A** **FLU B** **RSV** **INADEQUATE**
SPECIMEN

Referred Specimen (circle one): **Ethanol Preserved** **Frozen**

Name of Reference Lab:.....**Date Shipped:**.....

Signature and Date:

Reference Lab Conclusion (circle result): **NEGATIVE** **FLU A** **FLU B**

APPENDIX 17: PATIENT RAPID DISCHARGE PLAN

In preparation for a Pandemic Influenza crisis, Nursing Services will assess all patients for possible discharges from GMHA. The following composes the facility's effective rules for expediting patient discharge during periods of anticipated high demand. Designation of triage physicians and nurses to the appropriate services and procedures for discharge and transfer of patients to home, a skilled nursing facility, or other facilities will be taken into consideration and managed by relevant departments.

Utilization Review Staff may be targeted as additional personnel available for evaluation of inpatients for possible discharge to make beds available.

PROCEDURE

Discharge Planning

Patient discharge needs will be assessed upon admission and a discharge plan will be developed. Increased importance of expediting patient discharge during a pandemic and staffing shortage that may ensue must be considered with implementation of the following process.

1. All initial discharge assessments must be completed within 4 hours of admission.
2. The nurse collecting the information will be responsible for reviewing and finalizing the information
3. A completed discharge assessment must be printed, signed, and placed in the patient's chart.
4. The nurse will make applicable referrals, based on physician orders, to other interdisciplinary care teams or to community agencies as appropriate to patient's condition.
5. The use of the discharge preparation message on the order communication system will be utilized to ensure that documentation of nursing referrals have been forwarded to appropriate departments (ex. Social Services, Rehabilitative Services, Education Services, Pastoral Care, or other outside agencies.)
6. The interdisciplinary team must acknowledge discharge preparation request similar to other patient requests with expedience in mind for the crisis situation.

Patient Discharge Preparation

Prepare the patient for discharge once discharge orders are written.

1. Check clinical record for discharge order.
 - a. If patient insists on leaving without a physician's order, he/she must sign a Release slip, AMA.

- b. If a patient leaves without an order and without the knowledge of Nursing personnel, an incident report shall be completed; an entry made on the Progress notes; and the patient's physician notified.
2. Note discharge orders and notify departments involved. Follow agency's discharge procedure as follows:
 - a. Stamp discharge voucher slip with patient's addressograph and send patient's (yellow) copy to Pharmacy, (with prescription if any), 2nd and 3rd copies to credit and collection office for billing process and signature.
 - b. After 2nd and 3rd copies are signed, 2nd copy goes to Admission and the 3rd copy is returned to the unit.
 - c. Relatives will return the signed copy of the Discharge Voucher to the nurses' station; if not, nursing personnel will take patient to credit and collection office when discharged.
 - d. Minors must be accompanied by their parents or legal guardian.
3. Assess the patients discharge planning and health needs and provide appropriate instruction to patient and family.
 - a. If the patient is discharged while possibly still infectious, family members should be educated in personal hygiene and infection control measures (e.g. hand hygiene and the use of a surgical or procedure mask by a patient who is still coughing).
 - b. Family members should be educated to avoid exposure to crowds and other individuals who may have similar signs and symptoms until they have been vaccinated.
4. Transcribe Discharge instructions as per order and instruct patient.
5. Complete referral forms as needed. In the event of Pandemic Flu crisis and for epidemiological purposes, notifications to the CDC office must be made via the Infection Control reports or CDC Morbidity reports.
 - a. Public Health Home Care. If patient's condition warrants Nurse Supervision or medication, treatments and other rehabilitative objectives, the physician will refer this patient to Home Care Services. Referral form should be sent to Home Care Supervisor/designee, one week prior to discharge.
 - b. Physical Therapy. Physical Therapy shall develop a treatment plan in accordance with physician's orders, and shall instruct the patient/family and coordinate acquisition of needed supplies.
 - c. Social Services. Social Services referrals should be sent as early as possible in the patient's stay. (Social Worker follows up on social and emotional needs of the patient and investigates family home situation.)

6. To expedite transport of discharged patients to their homes or other facilities, the ambulance or transport vehicle will be called by the nurse and provided with the following information:
 - a. Give name of patient
 - b. Room number
 - c. Address of destination
 - d. Time of departure
7. If feasible, a patient discharge holding area or a discharge lounge will be designated upon declaration of Phase I of the Pandemic. This holding area or lounge will be used to house patients who cannot immediately leave the facilities but whose discharge orders have been written. This will allow for necessary bed space to be freed up for critical patients coming into the institution.
8. As soon as transportation is available, the staff will assist the patient with gathering personal belongings and securing them in a wheelchair or other transport device.
9. Check with team leader/primary nurse/nursing supervisor for further instructions.
10. Accompany patient to vehicle and assist with transfer.
11. Family should be instructed to pick up patient in front of the hospital.
 - a. Complete Discharge summary, include time & date of discharge.
 - b. Assemble chart according to hospital policy
 - a) Admission and discharge record
 - b) History & Physical
 - c) Report of consultation
 - d) Laboratory Reports
 - e) Roentgenology (-X-Ray)reports
 - f) Electrocardiogram
 - g) Consent for surgery, treatment & anesthesia
 - h) Anesthesia sheet
 - i) Operation sheet
 - j) Surgical pathology report
 - k) Physician's orders Graphic chart
 - l) Nurses notes-Medication records
 - m) Intake & Output
 - n) Kardex with nursing care and discharge plan completed
12. Place completed chart, along with the old chart, in a designated area for return to Medical Records.

13. Credit medication (unopened vials and ampules) and return to Pharmacy. Label return drugs slip with identification stickers and send to Pharmacy.
14. Room and unit should be cleaned according to procedure according to Housekeeping
15. Requirements and Infection Control Practices.

Education and Training

Appropriate training and orientation regarding the implementation of above procedures and processes will be provided to relevant departments with coordination of managers/supervisors and staff development and training office.

APPENDIX 18: PHARMACY ANTIVIRAL/VACCINE CONTROL AND MANAGEMENT PLAN

Pharmacy Vaccine Control Plan

- a. Employee Health completes a Requisition Form for Pandemic Flu Vaccine
- b. Pharmacist on duty will complete a Control Sheet based on the request from Employee Health. Release of the Vaccine will only be to a Registered Nurse assigned to the Employee Health Department.
- c. Employee Health Nurse will be escorted by security personnel on transport to a secured storage space at the Mass Immunization Area.

Pharmacy Antiviral Control Plan, Employee Health

- a. Employee Health completes a Requisition Form for Pandemic Flu Vaccine
- b. Pharmacist on duty will complete a Control Sheet based on the request from Employee Health. Release of the Vaccine will only be to a Registered Nurse assigned to the Employee Health Department.
- c. Employee Health Nurse will be escorted by security personnel on transport to a secured storage space at the Mass Immunization Area.

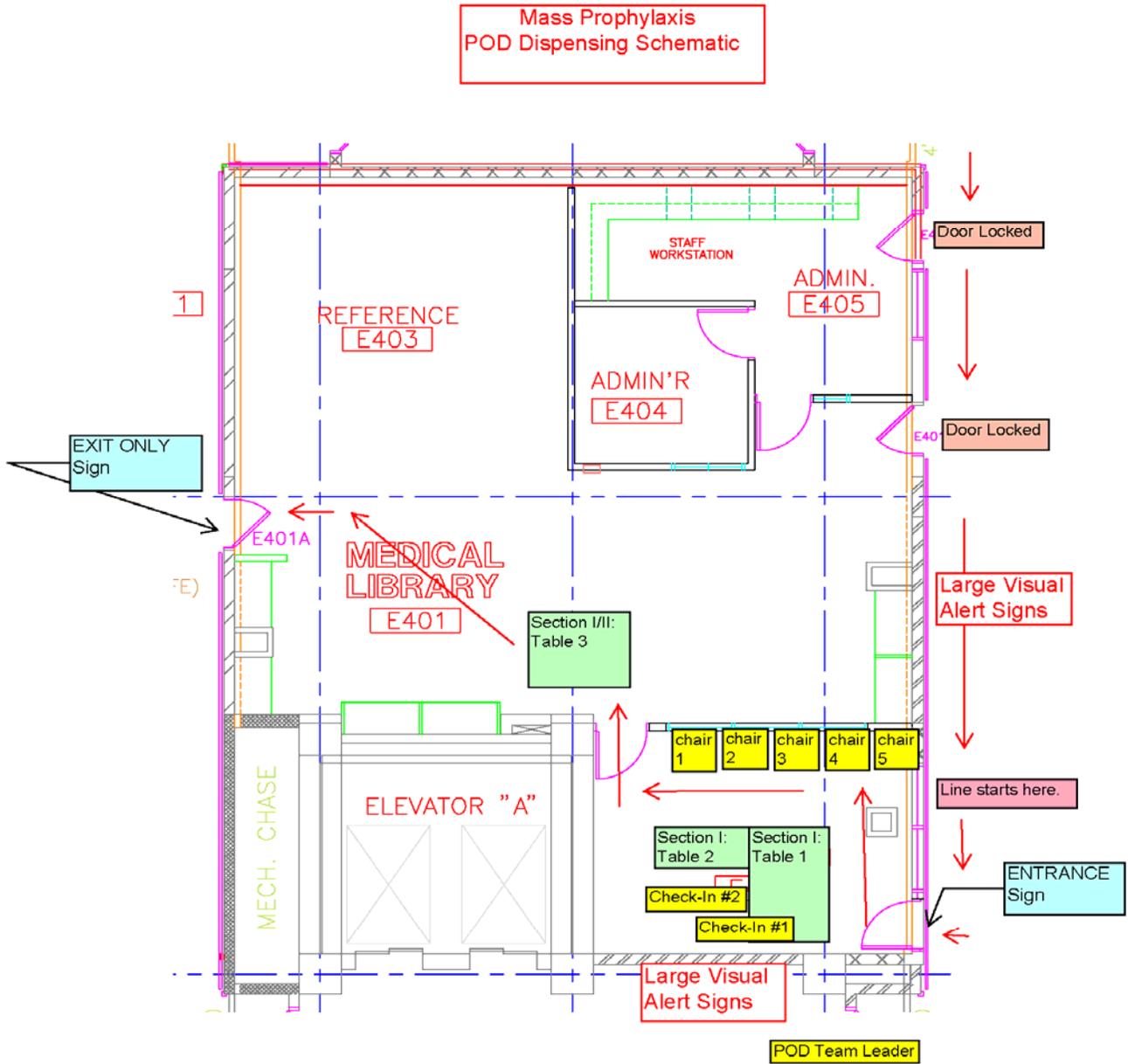
Pharmacy Antiviral Control Plan, Inpatient

- a. Registered Nurse completes a Requisition Form for Pandemic Flu Vaccine
- b. Pharmacist on duty will complete a Control Sheet based on the request from the Registered Nurse.
- c. Pharmacy Staff will call a security personnel to escort the Registered Nurse back to his(her) perspective unit secured storage area.
- d. Pharmacist controls the amount issued to the floor.

Antiviral and Vaccine Management and Administration Plan

- a. Identified priority groups will report to the Immunization Station at their scheduled time.
- b. Employee must bring a picture identification.
- c. Consent form detailing risks, benefits, and possible adverse events must be obtained prior to administration. In the event of refusal, the employee must sign refusal statement. That employee must be made aware their services with GMH may not be utilized during the pandemic period.
- d. Medwatch Forms will be distributed to employees. See *Medwatch Form*, See Appendix
- e. Employee Health Nurse in conjunction with Infection Control will continue to monitor CDC recommendations for antiviral use and possible wide-spread resistance.
- f. Employee Health Nurse will review and update management and administration plan as needed. This will be in conjunction with government of Guam mandates regarding administration.

APPENDIX 18A: ANTIVIRAL POINT OF DISTRIBUTION SCHEMATIC



APPENDIX 19: PRIORITIZATION LISTING FOR VACCINE DELIVERY

Note: Command Post will make final decisions during the pandemic period for any significant changes in the prioritization list below. This may be necessary due to the flotation of staff from their original place of duty to direct patient care duties.

Group 1: Healthcare workers, ER Dept

Rationale: The first line health care workers will be the first line of defense in a pandemic. Maintaining the health service response and the vaccine program is central to the implementation of the response plan, in order to reduce mortality and morbidity. Health services workers may be considered in the following work settings for vaccine program planning:

- Emergency Room Physicians (11 physicians)
- Medical Staff (34 employed)
- Nursing Services direct care personnel (397 staff)
- Respiratory Services direct care personnel (25 staff)
- Special Services (10 staff)**
- Laboratory Services direct care personnel (36 staff)
- Radiology Services direct care personnel (34 staff)
- Pharmacy Services direct care personnel (28 staff)
- Social Workers (5 staff)
- Patient Couriers (15 staff)
- Physicians with hospital privileges (88 staff)

(Total in group 1 = 683)

Group 2: Essential Service Providers

Rationale: The ability to mount an effective pandemic response may be highly dependent on persons, within the groups listed below, being in place to maintain key hospital services. These include:

- Communications Center Services (9 staff)
- Key emergency response decision makers (Administrators) (11 staff)
- Other hospital workers:
 - Dietary services (49 staff),
 - Environmental services/Laundry (46 staff),
 - Facilities Maintenance (37 staff),
- Mortuary personnel (CME) (3 staff)
- Security Department (7 staff)
- Long term care facility staff (30 staff)
- Materials Management (Transporters of essential supplies) (18 staff)
- Central Supply and Receiving (10 staff)
- Patient Registration (22 staff)

- ❑ Employee Health (1 staff)
 - ❑ Pastoral Care Services (1 staff)
- (Total in group 2 = 244)**

Group 3: Support services.

Rationale: Certain services, although not essential, are vital to the working/operations of the hospital.

- ❑ Medical Records (17 staff)
- ❑ Planning Department (3 staff)
- ❑ Safety Department (3 staff)
- ❑ Personnel Department (8 staff)
- ❑ EEO (1 staff)
- ❑ Medical Staff Department (2 staff)
- ❑ Guest Relations (1 staff)
- ❑ Data Processing (10 staff)
- ❑ General Accounting (14 staff)
- ❑ Patient Affairs (29 staff)
- ❑ Quality Management (9 staff)
- ❑ Education (4 staff)

(Total in group 3 = 101)

Group 4: Immediate Family Members of those in Group 1

Rationale: Health care workers will be essential to provide for the good of the hospital. They have to be assured that their own families are cared for before they care for others. Employee absenteeism may become a problem if workers need to stay home to care for sick family or are scared to expose family members.

Group 5: Persons at high-risk of developing severe complications from influenza

Rationale: To meet the goals of reducing morbidity and mortality, persons most likely to experience severe outcomes should be vaccinated. Prioritization of this sub-group would depend on the epidemiology of the disease at the time of the pandemic based on best information from DPHSS and National CDC. This group would include:

- ❑ *Persons in long-term care facilities, elderly housing*
- ❑ Persons with high-risk medical conditions
- ❑ Persons over 65 years or age
- ❑ Children 6 months to 23 months of age
- ❑ Pregnant women

Group 6: Persons providing care for those in Group 5

Rationale: Those at risk need to be provided care in place, to prevent them from coming to the hospital and to further stress the medical system.

Group 7: Healthy adults

Rationale: This group is at lower risk of developing severe outcomes from influenza during annual epidemics, but is a major work force and represent the most significant segment of the population from an economic impact perspective. Vaccination of healthy adults would reduce the demand for medical services and allow individuals to continue normal daily activities. Simultaneous absence of large numbers of individuals from their site of employment could produce major social disruption even in non-essential personnel.

Group 8: Children 24 months to 18 years of age

Rationale: This group is at lowest risk of developing severe outcomes from influenza but may play a major role in the spread of the disease. While children's absence from school might not have a direct economic and disruptive impact of illness in adults, it could have the effect indirectly, since care for ill children would be required. This group, however, may be at higher risk if a response results similar to the 1918 Influenza.

APPENDIX 19A: ANTIVIRAL PROPHYLAXIS CONSENT/REFUSAL FORM

GMHA Antiviral Prophylaxis Consent/Refusal Form

Name: _____ Department: _____
 GMHA ID#: _____ D.O.B.: _____

Please initial in the appropriate section for the table provided below:

Question	Yes	No
Do you have any known allergy to Tamiflu (Oseltamivir phosphate) or any of its preservatives or dyes? (Ingredients include: Black iron oxide (E172), Croscarmellose Sodium, FD and C Blue 2 (indigo carmine, E132) Gelatin, Oseltamivir, Povidone , Pregelatinised maize starch, Red iron oxide (E172), Shellac, Sodium Stearyl Fumarate, Talc, Titanium dioxide (E171), Yellow iron oxide (E172)		
Do you have any medical history of chronic lung disease (e.g. COPD)?		
Do you have any medical history of heart problems?		
Do you have any medical history of kidney disease?		
Do you have any medical history of liver disease?		
Are you currently pregnant?		
Are you currently breastfeeding?		

I understand that I am being offered Tamiflu (oseltamivir phosphate) to help prevent flu in case I have been exposed to people infected with flu. I am also aware that it decreases other ailments accompanied by flu such as weakness, headache, cough, fever and sore throat in just the first day of intake. However, I know that taking Tamiflu alone will not guarantee that I do not get the flu especially if I do not practice appropriate infection control precautions.

I understand that some of the adverse effects associated with taking Tamiflu (oseltamivir phosphate) include: headache, dizziness, nausea, vomiting, diarrhea, anorexia, cough, rhinitis, and bronchitis.

Consent for Prophylactic treatment:

I have been informed of the benefits and risks of receiving Tamiflu for prophylactic treatment. As with all medical treatment, there is no guarantee that I will not experience an adverse effect from the medication. I request that the antiviral prophylaxis be given to me.

Signature: _____ Date: _____

Witness: _____ Date: _____

Refusal of Prophylactic Treatment:

I have been informed of and am aware of the benefits and risks of taking the antiviral prophylactic treatment.

I do not wish to take the prophylactic treatment at this time.

Signature: _____ Date: _____

Witness: _____ Date: _____

Please indicate reason for refusal of the antiviral prophylaxis:

- () Allergy
- () Medical history contraindication
- () Other: _____

APPENDIX 19B: **Tamiflu® (oseltamivir phosphate) PATIENT PACKAGE INSERT**

This leaflet contains important information about Tamiflu (TAM-ih-flew). Read it well before you begin treatment. This information does not take the place of talking with your healthcare professional about your medical condition or your treatment. This leaflet does not list all the benefits and risks of Tamiflu. If you have any questions about Tamiflu, ask your healthcare professional. Only your healthcare professional can determine if Tamiflu is right for you.

What is Tamiflu?

Tamiflu attacks the influenza virus and stops it from spreading inside your body. Tamiflu treats flu at its source, by attacking the virus that causes the flu, rather than simply masking symptoms. Tamiflu is for treating adults and children age 1 and older with the flu whose flu symptoms started within the last day or two. Tamiflu can also reduce the chance of getting the flu in people age 1 and older who have a higher chance of getting the flu because they spend time with someone who has the flu. Tamiflu can also reduce the chance of getting the flu if there is a flu outbreak in the community.

What is “Flu”?

“The flu” is an infection caused by the influenza virus. Flu symptoms include fever (usually 100°F to 103°F in adults, and sometimes higher in children) and problems such as cough, sore throat, runny or stuffy nose, headaches, muscle aches, fever, and extreme tiredness. Many people use the term “flu” to mean any combination of these symptoms, such as the common cold, but true influenza infection is often worse and may last longer than a cold. Flu outbreaks happen about once a year, usually in the winter, when the influenza virus spreads widely in the community. Outside of those outbreaks, only a very tiny number of respiratory infections are caused by the influenza virus.

Should I get a flu shot?

Tamiflu is not a substitute for a flu vaccination. You should continue to get a flu vaccination every year, according to your healthcare professional’s advice.

Who should not take Tamiflu?

Do not take Tamiflu if you are allergic to the main ingredient, oseltamivir phosphate, or to any other ingredients of Tamiflu. Before starting treatment, make sure your healthcare professional knows if you take any other medicines, or are pregnant, planning to become pregnant, or breastfeeding. Tamiflu is normally not recommended for use during pregnancy or nursing, as the effects on the unborn child or nursing infant are unknown. Tamiflu is not recommended for use in children younger than 1 year of age.

Tell your healthcare professional if you have any type of kidney disease, heart disease, respiratory disease, or any serious health condition.

How should I take Tamiflu?

It is important that you begin your treatment with Tamiflu as soon as possible from the first appearance of your flu symptoms or soon after you are exposed to the flu. If you feel worse or develop new symptoms during treatment with Tamiflu, or if your flu symptoms do not start to get better, you should contact your healthcare professional.

If you have the flu: Take Tamiflu twice a day for 5 days, once in the morning and once in the evening. You should complete the entire treatment of 10 doses, even if you feel better.

To prevent the flu: If someone in your home has the flu, take Tamiflu once a day for 10 days or for as long as prescribed. You can take Tamiflu for up to 6 weeks if you are exposed to the flu because of an outbreak in your community. Follow your healthcare professional’s advice on how long to take Tamiflu.

Tamiflu has not been studied in children 1 to 12 years of age for preventing flu during an outbreak in your community or for use for more than 10 days.

You can **take Tamiflu with food or without food**. There is less chance of stomach upset if you take it with a light snack, milk, or a meal.

If you forget to take your medicine, take the missed dose as soon as you remember, except if it is 2 hours or less before your next dose. Then continue to take Tamiflu at the usual times. Do not take 2 doses at a time to make up for a missed dose. If you miss several doses, tell your healthcare professional and follow the advice given to you.

What are the possible side effects of Tamiflu?

The most common side effects of Tamiflu are nausea and vomiting. These are usually mild to moderate. They usually happen in the first 2 days of treatment. Taking Tamiflu with food may reduce the chance of getting these side effects.

If you develop an allergic reaction or severe rash, stop taking Tamiflu and contact your healthcare professional.

People with the flu, particularly children and adolescents, may be at an increased risk of seizures, confusion, or abnormal behavior early during their illness. These events may occur shortly after beginning Tamiflu or may occur when flu is not treated. These events are uncommon but may result in accidental injury to the patient. Therefore, patients should be observed for signs of unusual behavior and a healthcare professional should be contacted immediately if the patient shows any signs of unusual behavior.

Before taking Tamiflu, please let your healthcare provider know if you have received nasally administered influenza virus vaccine during the past two weeks.

If you notice any side effects not mentioned in this leaflet, or if you have any concerns about the side effects you get, tell your healthcare professional.

How and where should I store Tamiflu?

Tamiflu Capsules should be stored at room temperature, 77°F (25°C) and kept in a dry place. Keep this medication out of reach of children.

General advice about prescription medicines:

Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets. Do not use Tamiflu for a condition for which it was not prescribed. Do not give Tamiflu to other people, even if they have the same symptoms you have. It may not be right for them.

This leaflet summarizes the most important information about Tamiflu. If you would like more information, talk with your healthcare professional. You can ask your pharmacist or healthcare professional for information about Tamiflu that is written for health professionals.

- Turn the entire unit right side up and remove the oral dispenser slowly from the bottle.
- Dispense directly into mouth. Do not mix with any liquid prior to dispensing.
- Close bottle with child-resistant cap after each use.
- Disassemble oral dispenser, rinse under running tap water and air dry prior to next use.

If Directed by My Healthcare Provider, How Do I Mix the Contents of Tamiflu Capsules with Sweetened Liquids?

Please follow instructions carefully to ensure proper dosing.

- Holding one capsule over a small bowl, carefully pull the capsule open and pour the complete contents of the capsule into the bowl.
- Add a small amount of a sweetened liquid such as chocolate syrup (regular or sugar-free) that the child will consume completely.
- Stir the mixture and give the entire dose to the child

Reviewed: 5/06, 7/06, 9/06, 2/07, 12/08, 09/09

Revised: 6/06, 8/06, 9/06, 2/07, 03/09, 09/09

APPENDIX 19C: ANTIVIRAL PROPHYLAXIS ACKNOWLEDGEMENT OF RECEIPT FORM

GMHA Antiviral Prophylaxis Acknowledgement of Receipt Form

Name: _____ Department: _____
GMHA ID#: _____ D.O.B.: _____

I acknowledge that I have received 10 doses of Tamiflu (Oseltamivir Phosphate) for my antiviral prophylaxis against the flu.

I am aware that I must take the Tamiflu as directed and not deviate from the instructions that have been given to me. Those instructions are as follows:

- I must take one **75 mg tablet once a day, by mouth, for to 10 days**

I am aware that Tamiflu is not a stomach irritant and that I can take it with or without food. If I should take it with food I may have less chances of stomach upset.

I will ensure that no dose of Tamiflu is missed. However, if I should miss a dose of Tamiflu, I know that I should take the dose I missed as soon as I remember provided that it is not near the time for the next dose. I will never take the missed dose of Tamiflu two hours (or earlier) before the next dose of Tamiflu. I must also NOT take double doses of Tamiflu to make up for a missed dose.

Signature: _____ Date: _____

Witness: _____ Date: _____

APPENDIX 20: EMPLOYEE HEALTH FIT TO WORK

Fit for Work

1. Ideally, HCWs are fit to work when one of the following conditions apply:
2. They have recovered from pandemic flu, during earlier phases of the pandemic;
3. They have been immunized against the pandemic strain of influenza; or
4. They are on appropriate antivirals.
 - 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.
 - Whenever possible, well, unexposed HCWs should work in non-influenza areas.
 - Asymptomatic HCWs may work even if influenza vaccine and antivirals are unavailable.

Unfit for Work:

Ideally staff with ILI should be considered “unfit for work” and should not work; nonetheless, due to limited resources, these HCWs may be asked to work if they are well enough to do so. See *Fit to Work With Restrictions*, See Below.

Fit to Work With Restrictions:

1. Ideally, symptomatic staff who are considered “fit to work with restrictions” should only work with patients with ILI. Health Care Workers who must work with non-exposed patients (non-influenza areas) should be required to wear a mask if they are coughing and must pay meticulous attention to hand hygiene.
2. Symptomatic HCWs who are well enough to work should not be redeployed to intensive care areas, nurseries or units 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 21: EMPLOYEE HEALTH PANDEMIC FLU SCREENING
QUESTIONNAIRE**

Employee Health Pandemic Flu Screening Questionnaire

Name: _____ Department: _____
Social Sec. No.: _____ D.O.B.: _____

History

1. Have you had a recent fever (Temperature > 100.4 °F)? Yes No
If yes, when: _____
2. Did you have a cough, sore throat, or dyspnea? Yes No
If yes, when: _____
3. Have you required a recent hospitalization? Yes No
If yes, why: _____
4. Any history of recent (within 10 days) travel? Yes No
If yes, what areas have you visited in the past 10 days:

5. Did you have direct contact with poultry/poultry products? Yes No
6. Did you have close contact with a person with suspected or confirmed Pandemic Flu? Yes No
7. Did you have close contact with a person who died or was hospitalized due to severe respiratory illness? Yes No

I, the undersigned, claim that all the statements are true to the best of my knowledge.

Signature: _____ Date: _____

Witness: _____ Date: _____

APPENDIX 22: PANDEMIC INFLUENZA VACCINE CONSENT FORM

GMHA Pandemic Influenza Vaccine Consent Form

Name: _____ Department: _____
Social Sec. No.: _____ D.O.B.: _____

History

1. Have you had an influenza vaccination in the past? Yes No
If yes, when: _____
2. Do you have an allergy to egg products, chicken, chicken feathers or chicken dander? Yes No
3. Are you pregnant? Yes No
4. Are you suffering from any cold or flu symptoms? Yes No
If yes, what: _____
5. Have you ever had Guillian Barre Syndrome? Yes No
5. Have you had fever (Temperature > 100.5°F) in the last 2-3 days? Yes No
6. Current Temperature: _____

Consent for Vaccination:

I have been informed of the benefits and risks of receiving influenza vaccination. As with all medical treatment, there is no guarantee that I will not experience an adverse effect from the vaccine. I request that the vaccine be given to me.

Signature: _____ Date: _____

_____	_____	_____	_____	_____	_____	_____	_____
Date	Manufacturer	Lot No.	Exp. Date	Inject. Site	Dose	0.5 ml.	Provider's Signature

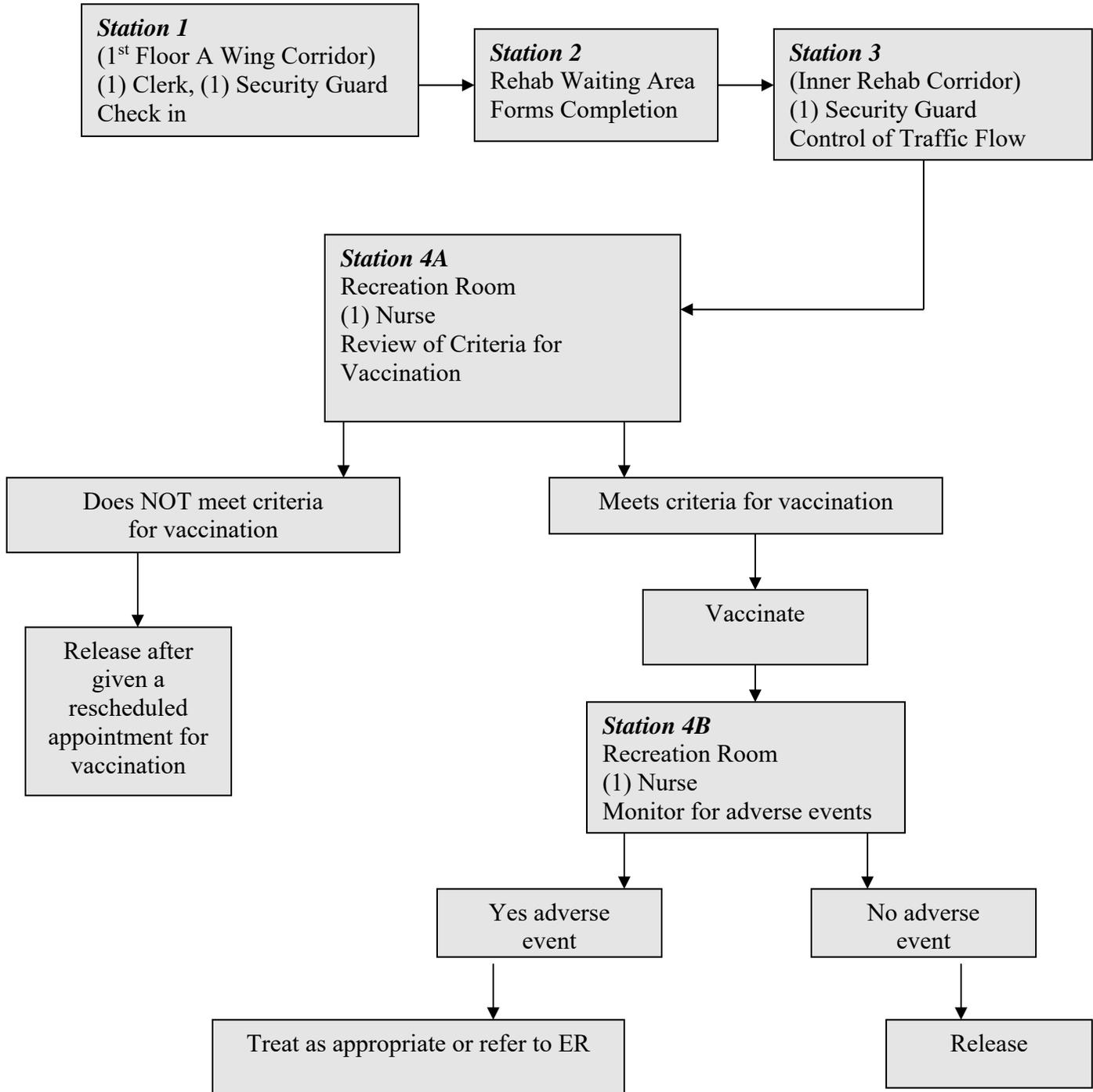
I have been informed of and am aware of the benefits and risks of taking the pandemic influenza vaccination. **I do not wish to take the vaccine at this time.**

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTE: This refusal statement may be overridden by an executive order that will mandate employees to obtain a pandemic flu vaccine as a ___ for employment in the hospital. Any employees refusing to be vaccinated may therefore, be placed on administrative leave without pay.

APPENDIX 23: GMHA ANTIVIRAL/VACCINE ADMINISTRATION PLAN



Footnotes to Appendix 23:

- (1) Identified priority groups will report to the Immunization *Station 1* at their scheduled time.
- (2) Vaccinees should arrive at prescheduled appointment time and present photo identification.
- (3) Assigned clerk will confirm that the potential vaccinee is on the preprinted list of names or priority groups. If not on the list, potential vaccinee will not be vaccinated.
- (4) Clerk will check potential vaccinee's photo identification and have potential vaccinee sign and date preprinted list.
- (5) Clerk will have all potential vaccinees complete vaccine questionnaire. Clerk will check their temperatures and document it on the screening form.
- (6) Potential vaccinee will be given a number and will proceed to *Station 2* (Rehab Waiting Area).
- (7) Security Guard, situated in *Station 3* will control flow of vaccinees entering and exiting Recreation Room (*Station 4A and 4B*).
- (8) Nurse will call for the next vaccinee and review screening form prior to vaccination.
- (9) Those potential vaccinees that do not meet criteria for vaccination will be given a rescheduled appointment for vaccination and then released.
- (10) Those potential vaccinees that meet criteria for vaccination will be vaccinated in accordance with existing recommendation. Note: Provide a second dose, if required for immunity.
- (11) The nurse will document date and time of vaccination and sign vaccination consent form.
- (12) Vaccinee will proceed to *Station 4B* (Recreation Room) for adverse event screening. Nurse will monitor each vaccinee for up to 30 minutes prior to release.
- (13) If no adverse events are noted after 30 minutes of monitoring, vaccinee will be released.
- (14) If adverse events are noted, nurse will intervene as appropriate or make a referral to ER as deemed necessary.

Resource/Supply Listing for Appendix 23:
(Needs per Station)

Station 1 (1st Floor A Wing Corridor)

- (1) One (1) Clerk
- (2) One (1) Security Guard
- (3) Preprinted List of Potential Vaccinees
- (4) Check in booth and chair
- (5) Pens, Clipboards
- (6) Vaccine Questionnaire and Consent Forms
- (7) Influenza Vaccine Benefits and Risks Informational Sheet
- (8) Thermometers

Station 2 (Rehab Waiting Area)

- (1) Chairs

Station 3 (Inner Rehab Corridor)

- (1) One (1) Security Guard

Station 4 (A&B) (Recreation Room)

- (1) Two (2) Nurses
- (2) Pens, Clipboards
- (3) Refrigerator with temperature monitor and temperature log
- (4) Vaccines in needles (3cc), Syringes, Alcohol Prep Pads, Band-Aids
- (5) Vaccine Control Sheet (Provided by pharmacy)
- (6) Sharps Container, Regular Waste Container
- (7) Epinephrine 1:1000, Benadryl Injectable

**APPENDIX 24: PANDEMIC INFLUENZA POST VACCINATION WORKSHEET
 AND ADVERSE EVENTS MONITORING**

**GMHA Post Vaccination Worksheet and Adverse Events
 Monitoring**

Vaccinee Name: _____ Department: _____
 Social Sec. No.: _____ D.O.B.: _____

Time of Vaccination: _____

Initial next to procedures completed:

- Provide comfort measures or teach patient to provide comfort measures (analgesics, antipyretics, warm soaks to injection site).
- Provide written record of vaccination and dates of when second injection would be appropriate.
- Monitored for adverse events
- Discharged/released after adverse event monitoring at _____ a.m./p.m.
- Referred to Emergency Room or Clinician for medical evaluation at _____ a.m./p.m.

Check if any of the following apply post vaccination:

Symptom	Symptom Present	Not Present
Tenderness, redness, and induration at injection site		
Fever		
Malaise		
Myalgia		
Allergic responses (flare, wheal, difficulty breathing, hoarseness or wheezing, paleness, weakness, tachycardia, dizziness)		
Gullain Barre Syndrome		

Vaccinator's Signature: _____ Date: _____ Time: _____

APPENDIX 25: EDUCATION AND TRAINING PLAN

PROCEDURES:

1. Education Department staff will conduct surveys to identify the current knowledge base of employees regarding Pandemic flu.
2. Pan Flu Committee will assist in identifying education needs for employees, for patients and visitors prior/during an influenza pandemic.
3. Infection Control and others providing inservices shall coordinate education activities with Education Department.
4. Establish content, methods, and a schedule for the education/cross-training for clinical personnel, including outpatient healthcare workers (HCWs), who can provide support for essential patient-care areas (i.e. emergency department, ICU, medical unit).
5. Establish content and schedule for an educational/training “quick” course for non-clinical staff who may be asked to assist clinical personnel with certain patient care needs (i.e. distribution of food trays, transportation of patients, Security duties).
6. Train intake and triage staff to implement immediate containment measures to prevent transmission of influenza.
7. Train all hospital staff on *Facility Access Flow Chart*, See [Appendix 8](#)
8. Initiate education/cross-training for clinical personnel, including out-of-hospital healthcare workers (HCWs), who can provide support for essential patient-care areas (i.e. emergency department, ICU, medical unit).
9. Initiate education/training “quick” course for non-clinical staff who may be asked to assist clinical personnel with certain patient care needs (i.e. distribution of food trays, transportation of patients, Security duties).
10. Update Education and Training Plan as needed.
11. Continue to educate on pandemic flu updates as needed.

Training and Education shall be provided to hospital personnel and providers in conjunction with the Education Department on the following **topics**

- explanation of seasonal vs. pandemic influenza and implications of pandemic influenza
- difference between upper respiratory infection and influenza
- prevention and control of influenza
- benefits of annual influenza vaccination
- 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

- provide information to encourage those who are symptomatic with influenza-like illness, but do not require formal healthcare to remain at home until their symptoms have been resolved; and to encourage them to avoid visiting/contact with those who are at high risk for complications if they developed influenza surveillance activities in all patient intake areas, including Triage (ER)
- Train staff and volunteers on hotline response:
 - telephone triage
 - answers to frequently asked questions
 - referral resources
 - documentation of calls (see Communication Plan)

Train Staff assigned to Communication Component on the goals of GMHA communication with regard to pandemic influenza: (Adapted from Centers for Disease Control and Prevention)

- Avoid panic.
- Reduce contagion.
- Control use of scarce hospital resources (human, supplies, and financial).
- Answer questions and concerns.

Train staff on some of the Key issues in communicating(Adapted from Centers for Disease Control and Prevention)

- Give people things to do.
- Don't say, "Don't worry,"—give facts and let people decide for themselves.
- Uncertainty causes panic. Contradictory messages create uncertainty; information is empowering.
- Don't make promises we can't keep, be truthful.
- No jargon.
- Avoid humor.
- Refute allegations—don't repeat them.
- Discuss what you know, not what you think.
- Be regretful, not defensive.
- Acknowledge fears.
- Establish content, methods, and a schedule for the education/cross-training for clinical personnel, including outpatient healthcare workers (such as those from GPSS, DPHSS, etc), who can provide support for essential patient-care areas (i.e. emergency department, ICU, medical unit).
- Establish content and schedule for an educational/training "quick" course for non-clinical staff who may be asked to assist clinical personnel with certain patient care needs (i.e. distribution of food trays, transportation of patients, Security duties).
- Train intake and triage staff to implement immediate containment measures to prevent transmission of influenza.
- Erect *Visual Alert Posters* ([Appendix 26](#)) for the education of visitors and patients on Respiratory Cough/Hygiene Etiquette.

APPENDIX 26: VISUAL ALERT POSTERS

Use Visual Alert Posters Readily available at the following site:

<http://www.health.state.ny.us/diseases/communicable/influenza/resources.htm>

Certain posters below may be available in more than one language.



The "Don't Spread it Around" poster is available below in English, Spanish, Chinese, and Russian.

.Select a Language

English

Spanish

Chinese

Russian



The "Your Health is in Your Hands" poster is available below in English, Spanish, Chinese, and Russian.

Select a Language

English

Spanish

Chinese

Russian

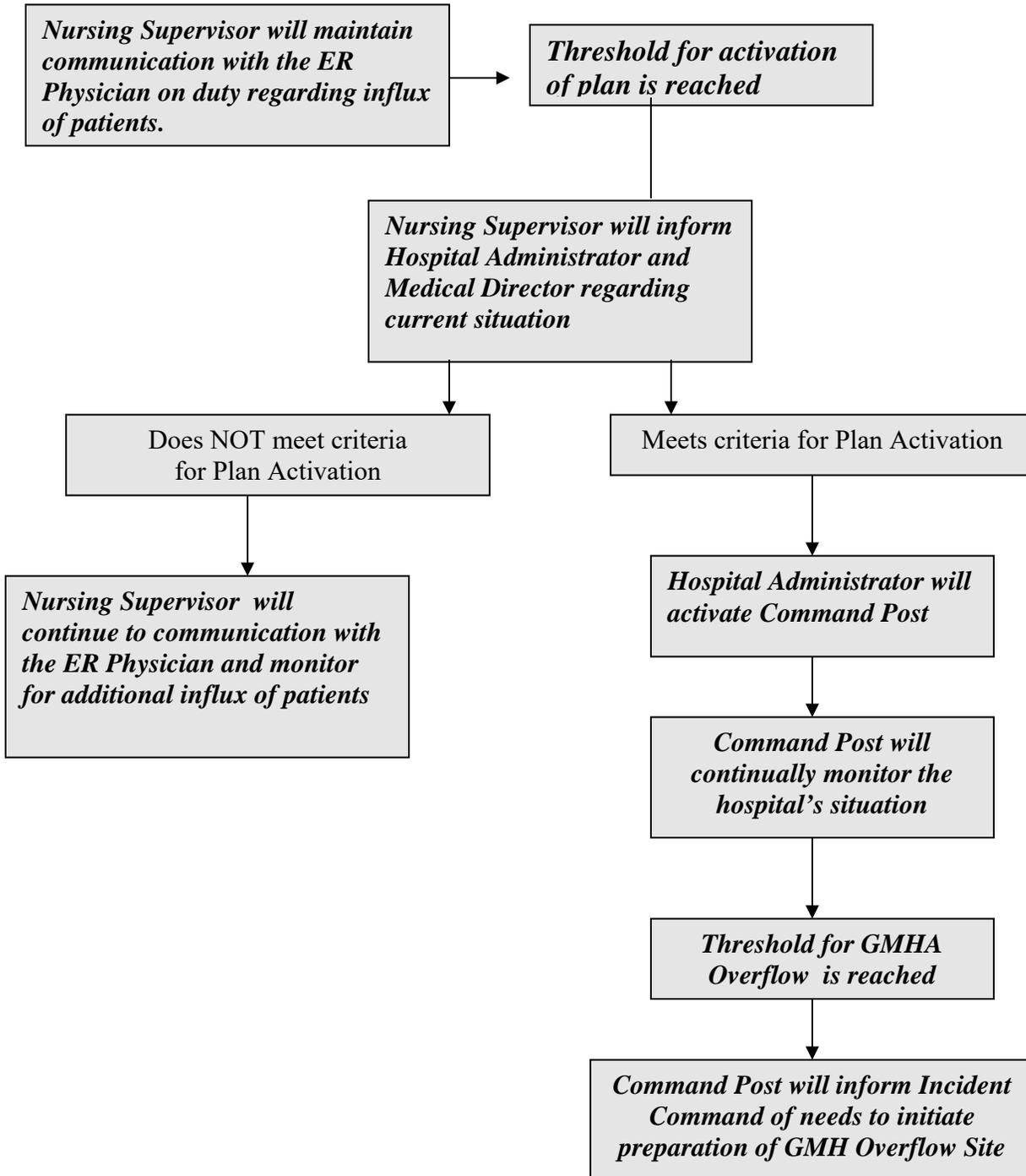


APPENDIX 27A: PLAN ACTIVATION PROCEDURES

PROCEDURE:

1. The Communications Department will activate the Pandemic Influenza Plan upon advice of the Hospital Administrator or the appointed designee. See *Communications Algorithm* below.
2. Upon receiving notice of activation of the Pandemic Influenza Plan, the operator on duty will carry out the following responsibilities:
 - a. All non-emergency incoming calls will be put on hold temporarily. If time permits the operator will explain the hospital's present situation and will request the caller to please call back later.
 - b. Announce the Pandemic Influenza Plan Activation Code over the public address system by saying it Three (3) times, "Calling Operation Pan Flu" as requested by the Hospital Administrator or appointed designee
 - c. Contact appropriate personnel in accordance with the protocol listings.
 - d. The Communication Supervisor or the operator on duty will ensure open lines of communication with command post at all times during activation of the Pandemic Flu Plan.
 - e. Recall and distribute radios and other communication equipment as necessary.

COMMUNICATION ALGORITHM



APPENDIX 27B: PHONE SCREENING GUIDELINES PLAN

1. Command Post shall identify non-essential staff to be assigned as Phone Screening staff to assist Communication Center staff.
2. All assigned personnel shall be trained with the Rapid training guidelines for phone screening, See *Box 4: Phone Screening Rapid Training Guidelines*, see below.

BOX 4: PHONE SCREENING RAPID TRAINING GUIDELINES

PROCEDURES:

1. Refer callers that are requesting for screening/triage to DPHSS “flu hotline” or to appropriate resources in the community. Inform callers of where they can get information.
2. Monitor call volume and the topic of questions. Document all incoming calls by date, time, person identification, reason for call, and response to call.
3. Do not provide direct services.
4. Communication Center will train staff on key messages for phone triage and response such as answers to frequently asked questions.

3. Communication Center shall keep a list of available interpreters of various languages. See *Box 5: Volunteer Translators Listing*, see below.

BOX 5: VOLUNTEER TRANSLATOR LISTING

Name	Contact Numbers
<u>Japanese</u>	
Gift Shop Volunteers	647-2168
Japan Consulate	646-1290/5220
Hisako Bordallo	734-8031
<u>Spanish</u>	
David Marinez (Fiscal)	647-2213
Jose Mendez (Radiology)	647-2137/2479
Jackie Chung	646-3500
<u>French</u>	
Jackie Chung	646-3500
<u>Creole (Haite)</u>	
Jackie Chung	646-3500
<u>Indian</u>	
Mohammad Afhraf (Pharmacy)	647-2440/2254
<u>Burmese</u>	

Name	Contact Numbers
c/o Atty. Charles Kinnunen	477-3300
<u>German</u>	
Margarit Atalig (SNU)	633-1800
Margot Camacho (Dietary)	647-2345/46
<u>Korean</u>	
Young Park (Pharmacy)	647-2254/5
Helem Kim (Pharmacy)	647-2254/5
Tae Lee (Pharmacy)	647-2254/5
Young Yoon (Med-Surg)	647-2496
Sue Kim (Peds)	647-2156
Edita Lee (Peds)	647-2156
Koream Consulate	649-5232
<u>Yapese</u>	
FSM Consulate	646-9154/6
<u>Chuukese</u>	
Marita Manibusan (Med-Surg)	647-2496
Chiswina Kasmi (Med. Reds.)	647-2360
FSM Consulate	646-9154/6
Isabel Cawal	472-8931/6
David Daris (ER)	647-2489
Aloha Tommy	647-2494
<u>Kosraian</u>	
Petrina Palsis (OB)	647-2295
FSM Consulate	646-9145/6
<u>Ulithian</u>	
Lolly Walsh (Soc. Svcs)	647-2140
Luis Roma	646-9154/6
<u>Palauan</u>	
Marlin Omengbar (Dietary)	647-2253
Margie Olkeril (Pt. Reg)	647-2238
Sowang Renguil (ER)	647-2489
Palau Consulate	646-9281/2
<u>Vietnamese</u>	
Lisa Quichocho (SNU)	647-2360/2296
Pascai Laird	646-7099
<u>Chinese</u>	
Una Choi (Fac. Maintenance)	647-2224
Su-Ching Huang (Pharmacy)	647-2254/5
Jackie Chung	646-3500

Name	Contact Numbers
Taiwan Consulate	472-5865/7
<u>American Sign Language</u>	
Mary Castro (Pat. Affairs)	647-2238/2344
Bertha Pangelinan (MIS)	647-2426
Frances Quintanilla (MIS)	647-2426
Jakín Dee Perez	789-4891/734-2011 after 3:00p.m.
Carol Sexton Samelo	653-1021
Connie Estes	646-8058
Catalina Santos	646-8058/632-2564
Monika Duenas	

Special Population Program :

- Program is coordinated through the Equal Employment Opportunity Office and the Guest Relations Department.
- The list is available at the nursing stations.
- Currently, the Hospital employs personnel who provide translation for various languages and the hearing impaired. Additionally, the list consists of translators from the community should additional services be needed.
- Meetings are not held, but phone calls are made with the Guest Relations Coordinator, periodically to reconfirm voluntary services.

Source: GMHA Guest Relations Department

APPENDIX 28: PSYCHOSOCIAL SUPPORT PLAN

*DRAFT Submitted 5/22/2006
Updated 5/23/06, 6/15/06, 6/16/06*

The Social Services Department shall be responsible for:

- 1) Responding to patient referrals for **discharge planning** in a pandemic episode
- 2) **Addressing the psychosocial needs** of GMHA's first responders, patients/families in a pandemic event

What is available?

GMHA has a staff of 5 social workers assigned to cover all units of GMHA.

Assumptions:

- GMHA staff will report for duty in a pandemic event
- 40% of the workforce will be absent in a pandemic event
- Chaos and panic will erupt at GMHA in this pandemic event
- GMHA's psychosocial needs will be different and apart from the community
- Safety at GMHA will be diminished as chaos and panic erupt
- Security will be needed for isolated "Code 60" (disturbance) cases
- Standard operating procedures in this event will be altered
- Patients and their families as well as GMHA's first responders will react
- Reactions will vary from individual to individual
- Those providing psychosocial support must be prepared for the various responses of patients/families and the first responders
- Beyond supportive counseling from GMHA SWs, therapeutic intervention via direction from DMHSA or DPHSS (lead agency) will be available
- Spiritual counseling may bring comfort to individuals
- Vaccine will be available 6 months from outbreak
- There will be enough vaccinations
- Employees who report for duty will expect their families to be vaccinated and protected while they assume their responsibilities at GMHA
- GMHA's criteria for who gets vaccinated must be supported
- Limitations on those vaccinated will impact moral of employees
- Absenteeism and reduction in workforce will impact the delivery of service
- Absenteeism will require coverage, coverage may result in employee burn out
- Chaos is anticipated all over the island and fear will paralyze the island

What Social Services' response will entail in Discharge Planning:

- Social Workers shall respond to referrals initiated by their assigned units in this pandemic response. Patients' post-care placement will be an area of concentration if patients' return to their homes and families is not feasible

- Direction regarding patients' discharge status and whether isolation will or will not be needed will be given by the attending physician or the Charge RN
- Immediate placement of those discharged will be necessary to make beds available for incoming admissions
- Knowledge of alternate housing will be necessary for the placement of patients
- Information on housing of infected individuals shall be guided by GMHA Administration or DPHSS which is the lead agency in a pandemic event
- When need is identified, a referral to the Spiritual Care Services Coordinator shall be initiated

The following concerns are presented in Social Services' response plan for Discharge Planning:

- A 40% workforce reduction will mean 2 of the 5 social workers are expected to report for duty
- Whether staff will report to work for fear of exposure or because they choose to stay home to be with and protect their families
- Direction will be needed by GMHA Administration on whether the 5 Social Services staff members who may be exposed from the community will be allowed into GMHA for duty when the hospital goes into emergency operations
- Guidance will be needed from GMHA's Human Resources department to tap on other agencies to augment SS staffing in this crisis situation
- Exposure and the possibility of contracting the avian flu will be a constant concern while staff are on duty
- Performance may be affected by this pandemic event
- Training will be needed for prevention, protection and containment
- Care unit beds will be at full capacity if post-care placement is not identified immediately
- Service provider operations for durable medical equipment, Home Health Care, pharmacies, St. Dominic's, senior housing units, etc., are expected to change (if even available at all), therefore anticipate that the inability to access services will delay patient discharges
- For post-hospital placement, DPHSS-identified housing for those deemed unable to return home/to the community must be available in order to keep the hospital patient flow active
- Anticipate negative response from patients/family if patient must be isolated
- What operational role will SNU be in as one SW is assigned to the facility and her assignment to either SNU or the main campus will need to be defined

What Social Services' response will entail in Psychosocial Support:

- GMHA Social Workers shall be tasked to provide supportive counseling for GMHA's first responders, patients and their families as they deal with a pandemic episode
- Social Workers shall respond to referrals either verbally or in writing by GMHA administration, staff or physicians to provide supportive counseling to individuals affected by the pandemic episode

- Social Workers will utilize rooms assigned for counseling either in the respective patient care areas or in the SS department as situation dictates
- Supportive counseling will be provided to help ease the stress the individual is experiencing
- When it is determined that more intensive or therapeutic counseling is needed, the Social Worker shall refer individual to DMHSA or to DPHSS' list of licensed therapists and initiate referrals
- Collaboration with the Spiritual Care Services Coordinator for assistance for individuals of all faith denominations to receive spiritual support

The following concerns are presented in Social Services' response plan for Psychosocial Support:

- The number of first responders or Social Workers may not allow any debrief sessions which may impact on performance/delivery of service
- Burn out may be experienced before individual recognizes the need for supportive counseling
- Social Workers themselves may experience burn out
- Mechanism(s) must be in place so all GMHA immediate supervisors will be able to identify those individuals who are in need of counseling
- Open communication and information sharing between Administration and employees is essential in this pandemic
- GMHA must provide a means of communication between first responders or patients/families to reach home
- GMHA employees who are quarantined for the prescribed amount of time shall be provided respite quarters (sleeping, dining, shower & recreation areas)
- Information will be needed on how soon DMHSA can be called upon for GMHA first responders requiring intensive, therapeutic counseling post supportive counseling by GMHA Social Workers
- Training by mental health professionals/DPHSS will be needed to guide the SWs as they assume their supportive counseling roles in this crisis event

What is needed to address concerns for both Discharge Planning and Psychosocial Support

- GMHA's procedure for call back in a pandemic event
- Human Resources must advise GMHA on the consequences should employee refuse to report for duty in this pandemic event
- GMHA's and/or DPHSS' identification of designated housing
- Enough Personal Protective Equipment (PPE) for staff who report for duty
- The eligibility of family members of employees for vaccinations must be clearly defined if the employee is to perform duties
- A mechanism must be in place by either GMHA Security or GPD for intervention in dealing with combative patients and families in a pandemic
- Will DMHSA assign personnel for GMHA first responders requiring intensive intervention in this pandemic episode?
- Employee Respite Quarters

- Phone lines for employees to keep contact with their families
- Phone lines for patients to keep contact with their families
- Spiritual Care Services

Resources available for Discharge Planning & Psychosocial Support

- 5 Social Workers
- GMHA Safety Department and Materials Management for PPE
- Employee Health for vaccination information (6 months later)
- DPHSS' state plan for direction on housing and psychosocial support staff (TBA)
- Spiritual Care Services
- GMHA Security, GPD

Resources needed for Discharge Planning & Psychosocial Support

- SS Administrator or designee will need to address staffing if any of the SWs does not report for duty (5 Social Workers will be reduced to 2 with the anticipated 40% reduction in workforce)
- Human Resources' guidance for staff to augment department absenteeism in this event
- Assistance from all Consulate offices in the identification of a community contact person for all ethnic groups on island to facilitate discharge & placement
- Guidance from DMHSA or DPHSS to tap other personnel to assist in GMHA first responders' support system
- Law enforcement and peace officers to address disturbances, maintain safety
- DMHSA's or DPHSS' list of private therapists for referrals beyond supportive counseling
- Mental health professionals for those individuals requiring intensive therapy
- Housing for those discharged from GMHA (isolation, non-isolation) as directed by either GMHA administration or DPHSS
- Respite Quarters for GMHA employees
- Spiritual Care Services

Information from community resource agencies to address the special needs population: elderly, developmentally challenged, disabled tap private agencies e.g. Catholic Social Services, Guma Mami and public agencies e.g. DISID

APPENDIX 29: MASS FATALITY PLAN

I. Introduction

A. Guam Laws Governing Dead Bodies

- III. The embalming, cremation, transport, burial, and record-keeping of dead bodies in Guam are governed by Title 10 GCA, Chapter 3 (and its rules and regulations), 4a, and 30:
 - a. All unembalmed dead human bodies shall be buried or cremated within 24 hours after death, unless kept under adequate refrigeration.
 - b. No human body shall be buried; deposited in a crypt, mausoleum or vault; cremated; or otherwise disposed of, unless a burial permit has first been issued by the Department of Public Health and Social Services (DPHSS).
 - c. DPHSS shall arrange for the burial or other disposition of unclaimed dead bodies.
 - d. In protecting public health, DPHSS in its discretion may order such form of burial or disposition of a dead human body as it deems necessary.
 - e. No person shall transport any dead human body of any person who died from, or while having, any communicable disease specified in Subchapter D, within Guam without the approval of DPHSS. (*Note: Influenza is not included in Subchapter D.*)
 - f. Establishment of all cemetery, crypt, mausoleum, vault, or crematory must be approved by DPHSS.
 - g. Every person in charge of a cemetery, crypt, mausoleum, vault, or crematory shall keep complete record of all dead human bodies interred, disinterred, removed, or cremated.
 - h. Only one (1) body shall be buried in each grave, unless approved by DPHSS.
 - i. Graves shall not be less than 6 feet in depth below the surface and shall not be less than 1 foot in width and length than the coffin; however, when vaults are used, it shall not be less than 18 inches in depth below surface.
 - j. The Governor of Guam is authorized to set aside form public lands such amount thereof as he may deem necessary for the establishment of a public cemetery.
2. The management of dead bodies is further governed by Title 10 GCA, Chapter 19 (Emergency Health Powers Act) during a declaration of public health emergency by the Governor. Under such state of emergency:
 - a. The Governor of Guam may suspend any Government of Guam regulatory statute, orders, and rules and regulations that would prevent, hinder, or delay necessary action to respond to the public health emergency, and seek the aid of the Federal Government in accordance with any emergency compact.
 - b. The Department of Public Health and Social Services (DPHSS) shall coordinate all matters pertaining to the public health emergency response of Guam, including the safe disposal of dead bodies.

- c. DPHSS may take measures to safely dispose of dead bodies, which includes, but not limited to, their embalming, burial, cremation, interment, disinterment, transportation, and disposal.
- d. DPHSS, when necessary, requires any business/facility that is authorized to embalm, bury, cremate, inter, disinter, transport, and dispose of dead bodies to accept any dead bodies or provide the use of its business/facility if such actions are reasonable and necessary as a condition of licensure, authorization, or ability to continue doing business on Guam. The use of business/facility by DPHSS may include the transferring of management and supervision of such business/facility to DPHSS until the end of the public health emergency.
- e. Government of Guam shall pay just compensation to the owner of any facilities or materials that are lawfully taken by DPHSS for temporary (or permanent) use during the public health emergency.

IV. Office of the Chief Medical Examiners and Autopsies

1. The Office of the Chief Medical Examiner (OCME) is responsible for the autopsies and/or certifications of death of individuals dying at home, from foul-play, and under non-hospital care. OCME had the ability to store nine (9) bodies in its morgue facility, and acts as a repository to accept the overflow of dead bodies from Guam Memorial Hospital when it's own morgue exceeds its capacity of twelve (12). Thus, the coroner's office and the hospital combined can accommodate the temporary storage of 21 corpses. The morgue of the U.S. Naval Hospital, Guam can manage 24 dead bodies at maximum capacity.
2. Majority of deaths during a pandemic would not require autopsies since autopsies are not indicated for the confirmation of influenza as the cause of death. However, for the purpose of public health surveillance (e.g., confirmation of the first cases at the start of the pandemic), respiratory tract specimens or lung tissue for culture or direct antigen testing could be collected post-mortem. Serological testing is not optimal but could be performed if 8-10 mL of blood can be collected from a subclavian puncture post-mortem. Permission will be required from next-of-kin for this purpose.
3. Chief Medical Examiner will act as a consultant to DPHSS for any proposed changes to the regular practices pertaining to the management of corpses as it relates to autopsy requirements during a pandemic.
4. If a physician requires that an autopsy be performed, normal protocols will be followed, including permission from the next-of-kin. In cases where the death is reportable to a medical examiner, the usual protocols prevail based on Guam law.

- V. During a pandemic and when the plan is activated and implemented, CME or designee will make public announcements to educate the public on when a body will and will not be autopsied.

II. Plan for Mass Fatalities

VI. Temporary Morgue Requirements

1. Additional temporary cold storage facilities will be required during a pandemic for the storage of corpses prior to their transfer to funeral homes.
 - a. A temporary morgue must be maintained at 36 °F to 40 °F (2.2 – 4.4 °C).
 - b. If a temporary morgue cannot reach such temperature range, 40 °F to 45 °F (4.0 – 7.2 °C) is acceptable; however, corpses may begin to decompose in a few days.
 - c. If the body will not be cremated, expedited embalming process will be necessary considering that bodies will likely be stored for an extended period of time.

B. Storage capacity in refrigerated containers

Without stacking the bodies, a refrigerated 40-ft container can generally hold 20-25 bodies without shelving. To increase storage capacity, temporary wooden shelves can be constructed of sufficient strength to double the capacity to 40-50 bodies. Shelves should be constructed in such a way that allows for safe movement and removal of bodies (i.e., storage of bodies above waist height is not recommended). To reduce any liability for business losses, containers and trucks with markings of a supermarket chain or other companies will be avoided since the use of such trucks for the storage of corpses may result in negative implications for business. Furthermore, utilization of local businesses for the storage of human remains will not be recommended and will only be considered as a last resort.

VII. Methods for maintaining recommended temps:

2. Use of refrigerated containers.
3. Dry ice (carbon dioxide frozen at -78.5 °C) may also be utilized for storage of dead bodies; however, cost and availability may prohibit it extended use. When using such method, groups of 20 bodies are surrounded by a low wall of dry ice (about 1.5 ft high) and covered with a plastic sheet, tarpaulin, or tent. Dry ice should never be placed on top of bodies, even when wrapped, since it may damage the body. About 22 lbs. (10 kg) of dry ice per body, per day is usually needed, pending on outside temperature. Because dry ice produces carbon dioxide when it sublimates (“melts”), its use should only occur in well-ventilated room or building.
4. Ice (frozen water) should be avoided since large quantities are needed and melting ice may produce contaminated waste water. The water may also damage bodies.

III. Other Technical and Logistic Consideration

A. Death Registration

In Guam, the pronouncement of death is primarily the responsibility of a licensed medical doctor, but it may be performed by a licensed nurse practitioner for a terminally ill patient who dies under his/her care at a hospice. The certification of death on the other hand is conducted only by the Chief Medical Examiner, unless the person dies of natural causes at a hospital and who has been admitted for more than 24 hours. In such case, the decedent's doctor may certify the death. During a pandemic, authorization to perform certification of death will be expanded to include authorized licensed medical physicians determined by the Chief Medical Examiner. **OCME must create and retain updated list of such authorized physicians.**

B. Certificate of Death Policy

1. All deaths occurring in Guam require the filing of the original "Certificate of Death" form with the Office of Vital Statistics (Vital Statistics) to be officially acknowledged and documented.
 - a. The form is commonly identified and called a death certificate.
 - b. Blank death certificates are provided to Guam Memorial Hospital (GMHA) and the Chief Medical Examiner (OCME) by Vital Statistics.
 - c. Relevant information about the deceased is typed on the certificate by GMHA or OCME representative before it is submitted to Vital Statistics.
 - d. It is on this form that pronouncement and certification of deaths are formalized through the signature(s) of applicable practitioner(s).
 - e. The original death certificate cannot be released to anyone; it is to be filed and maintained by the Office of Vital Statistics.
 - f. Death certificates issued to families and/or funeral homes by Vital Statistics are valid only if the forms have been properly certified.

C. Body Collection Plan

1. During a pandemic situation, with an increased number of deaths, a body collection plan will be implemented to ensure that there is no unnecessary delay in moving a body to the morgue. If the person's death does not meet any of the criteria for needing to be autopsied or further examined by the Chief Medical Examiner:
 - a. CME will determine if criteria are met for need to autopsy. If criteria are not met,
 - b. Then the body will be moved to a holding area soon after the pronouncement of death.
 - c. Then a designated physician will certify the death of the deceased.
 - d. Funeral directors will be prohibited from collecting a body from GMH until there is a completed certificate of death filed with Vital Statistics. In the event of a

pandemic with numerous deaths, it will be necessary to implement a plan that will allow the completion and issuance of death certificates in timely, efficient manner.

D. Infection Control

1. The World Health Organization's "Influenza A (H5N1): Interim Infection Control Guidelines for Health Care Facilities" indicates that embalming may be performed routinely. Thus, special infection control measures are not required for the handling of persons who died from influenza. Funeral homes are recommended to implement universal precautions for embalming of all dead bodies. In the event that infection control recommendations change for the handling of corpses, funeral homes, morticians, and others working in the field will be notified by DPHSS as soon as possible.
2. Designated personnel tasked to transport and process dead bodies, exclusive of embalmers, will be provided appropriate personal protection equipment, and personal hygiene and sanitizing supplies.
3. Visitations could be a concern in terms of influenza transmission amongst attendees. It is the responsibility of CEO in conjunction with OCME to place restrictions on the type and size of public gatherings if this seems necessary to reduce the spread of disease. This may apply to funerals and religious services. If families are permitted to view the body, they should be provided disposable gloves and masks.

E. Assistance from Disaster Mortuary Operational Response Team (DMORT)

When the capacity of local jurisdiction to manage mass fatalities is exceeded, U.S. Department of Health and Human Services (HHS) will coordinate with the Department of Homeland Security and the Department of Defense to assist in providing the mortuary services; establishing temporary morgue facilities; and processing, preparing, and the disposition of dead bodies through the Emergency Support Function #8 (ESF #8). Under the ESF #8, Disaster Mortuary Operational Response Team (DMORT) may be activated, which consists of voluntary staff of private citizens with expertise in mass fatalities that are activated in the event of disaster.

Guam will seek the assistance of HHS and the activation of DMORT when routine management of dead bodies can no longer be performed. In spite of this, DPHSS realizes that Guam cannot rely on the aid of DMORT and other off-island entities during a pandemic when the entire nation will be seeking similar assistance from HHS. An alternative to HSS/DMORT assistance is the U.S. Department of Defense (DoD) forces stationed on the island. DPHSS will seek their assistance to improve the department's capability to implement this plan for the management of mass fatalities.

APPENDIX 30: STAFFING BREAKDOWN

PROCEDURE:

1. Departments should consider creating and/or revising contingency staffing plans for a minimum duration of eight weeks.
2. Department Managers shall define what would constitute a “staffing crisis” that would enable the use of emergency staffing and alternative medical care levels, and that would meet Local government approval. Department Managers shall initiate cross-training of personnel (in collaboration with other department) to provide support for essential patient-care areas at times of severe staffing shortages
3. Department Managers shall be responsible for determination of the *ideal* minimum staffing for the numbers of patients with pandemic influenza. This is with consideration that the numbers of patients may vary dependent on the community situation.
4. Department Managers will inform Command Post of additional staffing needs. Command Post can make determinations, based on available internal staffing, the circulation of existing staff within the hospital. Command Post shall review the list of non-essential positions that can be re-assigned to support critical hospital services
5. Command Post shall determine needs for external staffing and coordinate with Incident Command as needed. Human Resources in conjunction with Hospital Administrator shall determine pay-scale and have established generic contracts available for use of external staff.
6. Command Post shall establish a list of non-essential positions that can be placed on administrative leave to limit the number of persons in the hospital.
7. See *Box 3: Total Number of Staff by Division* below.
8. Enact *Emergency System for Advanced Registration – Volunteer Health Professionals (ESAR-VHP)*, See [Appendix 44](#), as needed.
 - Human Resources Division will establish a rapid badging system with photo ID and title of existing personnel and those that are identified as additional staff for the hospital.

Note: A Plan for “Relaxation of Licensing Standards” will be included upon completion. This will allow for those non-licensed personnel with educational background to perform duties of licensed personnel during emergency situations. (e.g, a graduate nurse to perform duties of a registered nurse).

DIVISION	TOTAL # EMPLOYEES (As of September 18, 2006)
ADMINISTRATIVE DIVISION	
Administration	11
EEO	1
Medical Staff	2
Personnel	8
Volunteer Services	0
ADMINISTRATIVE SUPPORT DIVISION	

Communications	9
CSR	10
Facilities Maintenance	37
Guest Relations	1
Housekeeping	46
Laundry	0
Materials Management	18
Planning	4
Safety	3
Security	7
FISCAL DIVISION	
Data Processing	10
General Accounting	14
Medical Records	17
Patient Affairs	29
Patient Registration	22
MEDICAL DIVISION	
Anesthesia	8
Employee Health	1
Infection Control	1
Quality Management	9
Staff Physicians	37
NURSING DIVISION	
Emergency Room	48
Hemodialysis	26
ICU/CCU	29
Labor & Delivery	45
Medical Surgical	44
Medical Telemetry	46
NICU	27
Nursing Administration	10
OB/GYN	26
Operating Room	33
Pediatric	33
Skilled Nursing Unit	30
PROFESSIONAL SUPPORT DIVISION	
Dietary	49
Hospital Education	4
Laboratory	36
Spiritual Care Services	1
Pharmacy	28
Radiology Imaging Services	34
Rehab Services	17
Respiratory	25
Social Services	5
Special Services	10

Source: GMHA Human Resources Department

APPENDIX 31: GOVERNOR'S EXECUTIVE ORDER



EXECUTIVE ORDER NO. 2006-11

RELATIVE TO THE PROTECTION OF THE ISLAND IN THE EVENT OF A PANDEMIC AND TO THE CREATION OF A PANDEMIC PLANNING TASK FORCE

WHEREAS, the global community is extremely concerned about the possibility of an influenza pandemic that could lead to high levels of illness, death, social disruption, and economic loss; and

WHEREAS, under the direction of the United States Department of Health and Human Services and the Department of Homeland Security, the nation is working to ensure that every community prepares for the possibility of such a pandemic; and

WHEREAS, though it is difficult to predict when or how severe such a pandemic might be, a growing number of people around the world have died from the H5N1 virus since 2003, and experts feel it may be only a matter of time before this virus changes to allow rapid human to human transmission; and

WHEREAS, an extremely severe pandemic could lead to the closure of schools and businesses or the interruption of basic services such as utilities, but the effects of such a pandemic could be lessened with appropriate planning and preparation at all levels of the community; and

WHEREAS, the Government of Guam recently hosted the Western Pacific Regional Pandemic Summit to discuss federal preparations for such a pandemic, as well as local and regional needs and possible resources to handle such an event; and

WHEREAS, effective planning for a pandemic requires substantial resources and close coordination between all segments of the community, including public sector, private sector and individual efforts; and

WHEREAS, planning and preparation for an influenza pandemic will be a valuable exercise to help the island of Guam manage not just an influenza outbreak, but any severe epidemic or emerging infectious disease.

NOW, THEREFORE, I, FELIX P. CAMACHO, /Maga' Laben Guahan/, Governor of Guam, by virtue of the authority vested in me by the Organic Act of Guam, as amended, do order:

1. **Lead Agency.** The Department of Public Health and Social Services, which has already completed its draft pandemic plan, shall coordinate pandemic planning efforts between different segments of the community.
2. **Pandemic Plan Task Force.** A task force is hereby established to formulate a pandemic plan and work with all sectors of the community to ensure that any potentially affected entity takes the necessary steps to prepare for a pandemic. The task force shall be co-chaired by the Director of the Department of Public Health and Social Services and the governor's appointee to this task force.



The task force shall include the directors of the following government agencies, or their designees, provided that such designees are empowered to act on behalf of their respective agencies:

- a. Department of Public Health and Social Services
- b. Office of Homeland Security
- c. Guam Memorial Hospital Authority
- d. Department of Mental Health and Substance Abuse
- e. Department of Agriculture
- f. Guam Customs and Quarantine Agency
- g. Port Authority of Guam
- h. A. B. Win Pat International Airport Authority
- i. Guam Visitors Bureau
- j. Consolidated Commission on Utilities
- k. Guam Police Department
- l. Guam Fire Department
- m. Guam Public School System
- n. Mayor's Council of Guam

The task force also shall invite representatives from the Guam Medical Society, the American Red Cross, the Guam Chamber of Commerce, the Guam Hotel and Restaurant Association, the Salvation Army, the Guam National Guard, and the Air Force and Navy's command, and other members as they may deem appropriate.

- 3. The task force shall address measures, including a community education campaign that must be undertaken to protect public health in the event of a pandemic, and to ensure that our community is prepared in the face of such an event. The task force shall prepare a briefcase to create Guam's plan and provide this information to the Governor no later than May 31, 2006.

The task force shall prepare a tabletop exercise to be held not later than July 31, 2006, to measure the progress of preparation efforts.

- 4. The Director of Public Health and Social Services shall continue to work closely with the U.S. Department of Health and Human Services, the World Health Organization, and the Secretariat of the Pacific Community to coordinate the establishment, implementation, or enforcement of all applicable plans, programs, rules, regulations, or other such measures in connection with pandemic preparations.

SIGNED AND PROMULGATED at Hagåtña, Guam this 18th day of May, 2006.


FELIX P. CAMACHO
I Muga Lathen Gudhan
Governor of Guam

APPENDIX 32: MEDICAL SERVICES STAFFING PLAN

PROCEDURE:

1. Medical Director in conjunction Medical Staff President or their designees will ensure coverage of the hospital units during an influenza pandemic.
2. Medical Director and Medical Staff President will create a schedule of physicians covering all units for all shifts. The number of physicians covering the hospital patients should be based on the total number of patients and the patient’s level of acuity. The schedule shall reflect, as much as possible, assignment of physicians to patients they had been previously assigned. Physicians shall report to duty as scheduled or make arrangements for coverage through the Medical Director or his designee.
3. During an influenza pandemic, all physicians shall remain on “On-Call” status.
4. Assumptions for ideal staffing per shift shall be as follows:

Staffing Type	Approximated <i>ideal</i> ratio
Emergency Room physicians (to cover Annex, Annex Overflow site, Routine ER site, External triage area)	*5 per shift
In-House physicians (M/S, M/T, Surg, ICU/CCU, and Peds)	*4 – 5 per shift
OBW, L&D, OR, Nursery	*Routine coverage

*The total number of physicians per shift is considered fluid/flexible, dependent on the patient acuity level

5. For additional physician coverage, units shall inform Command Post. Command Post shall refer to the *Medical Staff Listing by Specialty* below for identification of current/existing physicians for hospital coverage.
6. Physicians on duty will ensure endorsement to incoming physicians prior to leaving the hospital to ensure coverage at all times.

Medical Staff Listing by Specialty (As of 09/15/06)

Specialty	Total Number of Medical Staff
Anesthesiology	9
Cardiology	2
Critical Care Medicine	1
Emergency Medicine	11
Endocrinology	2
Family Practice	19
General Dentistry	1
General Surgery	10
Hand Surgery	1
Infectious Disease	2
Internal Medicine	17
Neonatology	1

Nephrology	4
Neurology	3
Nuclear Medicine	2
Obstetric/Gynecology	13
Ophthalmology	2
Oral/Maxillofacial Surgery	1
Orthopedics	1
Otolaryngology	1
Pathology	3
Pediatrics	12
Plastic Surgery	1
Podiatry	3
Psychiatry (Child)	1
Pulmonary Disease	1
Radiology	6
Urology	1
Vascular Surgery	2

Source: GMHA Medical Staff Department

APPENDIX 33: NURSING SERVICE STAFFING PLAN

Current Staff-Nursing Availability:

Total Hospital Nurse Supervisors	8	
		Including Hospital Nursing Services Administrator
	16	
Total Hospital Unit Supervisors	7	

Total RN's by Department:

CCU	22
OR	17
ER	32
HEMO	11
MED/SURG	22
MED/TELE	22
SURGICAL	18
PEDIATRICS	15
LABOR & DELIVERY	20
OB WARD	9
OB NURSERY	23
SKILLED NURSING UNIT	9
TOTAL	220

Total LPN's by Department

CCU	0
OR	1
ER	2
HEMO	2
MED/SURG	2
MED/TELE	1
SURGICAL	4
PEDIATRICS	2
LABOR & DELIVERY	0
OB WARD	5
OB NURSERY	0
SKILLED NURSING UNIT	4
TOTAL	23

Total NA's by Department

		TECHS
CCU	0	4
OR	1	7
ER	0	18

HEMO	0	7
MED/SURG	11	0
MED/TELE	10	9
SURGICAL	11	0
PEDIATRICS	5	0
LABOR & DELIVERY	0	0
OB WARD	7	7
OB NURSERY	6	0
SKILLED NURSING UNIT	11	0
TOTAL	62	52

Total of WARD CLERKS by Department

CCU	1
OR	3
ER	3
HEMO	2
MED/SURG	3
MED/TELE	3
SURGICAL	3
PEDIATRICS	2
LABOR & DELIVERY	2
OB WARD	1
OB NURSERY	1
SKILLED NURSING UNIT	1
TOTAL	25

Total of Patient Couriers **15**

Source: GMHA Nursing Department

Nurse Staff Contingency Plan:

The plan to obtain additional nursing staff would be to look to nurses that are external to GMHA. This is being addressed at the Governor's Task Force Meetings and will be inserted upon completion

Breakdown of Staffing requirements for full capacity by shift per unit.

	7-3				3-11				11-7			
	RN	LPN	NA/TECH	WC	RN	LPN	NA/TECH	WC	RN	LPN	NA/TECH	WC
CCU	3		1	1	3		1	0	Same as 3-11 Shift			1
OR	4	1	2	1	3	1	2	2				
ER	4	2	3	1	4	2	3	1	Same as 3-11 Shift			1
HEMO								0	Same as 3-11 Shift			0
MED/SURG	3	2	3	1	3	1	2	0	Same as 3-11 Shift			0
MED/TELE	5		4	1	5		2	1	Same as 3-11 Shift			0
SURGICAL	5		4	1	5		3	1	Same as 3-11 Shift			0
PEDIATRICS	3	1	2	1	3		2	0	Same as 3-11 Shift			0
LABOR & DELIVERY	5		3	1	4		2	0	Same as 3-11 Shift			0
OB WARD	3		2	1	3		2	0	Same as 3-11 Shift			0
OB NURSERY	5		2	1	4		1	0	Same as 3-11 Shift			0
SKILLED NURSING UNIT	3		3	1	3		2	0	Same as 3-11 Shift			
NURSING SUPERVISOR	1 per Shift				1 per Shift				1 Per Shift			
PATIENT COURIERS	3 - floor 2 - EVOC				3 - floor 2 - EVOC				2 - floor			

APPENDIX 34: RESPIRATORY SERVICES PANDEMIC FLU PLAN

Because the nature of the illness affects the pulmonary system, the need for mechanical ventilation will substantially increase beyond the authority's capabilities. Currently, GMHA has a total of the following:

- 54 mechanical ventilators;
 - 41 adult
 - 13 infant
- Additional sources of mechanical ventilators and supplies must be identified

The Chief Respiratory Therapist will inform the Command Post of the need for additional resources.

The Strategic National Stockpile (SNS), when activated, will provide for additional mechanical ventilators and supplies, however, the arrival time for the SNS has been estimated to be approximately 48 to 72 hours. Measures must be put into place to provide manual ventilation prior to the arrival of the SNS supplies.

In addition to the equipment and supplies, additional manpower must be identified to provide the physical act of manual ventilation. While this role has been traditionally that of the Respiratory Therapist, consideration must be given to identifying other sources of manpower to provide this service as the Respiratory Therapist will be busy monitoring the increased number of mechanical ventilators and providing other mechanical ventilator related duties such as suctioning, securing endotracheal tubes, administering bronchodilator therapy, and performing arterial blood gas sampling and analysis. The next determination of assigning this role should be a collaborative effort with the following:

- nursing department,
- the Assistant Administrator of Professional Support,
- the Medical Staff Office,
- Human Resources, and
- Administration

APPENDIX 35: SECURITY PANDEMIC FLU PLAN

Current Situation (as of August, 2006)

Personnel: 5 Security Guards that GMHA employed
3 Security Guards provided via Contract with Pacific Security Alarm

NOTE: need to subtract the assumption that 40% of the security guards will not report to duty. This leaves our hospital with between 4 to 5 security guards. This does not include personnel available for relief of staff.

Assumption for Total Number of Security Guards Needed: 40 guards based on the following:

- 2 guards Ground Floor Security Station and Screening Area
- 2 Guards Emergency Department
- 2 Guards Visitor/Employee Parking Lot areas
- 2 + 3rd and 4th Floor areas
- 1 guard 1st Floor Public/Staff elevators
- 1 guard Hospital Entry by the Physicians' Parking Lot and the Emergency Department Entrance.
- Lock gate Service Entrance by the Power Plant/Ground Floor Entry by Personnel Department
- ??? 2nd Floor B-Wing/C-Wing areas
- 4 guards 4 Treatment cohort areas
- 1 or 2 guards Family Holding Area(s)- (as needed)
- 1 guard Pharmacy
- 1 guard External Tent Station
- 1 guard ER Triage Station
- 1 guard During Mass Immunization

MOU with an external agency such as Guam Police Department and National Guard are necessary to augment staffing for security needs during a influenza pandemic. This MOU will be inserted upon completion.

PROCEDURES:

- The Chief of Security will verify the location of the guards on site and assign them to one of the following areas:
 - Post 1 - Ground Floor Security Station
 - Post 2 - Emergency Department
 - Post 3 - Visitor/Employee Parking Lot areas
 - Post 4 - 3rd and 4th Floor areas
 - Post 5 - 1st Floor Public/Staff elevators
 - Post 6 - Hospital Entry by the Physicians' Parking Lot and the Emergency Department Entrance.
 - Post 7 - Service Entrance by the Power Plant/Ground Floor Entry by Personnel Department

- Post 8 - 2nd Floor B-Wing/C-Wing areas
 - Post 9 - Treatment areas
 - Post 10 - Family Holding Area(s)- (as needed)
-
- The Chief of Security will assign one (1) Security Officer to control vehicular access to the Emergency Room. Access will be restricted to emergency vehicles only.
 - The Chief of Security will assign Fiscal Services personnel to escort visitors to the ground floor main lobby.
 - The Chief of Security will contact the Safety Administrator at the Command Station with a report as to the areas covered by Security and Fiscal Services. **Plan will need to include training of fiscal services staff.**
 - In the event that the plan is activated, the guards will direct all visitors to the ground floor main lobby. One (1) **watcher** per patient is allowed to remain with the patient. **Are we going to allow any watchers or visitors considering the possibility of transmission. These persons will need training and additional plan needs to be included.**
 - As additional security guards arrive, they are to report to Post 1, the Security Station at the main Hospital entry. The Chief of Security will assign the additional security to:
 - a. Assist in controlling vehicular traffic;
 - b. Assist in controlling traffic within the Hospital;
 - c. Assist in directing visitors to the ground floor main lobby; and
 - d. Assist in monitoring entrances and exits of Emergency Room Department.
 - e. Prevent unauthorized persons from entering Hospital premises; and
 - f. Close the Walk-In Entry and re-route traffic through the Ambulance Entry
 - Employees of the hospital are required to wear name tags identifying them as employees. Only persons with proper identification shall be admitted into the hospital during a disaster. **Need to have additional means for identification of personnel who are coming in to assist with staffing shortages Access Plan for Responders**
 - The Chief of Security and/or the Safety Administrator with the approval of the Command Station may grant clearance for unauthorized person(s) who needs access to the Hospital. If authorized, individuals are to be escorted to the requested area.
 - Employees who are recalled to assist in handling the emergency situation may park in either the employee or public parking areas. The physicians parking lot will be restricted to medical staff use.
12. Home pick up for essential staff will be provided for those personnel who may not be able to travel to the hospital. GMHA Command Post will coordinate pickup with Civil Defense as needed. **Is there an existing MOU for this?**

APPENDIX 36: ENVIRONMENTAL SERVICES PANDEMIC FLU PLAN

- I. The Chief of Environmental Services shall up-date the departments recall list as necessary and quarterly. The list shall include the employee's name, position title, telephone number and street address.
- II. The Chief of Environmental Services shall review the Pandemic Influenza Plan and complete the Pandemic Influenza checklist as appropriate.
- III. The Chief of Environmental Services shall convene a meeting with the Housekeeping and Laundry Supervisors to discuss preliminary preparations for the Pandemic Influenza Plan.
- IV. Ensure orientation and training of all employees on the contents and requirements of the Pandemic Influenza Preparedness Plan.
- V. Upon Implementation of the Hospital Wide Pandemic Influenza plan:
 - A. The Housekeeping personnel will, with the assistance of Facilities Maintenance, clear the Emergency Department of unnecessary furniture and shall move the stretchers from the Janitor's Locker in the Emergency Department to the Triage area.
 - B. Housekeepers will assist Nursing personnel in moving patients to designated areas as needed.
 - C. The Chief of Environmental Services or Housekeeping Supervisor will oversee the distribution of hand sanitizers and chemicals.
 - D. Housekeepers will report to their assigned areas(s) of responsibility.
- VI. Upon announcement of "Dr. Clearwater"
 - A. The Chief of Environmental Services will release those employees who worked during the Pandemic Influenza Plan and issue assignments to those Housekeepers who report to work for regular duty after the Pandemic Influenza Plan.
 - B. The Chief of Environmental Services will complete and submit a Progress Report and Post-Pandemic Influenza Assessment Report to the Hospital Administrator via the Associate Administrator of Operations or Assistant Administrator of Administrative Services.
- VII. Post- Pandemic Influenza Assessment
 - I. The Chief of Environmental Services shall conduct a meeting with the Housekeeping staff to assess performance prior to, during and immediately after the time period of the Pandemic Influenza Plan
 - II. The Chief of Environmental Services shall give a verbal report on problems encountered and status reports on Post-Pandemic Influenza activities to the Hospital Administrator/designated alternative during the meeting convened.
 - III. The Post-Pandemic Influenza Assessment Report shall be completed and submitted to the Hospital Administrator via the Associate Administrator of Operations or Assistant Administrator of Administrative Services within seventy-two (72) hours after Dr. Clearwater has been declared.

APPENDIX 37: SPIRITUAL CARE SERVICES PANDEMIC FLU PLAN

PURPOSE:

To define the role of the Spiritual Care Coordinator during a pandemic flu event.

POLICY:

The Spiritual Care Coordinator is responsible for providing spiritual care to victims, families and Hospital employees during a pandemic flu event.

PROCEDURES:

1. Upon activation of the Pandemic Flu event Plan, the Spiritual Care Coordinator will contact the chaplain(s) on duty. The Spiritual Care Coordinator will keep a copy of the chaplains' recall list in the Family Holding Area.
 - a. The chaplain(s) will report to the Family Assistance Area (in the classrooms) to assist in comforting family members.
 - b. Upon request, the chaplain(s) will visit the Critical Care Unit (CCU) to serious victims and the morgue to bless the deceased victims.
2. The Spiritual Care Coordinator(s) will report to the Family Assistance Area to assist in comforting relatives of victims.
3. The Spiritual Care Coordinator will receive the Family Health Kit from Central Receiving Supplies staff.
 - a. The Kit shall include aspirin, Tylenol and spirit of ammonia as provided by Pharmacy.
 - b. The Spiritual Care Coordinator will store the Family Health Kit in a secured area
 - c. The Spiritual Car Coordinator will be responsible to record the disposition of contents on the issuance log sheet and ensure the waiver section is signed by the use.
 - d. The Spiritual Care Coordinator will monitor the expiration date of the contents of the kit and arrange CSR staff to replace the supplies in the Family Health Kit.

APPENDIX 38: DIETETIC SERVICES PANDEMIC FLU PLAN

POLICY: Established emergency preparedness guidelines and standards and contingency plans shall be implemented in response to pandemic influenza. If necessary, the Dietetic Services Department staff will limit department operations in order to continue the provision of patient and staff meals.

PROCEDURE:

- A. If an influenza pandemic begins in another country, the Dietetic Services Department, in general, shall respond as follows:
 - 1. Heighten alertness and review training with personnel in
 - a) Prevention and control of influenza
 - b) Detecting signs and symptoms of influenza in healthcare personnel
 - 2. Review and update records of annual influenza vaccination of personnel, and the Disaster Recall List.
 - 3. Hospital Food Services Administrator will review the Department's Pandemic Influenza Plan.

- B. If an influenza pandemic begins in or enters in the United States, the Dietetic Services Department shall respond as follows:
 - 1. Continue heightened alertness and review training of personnel in Infection control strategies for the control of influenza, to include hand hygiene, PPE and Standard and Expanded Isolation Precautions.
 - a) Schedule and document the mandatory education and training of Department personnel.
 - b) Identify highly susceptible department personnel at risk (e.g. pregnant women, immuno-compromised persons) and if necessary, plan for reassignment to low risk duties within the department.
 - 2. Make a preliminary assessment of food and beverage supplies, LP gas supply, and continued services of contractals (i.e. trash disposals, cooking oil waste disposal, hood cleaning, and pest control).
 - a) Contact all vendors to secure/reserve an adequate supply of consumables and stockpile of non-perishables and food disposables.
 - b) Prepare and process requisitions to ensure sustainability of food and beverage supply for at least 6-8 months.
 - c) Materials Management Department will assist in finding resources for maintenance of food supply at the hospital.
 - d) Registered dietitian will review the patient menus, and revise as necessary.
 - 3. With the assistance of GMHA's POC, determine staffing availability and possible transfer of assignment of nutrition and food service personnel in other Government of Guam agencies (e.g. Guam Public School System,

- Department of Public Health and Social Services, University of Guam) to GMHA Dietetic Services Department.
- a) Provide orientation and training in hospital nutrition and food service delivery to transferable government personnel.
 - b) Keep transferred personnel assigned in non-clinical areas
4. Open dialogue with the U.S. Naval Hospital's Food Services Administrator.
- a) Review contingency plans for possible interruption of food supply and delivery from the mainland United States.
 - b) Prepare MOU for transfer of medical nutritional products (enteral nutrition formulas for patients' sole nutrition source) between agencies.
- C. If an influenza pandemic begins in or enters Guam, the Dietetic Services Department shall respond as follows:
1. When the activation of the hospital's Pandemic Influenza Plan is announced through the P.A. System, department personnel will
 - a) Secure all doors, restricting entry of unauthorized individuals,
 - b) Remain in their respective areas for further instructions, except in the case of fire alarm and bomb threats. In either of those cases, personnel will promptly secure the department and evacuate the premises. Report to work as scheduled.
 - c) Comply with department-specific and hospital mandates on Standard and Expanded Isolation Precautions.
 - d) Meet with the Hospital Food Services Administrator, as called or scheduled, for updates and information/instructions.
 - e) Continue work as scheduled, unless otherwise directed by the Hospital Food Services Administrator, or designee on duty.
 - f) Report any illnesses to immediate supervisor and follow Employee Health protocol for returning to work after an illness.
 - g) Supply personnel will assess current supply of food, water, and supplies, LP gas fuel, PPE, and continuance of contractual services (trash disposal, cooking oil waste disposal, battery hood cleaning, and pest control) at both SNU and GMH facilities.
 - (1) Contact all vendors to secure/reserve current supply of consumables, non-perishables and food disposables for the hospital for the next 6-8 months.
 - (2) Immediately prepare requisitions for submittal to Materials Management.
 - (3) Materials Management will secure storage space for influx of supplies.
 - (4) Registered dietitian will review and revise, as necessary, the patient menus in accordance to the availability of food supply.
 2. If the Command Post is activated, the Hospital Food Services Administrator, or designee on duty, shall

- a) Report to the Assistant Administrator of Professional Support at the Command Post for administrative briefing and/or department-specific instructions.
 - b) Report the current assessment of food and beverage supplies for patient and staff, and address any inadequacy of supply or personnel issues.
 - (1) Specify staffing requirements of essential personnel to GMHA's POC.
 - (a) Begin transfer of assignment of previously identified and trained nutrition and food service personnel from other Government of Guam agencies to GMHA.
 - (2) Identify highly susceptible department personnel at risk (e.g. pregnant women, immuno-compromised persons) and if necessary, plan for reassignment to low risk duties within the department.
 - c) Ensure staffing adequacy and, if necessary, activate the Dietary Disaster Recall Plan.
 - (1) At GMH facility, each shift should be staffed with the following essential personnel:
 - (a) one Production Supervisor
 - (b) one Cook II
 - (c) two Cook I
 - (d) five Food Service Workers
 - (e) three Special Diet Assistants
 - (f) one Dietetic Technician
 - (g) one Clinical Dietitian
 - (h) one Clerk II
 - (i) one Cashier I or II
 - (2) At SNU facility, each shift should be staffed with the following essential personnel:
 - (a) One Cook II
 - (b) One Food Service Worker
 - (c) One Special Diet Assistant
 - (d) One Dietetic Technician or Clinical Dietitian
3. Implement the MOU between GMHA and U.S. Naval Hospital for transfer of medical nutritional products, if necessary.
 4. Activate the Department's Contingency Plan for provision of food, water, beverage, and supplies when importation of food is interrupted and curtailed.
 - a) Claim all food and supply inventory from the GPSS food warehouse and effectuate transfer to GMHA as needed.
 - b) Registered dietitian to review and revise patient menus as necessary in accordance to availability of food supply.
 - c) Hospital Food Services Administrator may recommend closure of cafeteria to general public when food supply is compromised. The

Hospital Administrator shall choose at any time to close the cafeteria to the general public, restrict dining facility and limit sale of food and beverages only to authorized hospital personnel.

5. Department will continue compliance of cleaning and sanitizing dishware.
 - a) Standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic influenza:
 - (1) Wash reusable dishes and utensils in the dish machine and follow established water temperature standards.
 - (2) Disposable dishes and utensils (e.g. used in an alternative care site set-up for large numbers of patients) should be discarded with other general waste.
 - (3) Wear gloves when handling patient trays, dishes, and utensils.

NOTE: Other Considerations-

- **Use of cafeteria for holding area of discharged patients?**
- **Use of PPE in cafeteria by staff from contaminated areas of hospital?**

Dietary Services Pandemic Flu Working Tool and Checklist

ACTIVATION DATE:
TIME:
PERSON IN CHARGE:
ALTERNATE:

INFLUENZA BEGINS IN ANOTHER COUNTRY

	YES	NO	N/A
1. Training reviewed & documented with department personnel in			
a. Prevention and control of influenza.			
b. Detecting signs and symptoms of influenza in healthcare personnel.			
2. Personnel records of annual influenza immunization reviewed and updated.			
3. Disaster Recall list reviewed and updated.			
4. Department's Pandemic Influenza Plan reviewed by the Hospital Food Services Administrator			

INFLUENZA BEGINS IN OR ENTERS THE U.S.

	YES	NO	N/A
1. Training reviewed & documented with department personnel in			
a. Infection control strategies			
b. Hand hygiene			
c. PPE			
d. Standard and Expanded Isolation Precautions			
2. Highly susceptible personnel at risk identified			
3. Preliminary assessment of food and beverage supplies			
LP gas fuel supply			
Other contractals (trash disposal, cooking oil waste disposal, battery hood cleaning, pest control, etc.)			
4. Vendors contacted			
5. Requisitions prepared and processed			
6. Patient menus reviewed/revised by RD			
7. Meet with GMHA's Point of Contact			
a. staffing availability & transfer from GPSS, UOG, DPHSS			
b. schedule orientation & training of transferable government personnel.			

c. Dialogue with U.S. Naval Hospital Food Services administrators.			
d. Review contingency plans for possible interruption of food supply to Guam			
e. MOU prepared between USNH and GMHA for transfer and sharing of medical nutritional products.			

INFLUENZA BEGINS IN OR ENTERS GUAM

	YES	NO	N/A
1. Dietetic Services Department doors secured			
2. Personnel remain in respective work areas and continue provision of meals for patients and cafeteria			
3. Standard and Expanded Isolation Precautions observed			
a. PPE available, issued			
4. Food, water, supplies assessed			
5. Vendors contacted to secure reservation of food supply			
6. Requisitions prepared for 6-8 month supply			
7. Patient menu reviewed and revised by RD as needed			
8. Other contractuels contacted (trash disposal, cooking oil waste disposal, battery hood cleaning, pest control, etc.) to secure continual services.			
9. Essential staffing requirements identified as per policy			
10. Department staffing needs determined			
a. Work schedule revised and updated.			
b. Begin transfer of government nutrition/food service personnel from GPSS, UOG, DPHSS to GMHA			
11. Highly susceptible personnel at risk identified and reassigned to low risk work areas of the department.			
12. Hospital Food Services Administrator reports to Assistant Administrator of Professional Support at the Command Post, when activated.			
13. MOU between USNH and GMHA effectuated for transfer of medical nutrition products			
14. Activate contingency plan for provision of food when food supply is curtailed by non-delivery of imports.			
a. GPSS food and supply inventory reserved for GMHA			
b. Closure of cafeteria to the general public: Only authorized hospital personnel are permitted			

to purchase food/beverage and dine in cafeteria facility			
15. Dish washing procedures followed			
16. Gloves worn when handling patient trays, dishes, utensils			

APPENDIX 39: SATELLITE OUTPATIENT TRIAGE AND TREATMENT SITE

Area identified as Satellite Outpatient Triage and Treatment Site is as follows:

1) UOG Education Building:

- Pros:
 - Laboratory/Microbiology capabilities available through Micro and chemistry labs in a building next door
 - Easy mobilization because of large parking space
 - Close proximity to DPHSS Mangilao
 - Student Center with kitchen for meals
- Cons:
 - Distance from the hospital and overflow sites for transport of patients needing critical care

PROCEDURE:

1. Office of Civil Defense (Incident Command) will prepare and open the Satellite Outpatient Triage and Treatment Site when Guam is in Phase 6.
2. OCD will make arrangements for transport of the patients to GMHA or Overflow sites.
3. OCD will monitor the Satellite Site capacity.
4. OCD will arrange for mobilization of resources to the Satellite Site. Resources mobilized by OCD will include:
 - a. Appropriate staff (nurses, physicians, respiratory therapist, etc)
 - b. Medical supplies and equipment (to include ventilators and oxygen supply)
 - c. Patient needs (such as cots, chairs, etc)
 - d. Food and beverages as needed for patients and staff

OCD will ensure continued supply of water and power and communication capabilities at the Satellite Site.

APPENDIX 40: GUAM HEALTHCARE NETWORK

In the event of a Pandemic Influenza, the primary acute care sites are listed below as “Tier 1” acute care facilities. However, if these facilities are overwhelmed by a Pandemic Influenza, the “Tier 2 and 3” sites, listed below, shall be utilized as Alternate Care Sites (ACS).

Tier 1:

- GMHA (Civilian population)
- Naval Hospital Guam (Active Military, Reservists and their dependents)

Tier 2:

- DPHSS Northern, Central and Southern Clinics
- All Private Clinics (Total No.: 30)
 - Northern (30)
 - Central (0)
 - Southern (0)

Tier 3:

- Tamuning Elementary School
- Tamuning Mayor’s Gymnasium

PROCEDURE: (Process for Activating Overflow Sites via OCD)

1. GMHA will contact the Office of Civil Defense (Incident Command) when trigger/threshold has been met for overflow.
2. GMHA will make endorsements to OCD regarding patients for transfer to the overflow site. OCD will make arrangements for transport of the patients to the overflow sites.
3. OCD will monitor the overflow site capacity.
4. OCD will arrange for mobilization of resources to the overflow sites. Resources mobilized by OCD will include:
 - a. Appropriate staff (nurses, physicians, respiratory therapist, etc)
 - b. Medical supplies and equipment (to include ventilators and oxygen supply)
 - c. Patient needs (such as cots, chairs, etc)
 - d. Food and beverages as needed for patients and staff
5. OCD will ensure continued supply of water and power and communication capabilities at the overflow sites.

APPENDIX 41: GMHA COHORT PLAN

PROCEDURE:

1. Command Post will identify the trigger points during the pandemic phases for determining implementation of the cohort plan. Cohort units will be opened in the following order:
 - a. the first cohort unit will be the Pediatrics Department (4th floor B Wing).
 - b. the second cohort unit will be the New Surgical Unit (4th floor A Wing)
 - c. the third cohort unit will be Medical Surgical Unit (3rd floor A Wing)
 - d. the fourth cohort unit will be the Old Surgical Unit (3rd floor A Wing)
 - e. **NOTE:** Command Post will determine the threshold for preparation by OCD of the GMHA Overflow Site (see *GMHA Overflow Plan*, See [Appendix 40](#)).
2. The Nursing Supervisor on duty will coordinate transport of existing inpatients from the identified cohort unit to a non-influenza patient care area before transport of pandemic influenza patients to that unit. If rooms are not available, the Nursing Supervisor will work with Command Post to assist with implementation of the *Patient Rapid Discharge Plan*, See [Appendix 17](#). If staff are not available to assist with transporting patients, the Nursing Supervisor on duty will work with Command Post to identify additional assistance.
 - a. Infection Control practices for cohorting should be followed by all personnel. See *Infection Control Plan*, See [Appendix 2](#).
3. Command Post must be sought for assistance in identifying security needed for a patient who may need to be isolated against his/her will. Implement *Quarantine/Isolation Law* as needed.

APPENDIX 42: PATIENT REGISTRATION PANDEMIC FLU PLAN

1. Upon the announcement of a “Pandemic Flu Outbreak”, the Chief of Admissions shall report to the Hospital Comptroller for specific instructions.
2. Upon the announcement of “Pandemic Flu Outbreak” :
 - a. The Chief of Admissions shall report to the Hospital Comptroller the availability of Patient Registration Personnel.
 - b. The Chief of Admissions shall identify available beds in the facility and report to the Disaster Chief.
 - c. The Chief of Admissions shall close the Main Registration Office on the first floor and have a minimum of two-(2) personnel report to the designed categories where they will process casualties.
 - d. If the transfer of personnel to the designated areas will leave Patient Registration Department understaffed, the Chief of Admissions will contact Command Post if additional personnel are needed from Patient Affairs to help in registering patients and escort.
3. Upon the announcement of “Pandemic Flu Outbreak,” the Chief of Admissions shall attend the Disaster Critique/Evaluation session and record the proceedings.
4. The Chief of Admissions shall report the findings and recommendations of the Disaster Critique/Evaluation to the Patient Registration staff for information and suggestions.
5. In the absence of the Chief of Admissions, the Patient Service Supervisor on duty shall assume the responsibilities of the Chief of Admissions during a disaster.
6. See *Patient Registration Functional Chart*, (Will be inserted upon conversion to Word document)

APPENDIX 43: HOME QUARANTINE AND SELF-HELP INFORMATION

Home Quarantine and Self-Help Information

What is Pandemic Flu?

A “pandemic” is a disease that spreads all over the world and affects a large number of people. If you are caring for a loved one during a pandemic, it’s important to take steps to protect yourself and others. Always follow the most current advice of the U.S. Department of Health and Human Services and your local health department.

Prevent the Spread of Pandemic Flu

These healthy habits will help keep you and others from getting and passing on the virus.

- Clean your hands often with soap and water or alcohol-based hand sanitizer.
- Cover your mouth and nose with a tissue and clean your hands afterward. Put used tissues in a wastebasket.
- Cough or sneeze into your upper sleeve if you don’t have a tissue.
- Keep your hands away from your eyes, nose and mouth to prevent germs from entering your body.

Also, a person with signs of flue should:

- Stay home from work, school and errands and avoid contact with others.
- Consider wearing a surgical mast when around others. There may be benefits.

When a Household Member is Sick

The flu virus is spread when contaminated droplets exit the mouth and nose of an infected person and the virus comes in contact with others. So, follow these tips to protect yourself and others in your home:

- Keep everyone’s personal items separate. All household members should avoid sharing computers, pens, papers, clothes, towels, sheets, blankets, food or eating utensils.
- Disinfect door knobs, switches, handles, toys and other surface that are commonly touched around the home or workplace.

Disinfectant:

1 gallon water
¼ cup of bleach

Mix up a fresh batch every time you use it.

- It is okay to wash everyone’s dishes and clothes together. Use detergent and very hot water. Wash your hands after handling dirty laundry.
- Wear disposable gloves when in contact with or cleaning up body fluids.

- One person should be the caregiver. He or she may benefit by wearing a mask when giving care.

Practice Hand Hygiene

Caregivers should always wash their hands before providing care. Afterward, wash again and apply alcohol-based hand sanitizer as well. Follow these steps for proper hand hygiene:

1. Wet hands with warm, running water and apply liquid soap.
2. Rub hands vigorously for at least 15 seconds, covering all surfaces and fingers.
3. Scrub nails by rubbing them against the palms of your hands.
4. Rinse your hands with water.
5. Dry your hands thoroughly with a paper towel and use it to turn off the faucet. A shared towel will spread germs.

Recognize Pandemic Flu Symptoms

Watch for these symptoms:

- Fever
- Cough
- Runny nose
- Muscle pain

Call your health-care professional at the first sign of the flu. Many symptoms can be treated by the health-care professional over the telephone.

Care for a Loved One with a Flu

A person recovering from flu should have:

- Rest and plenty of liquids
- No alcohol or tobacco
- Medications to relieve flu symptoms

In some cases, a health-care professional may prescribe antiviral drugs to treat the flu. Antibiotics (like penicillin) don't cure it.

Monitor Pandemic Flu Symptoms

Keep a care log. Write down the date, time, fever, symptoms, medicines given and dosage. Make a new entry at least every 4 hours or when the symptoms change. Call your health-care professional again if your loved one has:

- A high fever
 - Children and Adults:
Greater than 105°F (40.5°C).
 - Babies 3- to 24-months-old:
103°F (39.4°C) or higher.
 - Babies up to 3 months:

Rectal temperature or 100.4°F (38°C) or higher.

- Shaking chills
- Coughing that produces thick mucus
- Dehydration (feeling of dry mouth or excessive thirst)
- Worsening of an existing serious medical condition (for example: heart or lung disease, diabetes, HIV, cancer)

If you cannot reach your health-care professionals, **call 9-1-1** or local emergency number for any of the signs below:

- Irritability and/or confusion
- Difficult breathing or chest pain with each breath
- Bluish skin
- Stiff neck
- Inability to move an arm or leg
- First-time seizure

Prevent Dehydration

Dehydration occurs when the body loses too much water and it's not replaced quickly enough. It can be serious. Begin giving soothing drinks at the first signs of the flu and follow these tips:

- In addition to plenty of liquids, give ice and light, easily digested foods, such as soup or broth.
- If your loved one has diarrhea or vomiting, give fluids that contain electrolytes. These are available at your pharmacy or grocery store. Or you can make your own rehydration electrolyte drink for someone over the age of 12.

Electrolyte Drink:

1 quart water
½ tsp. baking soda
½ tsp. table salt
3 to 4 tbsp. sugar
¼ tsp. salt substitute

Mix well and flavor with lemon juice or sugar-free Kool-Aid®.

- If drinking liquids makes nausea worse, give one sip at a time until your loved one can drink again.

Reduce Fever

To help reduce a fever, do the following:

- Give plenty of fluids.
- Give fever-reducing medication, such as acetaminophen, aspirin or ibuprofen, as directed on the container's label.
Do not give aspirin to anyone younger than 20.
- Keep a record of your loved one's temperature in your care log.
- To relieve discomfort, give a sponge bath with lukewarm water.

After you have called your doctor or emergency number for a fever, continue to follow the home treatment recommendations above. If there is a delay in getting help, ask a health-care professional if you should start an additional dose of an alternate fever-reducing medication (acetaminophen, ibuprofen or aspirin) between the doses described on the label. Always continue to give plenty of fluids.

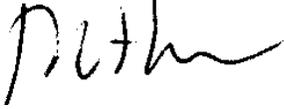
Preparing for a Flu Pandemic

Make a plan now for a flu pandemic. Figure out what you will do if members of your household have to stay home from work or school or stay separated from others for a period of time. Keep extra supplies of food, water, medications and your disaster supply kit on hand.

Pandemic Flu Caregiving Supplies:

- Thermometer
- Soap
- Box of disposable gloves
- Acetaminophen
- Ibuprofen
- Bleach
- Alcohol-based hand sanitizer
- Paper towels
- Tissues
- Surgical masks (one for each person)
- Sugar, baking soda, salt, salt substitute

APPENDIX 44: EMERGENCY SYSTEM FOR ADVANCED REGISTRATION – VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP)

APPROVED	RESPONSIBILITY	ORIGINATION DATE	POLICY NUMBER	PAGE
 Joseph Mesa, AAO Safety Management Chairperson	Emergency Preparedness Subcommittee (EPS) Safety Management Committee (SMC)	January 2007	107	1 of 4
TITLE: GUAM EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP)				
LAST REVIEW/REVISED: 8/08				
ENDORSED: EPS 6/08, HA 8/08				

I. Background

As a critical factor to its Hospital Preparedness Bioterrorism Program grant, the Guam Memorial Hospital Authority is required to manage a program designed to recruit, identify, credential, and train volunteer health professions with processes to deploy, track, and update a secured database for Guam’s Emergency System for Advance Registration of Volunteer Health Professionals (Guam ESAR-VHP Program).

II. Responsible Parties and Roles

As delegated and authorized by the Hospital Administrator/CEO, the Bioterrorism Grant Program Administrator is responsible for managing all aspects of the Hospital Preparedness Bioterrorism Grant which include the Guam ESAR-VHP Program, and, when necessary, may be assisted by staff from the Planning Department and/or Hospital Administration.

III. Joint Advisory Group

Once formed, a Joint Advisory Group will consist of local government and private partners and/or Micronesia islands stakeholders with the Guam Memorial Hospital Authority as the lead agency.

IV. Program Funding

At present, the Guam ESAR-VHP Program is federally-funded by the Hospital Preparedness Bioterrorism Grant administered by the Hospital Administrator/CEO with responsibility delegated to the Hospital Bioterrorism Grant Administrator.

V. Disaster Event/Categories

In accordance with the Authority’s Disaster Preparedness Plan, the volunteer health professionals are called, as necessary, when a Mass Casualty Plan, Category 1, 2, 3, 4 or 5 is declared by the Hospital Administrator/CEO, his alternate and/or the Governor of Guam or his delegate.

VI. Legal Issues (personal liability and injury)

Personal liability and workmen's compensation are defined and covered in Guam Code Annotated:

- 10GCA, Chapter 19, Emergency Health Powers
- 7GCA, Chapter 16, Volunteer Protection Act of 1999

VII. Health Information Privacy

The Authority will assure that information collected from the application submitted by volunteer health professionals is considered private, kept confidential and released only during special circumstances or upon consent from the volunteer health professional and using guidelines established by HRSA, JCAHO or other regulatory agencies relative to health information privacy.

The volunteer health professional will be timely advised of any release of information on his/her original ESAR-VHP application or information obtained subsequent to said application.

VIII. Confidential Database (Electronic and Manual Operation)

Information provided by volunteer health professionals are entered and maintained in a confidential database system under the custody of the assigned hospital staff. The database is kept in a secured computer server or a "stand along" computer with a password known only to the assigned hospital staff, alternates and the Hospital Administrator.

A hard copy of the application of the volunteer health professional is kept in a secured file accessible to the assigned hospital staff as a contingency plan when the electronic data system is not available or easily retrievable due to system or power breakdown.

IX. Eligibility

All licensed and certified health professions are eligible to register in the Guam ESAR-VHP Program and such individuals are required, when called, to report to duty at the Guam Memorial Hospital Authority or at a medical facility where the disaster is located on Guam to serve with or without benefits or entitlements. (Reference: 10 GCA, Emergency Health Powers)

The Guam ESAR-Program is *initially* recruiting medical, nursing and allied health volunteers in the following occupations:

- Medical doctors
- Registered Nurses
- Psychologists

Recruitment efforts will extend to others in the following occupations:

- Social Workers
- Radiology/Imaging Technologists
- Respiratory Technologists
- OR Technicians
- Licensed Practical Nurses
- Nurses Aides

X. Emergency Credentials, licensure, appointments and/or privileges

Emergency credentialing, licensing and privileges will be granted or continued in accordance with

- 10GCA, Article 6, Section 19608
- Guam Memorial Hospital Medical Staff Bylaw, Rules and Regulations.

XI. Identification Badge

Upon verification of credentials and acceptance by the Guam ESAR-VHP Program as a volunteer health professional, an identification badge bearing an ESAR-VHP unique staff number, color photograph, occupation and expiration date is issued to the volunteer health professional. When available, a bar-coded stripe may contain additional information regarding the volunteer health professional's training or other unique information. The photo identification badge is issued by the Human Resources Department or alternate department as identified by the Hospital Administrator/CEO or delegate. Badge is to be worn to clothing or hung around the neck, arm or other parts of the body and is conspicuous to officials, staff, patients and/or general public.

XII. Activation

- *Declaration.* The Governor, his delegate, and/or the Hospital Administrator may declare a state of emergency which will activate the Hospital Disaster Plan.

(Reference Authority: GMH Mass Casualty Plan – Overview, Policy No. 3500. 10GCA, Article 4, Section 19401)

- *Identity of Occupation and/or Specialty.* As necessary, the Hospital Medical Director shall instruct the assigned hospital staff to access the ESAR-VHP database to identify volunteer health professionals by occupation and/or specialty needed during the emergency.
- *A call to duty.* Once the appropriate occupation/specialty is determined from a list, the assigned hospital staff will call the volunteer health professional(s) to determine availability and acceptance of the assignment/deployment.
- *Determination of Availability and Acceptance of Assignment.* The assigned hospital staff will determine the availability of the volunteer(s) and acceptance or denial of the duty assignment. The verbal acceptance will be noted on the volunteer electronic records, registering time and date in the database.

XIII. Training

The volunteer health professional will undergo a required disaster-related training, orientation or refresher course that is practical, expedient and affordable.

The Guam ESAR-VHP Program will utilize a competency-based education model. Assessment of the volunteer's knowledge is done through written examination, wherein possible and as time permits during the emergency period and before deployment.

XIV. Release from private company or government agency

As allowed by local law, statutes, regulations or by private industry policies and procedures, the volunteer health professional must obtain a release-from-duty clearance before being deployed.

XV. Compensation

As a volunteer, the volunteer health professional is not entitled to any and/or additional compensation other than for reimbursement for actual expenses related to the emergency.

XVI. Deployment

On-island Location. Properly credentialed, privileged, identified and trained, the volunteer health professional is deployed to his/her assigned area or duty station.

Off-island Location. As requested by another local, state or federal government and with the duty assignment accepted by the volunteer health professional, he/she is deployed off-island and is under the direct purview and expenses, if applicable, of the requesting jurisdiction. The Guam ESAR-VHP Program is not responsible for any compensation, liability and/or personal injury while the volunteer is off-island and is not considered on GovGuam work status unless there is an affiliation, contract or other agreement previously arrangement and/or approved by the Governor of Guam or delegate.

XVII. Tracking & Program Evaluation

Duty assignments of the volunteer health professionals are registered into the secured database and weekly follow-up efforts will be done to track the performance of the volunteer health professional on-island or off-island. The Guam ESAR-VHP Program assigned hospital staff will use all forms of communications, as expedient, such as email, fax, telephone and other technology available subsequent to this writing.

A "Emergency Assignment Survey" will be sent to the volunteer health professional to solicit comments and/or suggestions to improve or enhance the Guam ESAR-VHP Program. This survey will assist in developing quality assessment factors and reporting such to the GMH Department-wide Quality Assessment Program.

XVIII. Program Maintenance

Information on the volunteer health professional will be updated every two years or as frequently as necessary and changes reflected accordingly in the Guam ESAR-VHP database by the assigned hospital staff. The call for updated information should also determine whether the volunteer health professional wishes to remain on the registry.

IXX. Definitions

Terms used in this interim policy may be found and/or defined by 10GCA, Chapter 19, Section No. 19104 and/or HRSA Interim Technical and Policy Guidelines, Standards and Definitions, Version 2, June 2005.

XX. Severability

If there is information, policy, procedure, rule and/or regulations that is contrary to law or guidelines, then that/those respective portion(s) shall be deleted from this policy while all others remain the same, current and valid.

Submitted by:

Approved by:

Marilyn C. Aflague
Administrative Services Officer
Interim Coordinator, Guam ESAR-VHP Program
Guam Memorial Hospital Authority

PeterJohn Diaz Camacho, MPH
Hospital Administrator/CEO
Guam ESAR-VHP Program
Guam Memorial Hospital Authority

APPENDIX 45: FUNDING PROCUREMENT AND SUPPLIES PLAN

Currently there are no available funds for the hospital's preparation for an Influenza Pandemic. Therefore, we are forwarding our total funds needed in order to be prepared. The total amount of funds is based on a needs listing by department in order to sustain emergency preparations for an 8 week period.

The estimated total funding request is: \$9.5 million

Please see [ATTACHMENT A](#), for detailed listing of breakdown for supplies and equipment.