PLAN #: CH:DIS:04

Children's National

Biological / Pandemic Plan

CODE NAVY

EOP Annex for

MANAGEMENT OF SUSPECTED OR CONFIRMED CASES OF INFECTIOUS ILLNESSES OF EPIDEMIC AND/OR PANDEMIC PROPORTIONS

July 1, 2014

Children's National
Code NAVY Disaster Plan
Table of Contents

Children's National
Code NAVY Epidemic / Pandemic Plan

I. PURPOSE

Children's National strives to protect its patients and employees from contagious epidemic or pandemic illnesses that arise within the community by proactively implementing a provisionary plan. This plan includes, but is not limited to administrative measures, engineering controls, patient and employee screening programs and education.

The objective of this plan is the prevention of the transmission of contagious epidemic/pandemic illnesses to patients, visitors, and health-care workers, and provision of an integrated response to community-wide outbreak of disease.

Children's National utilizes the Incident Command System to respond to incidents in an appropriate and timely fashion. Children's National uses pre-planning activities and assessments to prepare for, mitigate the effects of, and enhance recovery from incidents should they occur.

This EOP Annex is developed for situations in which the human resources and supplies needed preclude normal operations of the hospital and to provide a systematic, coordinated approach to an incident with the following goals:
A. To train personnel in their roles and responsibilities regarding a disaster creating an influx of injured persons.
B. To make available the personnel, supplies and equipment as they are needed.
C. To implement this plan with the least amount of disruption to delivery of care for non-incident related patients.
D. To lessen the effect of a potential incident through risk assessment, pre-planning and recovery planning.

Children's National's plan recognizes the Federal and District roles in an integrated response. The Federal government is responsible for nationwide coordination of a pandemic response, including surveillance, epidemiological investigations, development and deployment of federally purchased vaccine (including those that may be available through the Strategic National Stockpile), as well as assessment of measures to decrease transmission (such as travel restrictions, isolation and quarantine).

The District of Columbia is responsible for coordination of a pandemic response within and between jurisdictions, specific areas of response include identification of public and private sectors needed for effective response, planning for key components of preparedness, surveillance, distribution of vaccines and medications and communication. If needed, the Mayor of the District of Columbia will request activation of the Strategic National Stockpile. (see Base EOP Appendix B).

II. REPORTING OF A BIOLOGICAL EVENT OR POTENTIAL EVENT

External disaster notification usually occurs when the Emergency Communication Information Center (ECIC) is notified by the Emergency Medical Services (EMS) of the potential to receive large numbers of patients. The ECIC then obtains information such as when, where and what type of event has occurred; the expected number of casualties; whether radioactive, biological or chemical agents are suspected; and the name, position, agency and phone number of the person reporting. The ECIC immediately notifies the EMTC Charge Physician and Nurse. If first news of an event arrives via an ambulance or other vehicle presenting to the emergency department, by a government agency or via the media, the same information needs to be obtained and relayed as above and to 911.

Due to the insidious nature of a biological outbreak, Children's National participates in a variety of ongoing monitoring programs with the District of Columbia Department of Health. Information is shared to provide syndromic data for surveillance in the greater National Capital Region, as outlined in the DC DOH Pandemic Influenza Preparedness Plan (http://www.doh.dc.gov/doh/cwp/view,a,1370,q,601380,dohNav_GID,1787,dohNav,|33139|,.asp).

The District of Columbia Department of Health has identified the following phases of a pandemic:

DC DOH Pandemic Phase	Definition	Correlating WHO Pandemic Phase
--	No indications any new virus type have been reported. Influenza viruses antigenically related to those recently circulating among humans continue to evolve and cause disease.	**Inter-Pandemic Period** (WHO Phase 0 Preparedness level 0)
Novel Virus Alert	• Novel virus detected in one or more humans • Little or no immunity in the general population • Potential, but not inevitable precursor to a pandemic	**Novel Virus Alert** (WHO Phase 0 Preparedness level 1-2)
Pandemic Alert	Novel virus demonstrates sustained person-to-person transmission and causes multiple cases in the same geographic area.	**Pandemic Alert** (WHO Phase 0 Preparedness level 3)
Pandemic Imminent	Novel virus causing unusually high rates of morbidity and/or mortality in multiple, widespread geographic areas.	--
Pandemic	Further spread with involvement of multiple continents; formal declaration made.	**Pandemic** (WHO Phases 1-3)
"Second Wave"	Recrudescense of epidemic activity within several months following the initial wave of infection.	**Second Wave** (WHO Phase 4)
Pandemic Over	Cessation of successive pandemic "waves," accompanied by the return (in the US) of the more typical wintertime "epidemic" cycle.	**Post Pandemic** (WHO Phase 5)

The Infectious Disease attending on-call will notify the **Chief Medical Officer (CMO) or Executive Medical Director on-call** of the potential of exposure to our patients and health care workers from an infectious illness of epidemic and/or pandemic proportions.

III. AUTHORIZATION TO ACTIVATE RISK ASSESSMENT TASK FORCE

The CMO/designee will be responsible for activating the task force and the hospital operator will notify all members of the task force as soon as possible via pager.

A. ASSIGNMENT OF RESPONSIBILITY

A task force chaired by the CMO and ID Attending on call or designee will consist of, but is not limited to, the following people:

Infection Control/Epidemiology, responsible for: initial and on-going risk assessment; case surveillance; exposure-control investigations; health-care worker education; Public Health liaison; evaluation of unplanned problems; review of patients' medical records.

Occupational Health Staff, responsible for: employee risk assessment; employee screening; and management of exposed employees

Medical Director Emergency Department, responsible for implementation of ED triage screening

Director of the Ambulatory Care Center, responsible for the implementation of clinic triage screening

Engineering and Building Services, responsible for: risk assessment; evaluation of air filter effectiveness for decontamination of potentially contaminated air; and assessment of proper functioning negative pressure isolation rooms.

Environmental Services Director, responsible for: risk assessment; decontamination of potentially contaminated surfaces such as the floor, counters, and patient equipment.

Director of the Pharmacy, responsible for ensuring adequate supplies of medications used to treat the illness

Director of the Laboratory, responsible for making recommendations regarding the collection, transportation, and testing of specimens from potentially infected persons.

Biomedical Engineering, responsible for making recommendations regarding the use of HEPA filters and other such decontamination equipment

Communications and Public Relations, responsible for all internal and external communications regarding the status and treatment of patients with the illness

Respiratory Therapy, responsible for determining if specific respiratory therapies are contraindicated and the education of staff on these contraindications.

Chief Nursing Officer (CNO), responsible for determining the number of nursing personnel required to staff a isolation unit dedicated to the illness, and the process for acquisition of such staff.

Risk Management, responsible for assessing legal implications of the illness

Materials Management, responsible for the assessment and/or procurement of personal protective equipment (PPE) or other required materials.

B. RISK ASSESSMENT

The Illness:

Data on the number of cases and areas affected will be collected, reviewed by the Epidemiology program, and used to estimate the degree of risk to our institution.

The Facilities:

Engineering will assess the number of available isolation rooms and if they require negative airflow capabilities due to airborne transmission precautions.

Emergency Department's decontamination and asthma bays annex is able to be separated from the rest of the building via sliding glass doors. When these sliding doors are closed, the entire 1st floor annexed decon building is under negative pressure with respect to the rest of the ED. This allows us to use the 3 decon shower rooms doors to receive suspected infectious patients, screen them in the shower rooms, and mask them prior to distribution either to the ED for treatment or to the 5th floor isolation zones (see map in appendices).

Environmental Services will determine the products available for decontamination of potentially contaminated rooms and/or equipment.

Nursing will assess the availability of a specified unit and dedicated staff to be assigned to the treatment of such patients. If required, negative pressure rooms are currently located in the following areas:

UNIT	# Neg Pressure Rms	Always Neg or Variable?	Room Numbers
7 E	8	Negative	E703, E706, E710, E714,E728, E736, E739, E747
6EN	3	Negative	E602, E603, E609
Neurosciences	1	Negative	E548
Surgical Care	1	Negative	E500
Heart & Kidney	2	Negative	E339, E340
Hem/Onc	5	Negative	E403, E410, E411, E412, E 413
Pediatric ICU	5	Negative	E304, E305, E306, E307, E321
Cardiac ICU	2	Negative	M367, M378
Neonatal ICU	4	Negative	E642, E641, E640, E639
PACU	4	Negative	2.041-Rm 31, 2.042-Rm 32, 2.043-Rm 33, 2.022
ED Main	4	Negative	1.021, 1.022, 1.025, 1.026
ED UMC	2	Negative	Room 14, Room 15
ED Decon		Negative if decon mode on	Entire decon building including shower rooms
Radiology MRI	1	Negative	Recovery Rm 9 (E2260)
Hem/Onc Clinic	2	Negative	E4020 (Exam 2), E4006 (Consultation C)
Pulmonary Clinic	1	Negative	1034
Cardiology Clinic	1	Negative	M3108 (Exam Room 14)
Children's Clinic	2	Negative	EI-096 (Exam 3), EI-037 (Exam 21)
Adolescent Clinic	2	Negative	EI-071 (Exam 1), EI-057 (Exam 9)

The Employee:

Occupational Health and Epidemiology will assess the degree of risk to employees who may have been exposed and make recommendations regarding their return to regularly assigned duties.

Infection Control Practitioner and Director of Materials Management will evaluate the type and availability of Personal Protective Equipment (PPE).

IV. ACTIVATION OF THE BIOLOGICAL/PANDEMIC RESPONSE PLAN & NOTIFICATION OF PERSONNEL

The CMO/designee will be responsible for notifying the CEO/designee when the task force determines the Code Navy Plan needs to be activated due to confirmation of an epidemic / pandemic situation. The CEO or designated on-site person-in-charge has the authority to initiate this plan. He/she will notify the hospital operator.

When authorized, the hospital operator will activate the Code NAVY plan immediately and will use the emergency overhead page to announce three times over the PA system as follows: "ATTENTION - CODE NAVY"
The operator will then immediately send “Code Navy: Pandemic Plan now in effect” via pocket pager to all pagers.

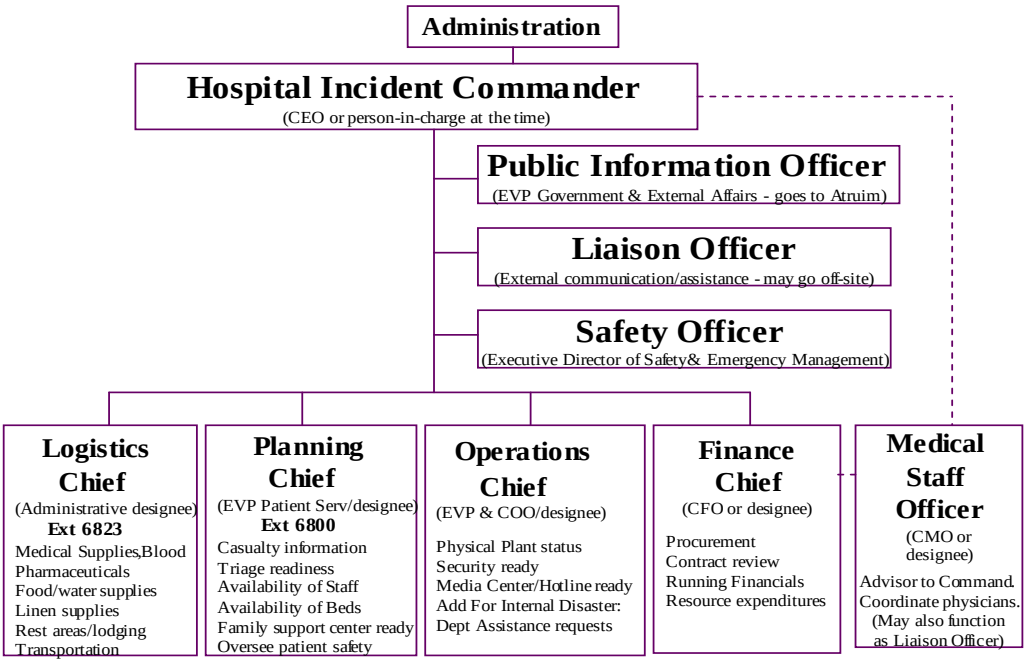
Staff unreachable by phone or pager who hear of an epidemic/pandemic event in the response area of the hospital should call in to their department. If unable to call in, staff should come in and report to their department.

All directors, managers and supervisors shall ensure that their departments are aware of activation of this plan and that their departmental-specific (see pages 17-23) response plans are put into action.

Upon receipt of notification, members of the Hospital Command Center team/AOCs and AMs (or their designees) will report to the Hospital Command Center off the main atrium.

A. HOSPITAL COMMAND CENTER

The hospital follows the National Fire Protection Association Standards 99 and 1600 for healthcare disaster response and incident command, as well as the National Incident Management System. The hospital Incident Commander (IC) shall be the CEO or his/her designee (administrator on-call at the time). Hospital Command Center team members (or designees) includes the AOCs and/or ADs, the safety officer/designee, public relations person on call and other administrative personnel as determined by the IC. When any of the above are not available, members of the hospital Administrator-On-Call (AOC) group and any other available hospital Vice Presidents may be summoned as command team members by the acting hospital Incident Commander. Administrative secretaries may also be summoned for phone coverage.



Hospital Command Center (HCC) responsibilities include (but are not limited to):

1. Initiating and terminating the plan. Termination will be done in conjunction with the Authority Having Jurisdiction (if appropriate) through communication with the hospital Incident Commander (IC).
2. Familiarity with organizational preparedness, mitigation, response and recovery activities related to hazard risk assessment disaster/incident profiles.
3. Communicating with the local community emergency response center.
4. Assessing the hospital's disaster/incident response and recovery capability.
5. Coordinating the hospital's immediate disaster/incident response and recovery activities, including staff/family support, housing and transportation in the event that is necessary.
6. Hospital Command Center/Administration will be responsible for ongoing re-assessment and coordination of recovery and response activities in follow up to a disaster/incident.
7. Arranging for debriefing as necessary or appropriate for those individuals involved in the disaster/incident and/or involved in the response to the disaster/incident.

Authority Having Jurisdiction

In times of disaster all persons are subject to certain constraints or authorities not present during normal circumstances. When the Authority Having Jurisdiction (AHJ) declares a state of disaster exists, the disaster plan shall be activated. The AHJ shall be cognizant of the requirements of a health care facility with respect to its uniqueness for its continued operation in an emergency. Discontinuation of the hospital disaster plan (when the AHJ is involved) must be coordinated with the AHJ. Such authorities include, but are not limited to, civil authorities (fire department, police department, public health department, or emergency medical service council), and civil defense or military authorities.

HOSPITAL COMMAND CENTER - TEAM ROLES AND RESPONSBILITIES:

HOSPITAL INCIDENT COMMANDER (IC)

Hospital Command Center leader, also known as "IC". During an incident involving external organizations, HCC facilitates cooperation between hospital response and needs of the AHJ. Responsibilities include:

1. Initiation of EOP/annexes and activation of HCC via call to the hospital operator.
2. Assign roles of Hospital Command Team as needed to coordinate Command response.
3. Determine hospital's response and recovery capability and the number of casualties the hospital is equipped to handle based upon actual and/or potential bed availability, manpower available in Triage and or Nursing units and type (acuity) of expected casualties.
4. Assess the need to utilize the personnel pool.
5. Order early discharges and transfers if and when necessary.
6. If damage has affected the hospital's ability to safely deliver service to the patient population in any way, or if the facility must be evacuated, call 911.
7. Approve release of information to the family information center (specific) and media (general info). This function may be delegated to the Public Information Officer (PIO).
8. Order provision of staff/family debriefing and support services as necessary or appropriate.

SEE BASE EOP (CH:DIS:00) for role specific information

B. COMMUNICATIONS PLANS AND BACKUP

Refer to the emergency communications plan should regular phone service be compromised. Red emergency phones are available. Radios are also available through the Engineering Control Room. Radios are sent to the Command Center upon activation of the disaster plan. The EMTC has four radios at all times. In an extreme emergency, cell phones may be used in non-patient areas approved for cell phone use (such as the West Wing). If IT services are affected, follow Information System's instructions for downtime procedures as necessary.

C. MANAGEMENT OF THE ILLNESS

1. Early detection is the first key to successful reduction in transmission of the illness.
    - **a. In the patient**
        1) Once the illness is determined to be a risk in our community, all admitted hospital patients, patients in Childrens Health Centers, Children's Regional Outpatient Centers, the Emergency Department and Ambulatory Care Clinics will be screened.

2) Every patient who presents to the ED or clinic with signs and symptoms consistent with the illness will have a detailed history elicited. At this time it will be determined if the patient is a suspect case. If the patient is deemed to be a suspect or a probable case,-appropriate implementation of Engineering and Infection Control measures is necessary.
3) Once a patient is suspected of the illness, Epidemiology and Infection Control should be immediately notified
4) The patient will be transferred to and cared for in a dedicated unit to be specified by the task force.

b. In the employee

1) Occupational Health will conduct screening of all employees with symptoms consistent with the illness. Employees may be asked to take administrative leave during the incubation period of the illness at no risk to their employment status.
2) All employees who travel to an area known to have a pandemic of respiratory illness must notify Occupational Health before returning to work for evaluation and risk assessment.
3) Additional recommendations regarding employee health safety specific to the illness may be made at the time the plan is activated.

2. Containment of infection in the community is a focus after a suspected case is identified. Notification of all regulating bodies, such as the Department of Health and Centers for Disease Control, is the responsibility of Epidemiology and Infection Control. Health-care workers must follow the policy of this institution for patient confidentiality under HIPAA regulations. Public Relations will be responsible for the fielding of all media coverage. Consider moving to another section.
3. Infection Control Measures are vital to the protection of personnel, visitors, and patients.
    a. Employees
        1) Personal Protective Equipment is to be worn as advised by the CDC for the specific illness before entering the patient's room, and removed after exiting the room.
        2) Ensure good **hand hygiene**.
        3) Except when entering or exiting, the door to the room must remain closed at all times
        4) Specimens for laboratory evaluation must be clearly labeled and transported as determined by the Director of the lab. A certificate of possession may be required.
    b. Patients:
        1) The patient must be kept in appropriate isolation precautions as recommended by Epidemiology and Infection Control.
        2) Signs should be posted on the door to the patient room and an order is to be written on the chart.
        3) A patient on transmission-based precautions, should only be transported for diagnostic tests within the institution when absolutely necessary. The area to which the patient is going needs to be notified of the patient's diagnosis prior to the transport. If on airborne precautions, the patient must wear a surgical mask while out of the isolation room
        4) Environmental Services should do a thorough cleaning of the patient's room at least every 24 hours. All garbage is to be disposed in a biohazard red bag if determined necessary by Epidemiology and infection Control.
    c. Visitation Policy
        1) Specific visitation policy restrictions will be evaluated at the time of the illness' identification as a pandemic.
        2) Any visitor may be required to first have clearance from a physician by means of examination and any available testing prior to entering the hospital. They must present proof of this evaluation that will be kept for hospital record.
        3) All visitors must wear appropriate PPE as recommended by the CDC as so determined by Epidemiology and Infection Control based upon available clinical knowledge.

4. Treatment Suggestions
    a. Infectious Diseases should be consulted to determine the most appropriate antimicrobial therapies.
    b. Microbial organisms are easily aerosolized in the environment when performing respiratory therapies and procedures. Therefore, avoiding the use of oxygen mists, nebulized medications, bi-pap, suctioning and intubation is recommended. Infectious Diseases will determine if the use of these therapies will be prohibited based upon available data about the illness. When these

therapies and/or procedures are required, proper respiratory protection must be used as indicated by Epidemiology and Infection Control.

5. Exposure Control Plan
    a. Employees exposed to the pandemic illness while in our institution must be reported to Epidemiology and Infection Control and Occupational Health as soon as possible. They will be treated in accordance with recommendations by the CDC, and may be asked to take leave for the duration of the incubation period at no penalty to themselves.
    b. Patients exposed, to the pandemic illness while in our institution should be moved to isolation rooms and monitored for signs and symptoms of the illness. Infectious Diseases will determine the necessity of prophylaxis as recommended by the CDC. It should be ordered and administered by the patient's health care team.
6. Deaths of affected persons*

    In cases of death from cholera, anthrax, diphtheria plague (bubonic and pneumonic), smallpox, or louse-borne typhus fever, the physician issuing the certificate of death shall give immediate notice by telephone of the death to the DC DOH Director.

    The body of a person who died from a disease listed in this section shall not be moved from the place of death except after issuance of a permit by the DC DOH Director, as required under CDDR 22-214 of the DC DOH Pandemic Influenza Preparedness Plan.

    Prior to being transported from the place of death to a licensed undertaker's establishment, the body of a person who died of a disease listed in this section shall have all of its orifices filled with absorbent cotton, and shall be wrapped in a sheet saturated with a 1:500 solution of bichloride of mercury or other equally effective germicidal agent. (*source: DC DPH Pandemic Influenza Preparedness Plan).

D. DEPARTMENT SPECIFIC ROLES AND RESPONSIBILITIES

Personnel who are at the end of their shift shall check with their supervisor before leaving the hospital.

NOTE: Hospital departments/personnel on-site at the time of the disaster who do not have specific roles and/or are not involved in patient care shall check with their supervisor and if able report to the Auditorium to be available for reassignment as part of the Employee Deployment Center personnel pool.

The following departments will immediately implement their department-specific plans when notified of an incident:

1. **Administration**

a. In charge of the conduct of the entire hospital. Hospital administrator-in-charge on site at the time of an incident is the automatic immediate administrative Hospital Incident Commander. Once additional resources arrive, hospital Incident Commander may delegate this role if appropriate.
b. Hospital Command Center team members may be pulled from Administration and other available areas as deemed necessary by the hospital Incident Commander.
c. May alter hospital policy if necessary.
d. May authorize emergency purchase orders.
e. May be responsible for communication with other area hospital administrators and resources.

2. **Admissions**

At the EMTC hospital triage corridor, or following decontamination of the victim(s), the admissions representative will assign each victim an acute patient pack, and place a corresponding identification band on the appropriate patient. This information will promptly be given to Medical Records at the tracking board.

a. Obtain necessary patient information from patients in the treatment areas, if possible.
b. Forward patient information to the Hospital Command Center Planning Chief at ext 6800 or via runner.
c. Obtain necessary patient information from parents/family when they have been identified by Social Work and Family Support Center staff.
d. Bed Control and the Admissions/ Discharge Nurse Coordinator will determine the current in-house bed status and notify the Planning Chief (ext 6800) in the Hospital Command Center.
e. Coordinate bed assignments, admissions and discharges.
f. During the evening and night shifts Admissions will monitor and maintain the Tracking Board until Medical Records personnel arrive, and will continue to assist with updating it once Medical Records has arrived.

3. **Anesthesiology**
Provides support services upon request. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

4. **Biomedical Engineering**
a. Available to repair medical equipment or fill other roles as assigned.
b. Accessed by contacting Biomedical Engineering or hospital operator.
c. Provides additional medical equipment to patient care areas as needed.
d. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

5. **Clinical Resource Management**
Identifies and expedites all potential discharges and transfers in conjunction with the health care team.

6. **Communications**
a. Directs incoming and outgoing calls, with the exception of calls to the Hospital Command Center or ECIC.
b. Activates on-call pagers as needed.
c. Coordinates use of the public address system.
d. Notifies by telephone Public Relations, Social Worker, Medical Records, Clinical Resource Management and other pertinent areas not reached by the public address system.
e. Records updates on status and instructions for staff on "Information Line" (ext 4444) per AOC instructions.
f. Sets up a HOTLINE upon request of the Hospital Command Center or Public Information Officer.
g. Set up phones for parent/family use in Family Support Center if directed by Hospital Command Center.

7. **Central Supply Service**
a. Delivers pandemic disaster supply cart to designated areas, as requested.
b. Delivers two resuscitation carts to expanded patient areas, if requested.
c. Obtains additional supplies from the warehouse and other hospitals, when necessary.
d. Emergency purchase orders are authorized by the administrator-on-call.
e. Call Hospital Command Center (ext 6823) to have runners dispatched to deliver additional supplies.
f. Sends sterile supplies to units and treatment areas as requested.

8. **Dietary**
a. Provides patient meals.
b. Provides refreshments to disaster patients and staff with authorization from the Hospital Command Center.
c. Refreshments may be served in the EMTC lounge, Cafeteria, or Employee lounges in patient care areas.

9. **ECIC**
a. Acts as EMTC response coordination center.
b. Accesses hospital and outside resources if directed by the administrative Hospital Command Center.
c. Keeps EMTC Team informed of number of victims, their conditions, and the estimated time of arrival.
d. If necessary, upon request of Hospital Command Center, arranges transfer of patients by emergency vehicle (including Pediatric and Neonatal Transport Service as appropriate).
e. Ascertains bed status of area facilities if requested to do so by the administrative Hospital Command Center.

10. **EMTC**
The EMTC will adapt its patient flow methods to accommodate large numbers of patients who have contracted or have been exposed to the pandemic/epidemic illness, while maintaining the ability to treat those patients presenting with non-pandemic/epidemic problems. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources. The main facets of the adaptations to flow involve 1) following any Transmission-based Precaution guidelines forwarded from Infection Control and the Risk Assessment Task Force, 2) alteration of patient entry, greeting, waiting, and flow routes, and 3) use of patient tacking and diagnostic testing to identify suspected and preliminarily confirmed cases. Plans for specific EMTC room and resource use based on varying levels of patient census and staffing patterns have been developed and are part of the EMTC Policy & Procedures.

1) Transmission-based precautions will be instituted following guidelines from Infection Control. It is expected that pandemic influenza will necessitate what are categorized as “Droplet Precautions” in Children’s National policy. Other pandemic/epidemic illnesses will be addressed specific to the illness.

a. Staff will have available and use appropriate hand washing and cleansing materials, as well as appropriate PPE.
b. Patients and visitors will be asked to follow appropriate precautions during their visit, and will be supplied with educational materials as well as appropriate cleansing materials and PPE.

2) Patient entranceways, greeting staff location, patient waiting areas, and patient flow through the EMTC will be altered to accommodate a population with a high rate of pandemic/epidemic illness exposure risk.
   a. Patients and visitors to the EMTC will require screening on arrival for signs and symptoms of illness. In the most likely scenario, the normal entryways will continue to be used. In that event, the Ambulatory Entrance can be cordoned to direct patients and visitors to the screening location. Patients and visitors arriving via ambulance or helicopter will be screened by staff as they arrive.
   b. If events dictate that use of the Decontamination Center entryways would be most prudent (e.g. numbers of patients, need to institute a negative airflow environment, etc) the three exterior decon shower doors will be used. If negative airflow is needed in that section of the EMTC, staff there must notify Engineering (x6040) to turn on the decon zone negative air pressure.
   c. Greeter Staff will be moved as close to the entryway as possible, and will screen patients and visitors for signs of pandemic/epidemic illness, determine if they are "unexposed" or "exposed," and direct them to cohorted triage.
   d. Patients who arrive in emergent or urgent medical need will be brought to treatment areas rapidly; they may need to be presumptively classified as "exposed" until definitive testing can be accomplished.
   e. Triage will be staffed with a senior-level physician, who can facilitate rapid assessment of patient acuity, and begin and direct treatment of both low- and high-acuity patients.
   f. The waiting area can be divided into sections for "exposed" and "unexposed" patients. Should the contingency arrive, the waiting areas can be moved or expanded to include waiting areas in the CHC or Orthopedic clinics. In times of extremely large patient volumes plans have been made to use the current waiting area as an "exposed" patient area and the Atrium as "unexposed" patient waiting area.
   g. Treatment rooms will be cohorted to accommodate both "exposed" and "unexposed" patients. The distribution of rooms for each cohort will vary depending on actual patient volumes and acuity. In the event that areas outside the EMTC are used for treatment of EMTC patients (e.g. CHC, Orthopedics Clinic) those areas will be similarly cohorted.
   h. Patients will be registered in the system on arrival following current procedures. Full registration will be done at the bedside for patients present in the EMTC, or at discharge for those whose visit is brief.

3) The EMTC patient tracking system can be used in conjunction with clinical screening and diagnostic testing to identify and record suspected and confirmed cases of pandemic/epidemic illness.
   a. Patients will be screened symptomatically on arrival and cohorted accordingly. This can be recorded through the tracking system, and information recorded for analysis by Infection Control.
   b. Diagnostic testing of cases will be performed according to guidelines provided by Infection Control. Test results will be available through the EMTC tacking system, and through the hospital laboratory.

11. **Engineering Services / Facilities Management**

a. Responsible for building maintenance and assessment as needed.
b. Responsible for switching the Decon Center to "Decon Mode" upon request, switching 5 East isolation zones 1, 2 and 3 to negative pressure on request, and ensuring negative pressure exists in each area (smoke test).
c. Prepares to supplement hospital utilities and emergency power as needed.
d. Notifies Hospital Command Center and Infectious Disease Attending on-call if water supply is contaminated.
e. Engineering will assist security as needed and may serve as runners if necessary.
f. May access Biomedical Engineering, if necessary.
g. Will operate elevators 8 and 9, if necessary.
h. Will supply electrical extension cords or extra radios, if necessary.
i. Will facilitate recovery activities utilizing inside resources and outside contractors as needed to restore hospital facility operational capacity as rapidly as possible.

12. **Environmental Services**

a. Immediately cleans all vacant in-patient rooms.
b. EVS supervisor assigns 5 staff to the EMTC to bring wheelchairs and stretchers to the trauma bay hallway, upon arrival they should report to the ED Charge Nurse. Assign 2 staff as runners outside the HCC room.
c. Assigns staff to EMTC and other designated patient care areas to keep areas clean and to allow quick

turnover of patients. Be prepared for large volumes of waste/linens that require removal from the area.

d. May serve as runners after initial housekeeping is complete, these staff should report to the Auditorium personnel pool for potential assignment as runners, others may be reassigned to EVS to assist with ongoing patient room cleaning/room turnover assignments.

13. **Epidemiology/ Infection Control**

Notified when a diagnosed or suspected communicable disease is encountered or in the event of a natural disaster with risk of or breakdown of normal disease control factors (e. g.: contaminated water).

a. Assists in determining the source or cause of the infection and limiting its spread in the community and hospital. Assists in an advisory capacity in the Hospital Command Center upon request.
b. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.
c. Provides consultation for bed assignment of patients.
d. Provides consultation for placement of portable negative air equipment/hepafiltration in patient areas, if needed.
e. Notifies appropriate outside agencies (including EMS agencies) and serves as liaison with other agencies when communicable diseases are seen during a disaster.
f. See ID Attending on-call specific Job Sheet (see below).

SPECIFIC JOB SHEET: **ID Attending on call** (or designee)

During disasters/incidents this individual, assigned by IC, is responsible for receiving and issuing reports from the Hospital Command Center to external healthcare agencies.

RESPONSIBILITIES:

Contact the DC Department of Health and/or Centers for Disease Control and Prevention for reporting and guidance.

Lead epidemiological investigation for index patients, outbreaks and exposures related to infectious diseases of pandemic proportions.

Maintain external communication as needed with:

DC Animal Control 202-576-6664
DC Department of Health 202-727-6161
Centers for Disease Control and Prevention……404-639-6412

Patient	Confirming Laboratory Data	Location in Hospital

14. **Family Services**

a. Will provide emotional support to patients and families.
b. A social worker and child life specialist shall report to the EMTC to direct family or guardians to the area designated for them (Family Support Center is located in the PMR Waiting Room).
c. EMTC social worker may request additional social workers and child life specialists. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.
d. Use social worker form from disaster packets to obtain victim information. (Victim names acquired by admitting/registration personnel in the EMTC and/or from Family Services must be provided to the HCC on an ongoing basis. Family Services may use runners to send updated information to the HCC as needed.)
e. Will keep parents/guardians and family informed of the status of their affected loved one.
f. Will assist in reuniting parents and children as soon as possible.
g. Will document identification/ notification efforts and final disposition.
h. Assesses the need for and notifies Family Services and Volunteers.
i. InterFaith Chaplain Services
    1. The Senior Chaplain or designee shall report to the EMTC to assess spiritual/cultural needs of victims, request additional chaplains from Children's National Chaplaincy staff (or on-call chaplains, tradition-specific religious personnel as needed) and ensure all chaplain services are properly documented in patient records.
    2. All chaplains shall work cooperatively with Social Workers, Child Life Specialists, Language Services personnel and clinical personnel to assess needs, provide services and documents services provided.
    3. Under the supervision of the Senior Chaplain, all chaplains shall be trained and supported in pandemic disaster response protocols for chaplains; and shall provide sensitive and appropriate service and support to patients, families and staff.

15. **Health Information Department** (Medical Records)

Assigns staff to EMTC to maintain patient status boards. Responsible for the location of patients within the ED.

16. **Human Resources Department**

The Human Resources Director/designee and HR staff will be prepared to report to the Auditorium and initiate the Employee Deployment Center (personnel pool). When the pool is activated the person in charge will immediately notify the Hospital Command Center (HCC) at x6800 that the deployment center is operational and advise them of the number of personnel available in the personnel pool. They will then update the HCC every 30 minutes of available personnel for assignment. (Note: nursing personnel will be deployed via the nursing office, physicians are deployed via the physician pool in the Main Atrium through the Medical Staff Officer.)

HR/designee shall deploy personnel to the main atrium phone banks to contact personnel/family members as needed. Personnel at this phone bank will establish an area marked "Volunteer Practitioner Identification" to perform emergency identification of volunteer practitioners to be assigned disaster responsibilities as indicated by patient needs. Volunteer must present a valid photo ID issued by a state/federal agency AND any of the following:

1. A current picture hospital ID card with professional designation;
2. A current license, certification or registration;
3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MTC, ESAR-VHP or other recognized state or federal group or organization.
4. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such as authority having been granted by federal, state or municipal entity);
5. As a last resort when the above are not immediately available, identification by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

Non-staff providers granted disaster privileges shall be given specific temporary ID badges with their name printed legibly on the card at the time disaster responsibilities are assigned. Such persons shall display the ID on their person at all times. Staff within each area where volunteers are assigned will oversee by direct observation the professional performance of volunteer practitioners. Problems will be immediately reported to HR and an aid in determining whether the volunteer practitioner will remain as assigned within 72 hours of appointment. Primary source verification shall be done as soon as possible, at least within 72 hours of appointment.

Guideline for physician volunteers: The MSO/designee assigns physician credentials and privileges. Extending emergency privileges to non-staff providers and emergency privileges to medical staff members beyond their

current privileges should be documented. Those privileges extended should be limited but sufficient to meet the important institutional and patient needs. As the MSO/designee extends emergency privileges, the provider being granted the privilege should provide to the MSO/designee's satisfaction information to support the ability to perform the emergency privilege being granted.

Critical Incident Stress Management (CISM) team will report to the Auditorium. Requests for CISM assistance will be managed by HR Training and Organizational Development Manager/designee who will dispatch teams of 2 individuals as needed to provide defusing sessions during the incident. Formal debriefing sessions will be available for employees directly involved in the incident two to three days later. Managers contact HR to schedule sessions.

17. **Intensive Care Units**
Attend to the most critical patients. Report staff availability to the nursing staffing office and be prepared to be reassigned if needed. Bring your stethoscopes if reassigned. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

18. **Laboratory/ Pathology**
a. Non point-of-care testing should be directed to the main lab.
b. Blood bank will ascertain in-house blood status as well as blood availability from the usual resources.
c. Blood bank keeps the Hospital Command Center updated on blood availability and blood needs.
d. Pathology will be responsible for temporary morgue facilities and notifying the City Medical Examiner. See section: C.6. *Deaths of affected persons*.
e. If the disaster involves suspected bioterrorism agent(s), specimens from affected patients should be labeled as such. Lab will handle specimens accordingly.
f. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

19. **Legal -** Responds upon request of Administration to support issues from a legal perspective.

20. **Nursing Transport Technicians**
a. Accessed through the Administrative Manager/ NAOC.
b. Will serve as runners (i. e. transporting patients, lab work, x-rays, supplies, messages, etc.).
c. Other potential sources of runners are Volunteers, New Horizons, Engineering or Personnel Pool.

21. **Operating Room** (OR)
a. General supervision will be the responsibility of the Perioperative Service Director (or designee). If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources. Acting Service Director will assess the availability of surgeons and anesthesiologists and report this to the Hospital Command Center Medical Staff Officer immediately.
b. Patients will receive triage for surgery by the senior in-house surgeon.
c. The Senior Anesthesiologist and acting Clinical Manager/ Service Director will determine the disposition of elective surgery.
d. The hall monitor and charge nurse will assign ORs. During off-hours, it will be the OR Trauma nurse.
e. Surgeons and anesthesiologists should report to the OR lounge.
f. Acting Perioperative Service Director or OR Trauma nurse shall assess the need to activate the Recovery Services call-in tree.

22. **Patient Services**
a. Nursing administrative person in charge/NAOC duties:
   1. The Administrative Manager/ NAOC will report to and collaborate with the Hospital Command Center to coordinate the inpatient nursing resources and response of the Hospital.
   2. The Administrative Manager/ NAOC will evaluate the hospital-wide situation and will work with the Hospital Command Center Planning Chief to assign nurses and unit clerks according to need, availability, and specialty. (The AM/NAOC may be assigned to act as the Planning Chief in the HCC).
   3. Provide regular updates on staff and bed availability to the Planning Chief in the Hospital Command Center.
   4. One nurse should be assigned to each of the following areas:
      - 7 East to receive inpatient discharges,

- NCU (5 East) and/ or 4 Main (4 Blue) Playroom to receive inpatient discharges
- Ortho and PMR waiting rooms for disaster patient discharge in order to monitor patients and answer questions they and/or their parents may have.

5. At the direction of the Administrative Manager/ NAOC, the Nursing Staffing Office will order refreshments for staff involved in the incident.

b. Service Director/designee duties:
   1. Determine how many nurses can be taken from that unit and/ or how many nurses must be called in. Report that number to the Nursing Staffing Office immediately.
   2. Assist physicians in determining which patients may be discharged/moved from that unit. Inpatients to be discharged will be sent to either 7 East, 4 Main (4 Blue) or NCU (5 East) to await discharge. Notify admissions of all discharges per usual protocol.
   3. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.
c. Patient unit duties:
   1. Prepare to receive victims admitted from the EMTC.
   2. Prepare to receive ETU patients from the EMTC, expect to receive these patients with only a chart (i.e., without orders, without report). ETUs may sit at a nursing station if space constraints prohibit bed availability.
   3. Provides nursing care in all areas of the hospital. Every effort should be made to have nurses serve in their area specialty. If reassigned, bring your stethoscope with you.
   4. In-house nurses (including advanced practice nurses and other RNs from non-clinical areas) as well as nurses called in from home should report to the Nurse Central Staffing Office, not to the EMTC, for assignment. Nurses voluntarily coming in from home should report to their regular unit to await assignment. NOTE: Building will be in lockdown, all personnel must bring and wear their access ID badges to gain entry.

23. **Pediatric and Neonatal Transport Service**

a. Provide ambulance transport of patients as assigned by the EMTC Charge Physician.
b. Peds Team reports to EMTC Charge Nurse to assist as needed; staff will remain available for transport assignment.
c. On-call Transport Physician may be called in at discretion of the Medical Control Physician (EMTC Attending).
d. Neonatal transport team will continue to report through the NICU.

24. **Pharmacy**

a. The senior ranking administrative/ supervisory pharmacist immediately contacts EMTC Charge Nurse to ascertain the degree of Pharmacy involvement.
b. If the Strategic National Stockpile is activated by the Mayor, upon arrival of the stockpile a pharmacist will go to the loading dock to receive it. See Base EOP (CH:DIS:00), Appendix B.
c. If Pharmacy involvement is required, the senior ranking administrative/ supervisory pharmacist or designee arranges delivery of the four medication supply boxes from the Main Pharmacy to the ED and notifies the ED Charge Nurse of their arrival. ED Charge RN will assign allocations for each med box as needed. If additional medications are needed, the Pharmacy will obtain the medication supplies needed to respond to the disaster. A pharmacist will remain in the EMTC to assist until dismissed by the EMTC charge nurse.
d. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

25. **Physician Staff**

a. Medical Fellows, Interns, Specialty Service Fellows and Residents not assigned to units will report to the Main Atrium by Stairwell #1 and will serve as the primary physician pool to be assigned as needed. Medical Attendings report to the Main Atrium by Stairwell #1 and serve as the secondary physician pool.
b. The appropriate (Medical or Surgical) Chief Resident will assist the EMTC Attending with Triage. The EMTC Attending will assign other Medical Staff to the most appropriate treatment areas.
c. House staff will assist in the assessment and stabilization of the patients in areas assigned.
d. Fellows and Residents will consult with Attendings to determine which patients may be discharged.
e. Surgical Attendings, Fellows, and Residents will report to the OR lounge for surgical assignment.
f. Medical students will report to their regularly scheduled units.
g. CEO/MSO/designee provide emergency credentialing/grant temporary privileges as needed per Medical Staff Bylaws policy. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

26. **Post Anesthesia Care Unit (PACU), i.e., Surgical Preparation and Recovery Unit**

a. Will serve as a holding area for patients awaiting surgery. The PACU has a 35-bed capacity, all of which are monitored. Three of these 35 beds are also isolation beds.
b. May serve as an overflow for the ICU for post-operative patients.
c. The EMTC Command Team will assign a physician here, if necessary.
d. Security needs to unlock this area during off hours.
e. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

27. **Psychiatry and Behavioral Sciences**

a. Inpatient psychiatry units report staff and bed availability to the Hospital Command Center (x6800).
b. Division Chief/designee will coordinate departmental response activity as needed per the ICC.
c. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

28. **Public Relations**

a. Upon notification of a MCI by the hospital operator, will activate the Public Relations Crisis Response Plan.
b. An interim Public Information Officer (PIO) will be appointed if necessary by the Vice President, Government and External Affairs. Upon arrival, the on-call Public Relations representative will assume the role of PIO.
c. The PIO reports to the Hospital Command Center, then establishes the Media Center from the Main Atrium.
d. The PIO determines the media location based upon the situation. If the Michigan Avenue entrance is used, media may be directed to park in the construction lot. A satellite uplink is available in the Auditorium, if needed.
e. No press personnel shall be allowed in patient care areas. A security officer is assigned to the Main Atrium to prevent media entry to patient care areas.
f. Business hours: direct calls to Public Relations. Off-hours: request operator page the PR representative.
g. Medical Spokesperson: The Vice President, Government and External Affairs (or designee) will identify the appropriate medical spokesperson; brief that person; and coordinate all interviews.
h. Public Information Officer may request Communications establish a family information HOTLINE.

29. **Radiology**

a. Will respond to the EMTC with portable x-ray machine(s) upon request.
b. Medical Director of Radiology in conjunction with the EMTC Attending will prioritize use of radiology facilities.
c. In the event of a radiation emergency, contact the Radiation Safety Officer (or designee) immediately.
d. Radiation Safety Officer/designee responds to the EMTC ambulance doors with a geiger counter and chemical detection equipment to screen incoming victims for possible exposure. Any positive readings must immediately be communicated to the EMTC Charge Physician and the Hospital Command Center. (see also Code Purple). If victims are positive for radiation, the Radiation Safety Officer will secure and distribute temporary dosimeter badges to personnel working directly with contaminated victims.
e. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

30. **Respiratory Care**

a. Will assist anesthesiologist with airway management.
b. Will provide ventilatory support.
c. Upon request, Will assign one staff member to EMTC and the PACU to assist Nursing Staff with airway management. At least one therapist must remain in each ICU (NICU, PICU, and CICU).
d. Remaining staff will continue providing patient care on the units unless paged to assist with disaster victims.
e. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

31. **Regional Outpatient Clinics (ROC) and Satellite Clinics**

a. The Ambulatory Manager of Ambulatory Nursing (or designee) will contact each ROC and clinic to determine manpower availability at each location and provide them with available information on the pandemic.
b. ROC and clinic staff will remain at their locations. If additional staffing is needed at the hospital, the ROC and clinic staff will be instructed to report to the hospital, travel conditions permitting.

c. ROC and clinic staff are not expected to provide emergency care at their locations, but should utilize the local emergency response (911). ROCs and clinics may receive affected patients in their practice, follow hospital Infectious Disease recommendations, their local health department and CDC guidelines.

32. **Security**
a. Officers will be stationed at primary hospital entrances and limit access to essential authorized personnel.
b. An Officer immediately opens the Hospital Command Center and delivers radios for distribution.
c. An officer will be stationed at the designated Media Area when requested.
d. Responds to the helipad per protocol.
e. Monitors and directs traffic at ambulance entrances and assists with crowd control.
f. Identifies parents/guardians of victims and guides them to the designated location.
g. The engineering department may provide additional support personnel and portable radios, as needed.

33. **Surgical Staff**
a. TRAUMA STAT team members report to EMTC. Other surgical staff report to the OR lounge.
b. Assists with triage and patient care.
c. Interns shall write discharge and transfer orders and shall provide in-house care on units as needed.
d. If volunteer practitioners are assigned, ensure their professional practice is appropriate through direct observation. Report any concerns immediately to Human Resources.

34. **Volunteer Services** (regular hospital volunteer personnel)
a. Report to the Volunteer office to be efficiently deployed.
b. Coordinate with family services for assignment of staff.
c. Will assist all personnel as requested.
d. Will be responsible to the unit director or charge nurse where assigned.

V. TERMINATION OF DISASTER RESPONSE PLAN

Pandemics are anticipated to occur in multiple 'waves' over a period of many months. Once the hospital initial Incident Command operations have established initial response and a long term course of action, the physical ICC may be stood down, and followup shall continue through general hospital administrative guidance processes. The ICC may be stood up again as needed to address peaks in waves in the patient population by whomever is the acting administrative person in charge at the time of that occurrence.

The Hospital Incident Commander shall initiate termination of the disaster response by contacting the hospital operator and requesting announcement over the PA system (3 times) "ATTENTION, ALL CLEAR FOR CODE NAVY". Hospital operators will also send this message out over the same pager groups used to announce the initial disaster response. In determining when to terminate the disaster response, the HIC will communicate closely with the ID Attending on-call/designee. When outside AHJ are involved in disaster activities, the HIC will coordinate termination of the disaster with the AHJ (i.e., the DC DOH for epidemics/pandemics).

VI. RECOVERY STRATEGIES

Recovery is the stage that addresses how Children's National restores the organization to pre-disaster conditions. This can include short term and long term activities, as well as activities designed to take care of staff and community needs. Recovery may encompass all disciplines at Children's National Medical Center. Initially, a team consisting of the Unit Manager, Biomed, Engineering, Safety, Construction, Infection Control, Medical AOC, Legal, Psychiatry, Administrative representative, Central Supply/Linen, and the Chief Nursing Officer will be convened to assess immediate and long term response needs and coordinate activities.

Recovery involves protection of property, protection of records, supplies and equipment essential to the operation of the hospital during an emergency, as well as, restoration of property to an efficient operating condition as quickly as possible, including the prompt servicing of equipment, restoration of ventilating and air conditioning services, and the restoration of utilities as needed.

Recovery entails financial stability planning and insurance coverage to provide monetary resources necessary to finance repairs and replacement of critical equipment and supplies. Financial recovery may include disaster related expenses reimbursement. A detailed listing of expenditures will be kept via the HCC Finance Chief.

Recovery strategies for personnel include provision of debriefing and stress management services when needed. In addition to the disaster plan provision for defusing sessions by the CISM Team, during the incident and debriefing sessions several days after, the Department of Psychiatry will coordinate additional support as needed. Staff experiencing post-disaster symptoms are encouraged to seek additional assistance through the hospital Employee Assistance Program.

VII. PRE-PLANNING PREPAREDNESS STRATEGIES

Children's National has assessed the hazards and risks most likely to occur in this geographic region, and has developed plans to address the most likely disaster-related scenarios. (see Children's National's Hazard Vulnerability Analysis on the following page).

To facilitate rapid communication during disasters and emergencies, Children's National has developed a set of Emergency Codes which staff are expected to know. Personnel are trained on these codes at New Employee Orientation, and at the department-specific level where applicable.

Annual re-training is conducted on emergency codes, and drills are held to further train staff. An educational color poster was developed as a quick reference for staff on the various emergency codes, and yellow emergency number stickers were placed on all phones for quick reference by personnel in an emergency.

Both the Hazard Vulnerability Analysis (HVA) and Emergency Codes follow this section. Personnel are encouraged to keep a minimum of 5 days of personal medications at the hospital in the event of a long-term disaster response. (Secure personal medication from access by children at all times.)

Preplanning for a pandemic includes the need to develop a plan for ethical decision making during a time of limited resources and overwhelming numbers of affected persons. Members of the bioethics and medical staff are critical to development of this pre-event planning component.

Appendix A of the Base EOP (CH:DIS:00) provides for staff sleeping accommodations.

Appendix B of the Base EOP (CH:DIS:00) provides for receipt and distribution of the strategic national stockpile.

Code Green, CH:DIS:0, provides for patient decontamination procedures and includes selection of personal protective equipment (PPE), donning PPE, decontamination of PPE and doffing of PPE.

Preparedness involves hospital activities to build surge capacity and identify needed resources. Children's National has entered into mutual aid Memorandums of Understanding (MOUs) with DC healthcare facilities via DCEHC, a separate MOU exists with Holy Cross Hospital, as well as with Malcolm Grow at Andrews Air Force Base. MOUs help hospitals achieve an effective level of incident medical preparedness by authorizing the exchange of medical personnel, pharmaceuticals, supplies, equipment, evacuation or admission of patients in the event of a disaster. CNMC maintains a DOH-funded stockpile of N-95 masks for biological surge, is an approved CPOD with DOH, and maintains a modest cache of grant –funded medications for anticipated biological surge needs. CNMC created three mass isolation negative pressure zones when building the east tower, these are located on the 5th floor, many of the single patient rooms have a second headwall, allowing us to surge from 60 regular patient beds to 138 isolation beds should an epidemic or pandemic require those accommodations (see Appendix A).

Children's National's Safety Officer is a member of DCEHC, pagers for ADs and the nursing staffing office receive DCEHC Alerts, this provides up-to-date information to the organization regarding emergency preparedness and response activities in the region. Employees complete annual safety training, which includes information regarding their roles/responsibilities during incidents. To further train employees, exercises are conducted at least semi-annually, using a variety of incident scenarios with activation of the EOP and applicable annexes.

VIII. PRE-PLANNING MITIGATION STRATEGIES

Mitigation activities are those actions that eliminate or reduce the chance of a disaster or the effect of a disaster. Children's National was designed, in accordance with local building codes, to provide multiple negative pressure rooms to care for persons with airborne infectious diseases. Children's National built a decon center annex to the ED which allows multiple treatment bays and exam rooms, and the three decon shower rooms, to be kept under negative pressure with respect to the rest of the ED when the sliding glass doors between the two are kept closed.

This provides for expansive screening and treatment areas during a pandemic/epidemic, as well as for separate entrance to the facility under negative pressure conditions.

Children's National has developed a list of necessary supplies which are kept in stockpile for disasters, including additional ventilators, surgical masks and N-95 respirators. Children's continues to seek preparedness opportunities in cooperation with District and Federal preparedness programs.

Since Children's National is located in Washington DC, terrorist attack has been identified as a possible threat. When there is a heightened possibility of attack in the region, the hospital is notified by the appropriate external agency. To reduce the effect of an attack or treating patients exposed to chemical agents or radiation, bio-terrorism and radiation readiness plans have been developed. Refer to the Code Purple annex for detailed plans for sheltering facility occupants in place, and for biological, chemical and radiation response.

In order to ensure that staffing is not affected during a disaster, a policy has been developed to address staffing in emergency situations (see Human Resource Policies -Section C (Employee Conduct & Work Rules).

IX. Plan Review and Revision

1. Disaster/incident responses and exercise observations will be critiqued and plans revised as needed.
2. The Executive Director of Safety & Emergency Management, respective departments with disaster plan responsibilities and the Safety & Emergency Management Committee, including members of the Medical Staff will review the plan at least every three years.
3. Departments submit suggestions for changes to the Executive Director of Safety & Emergency Management.
4. Departmental call in phone lists will be updated as information becomes outdated. They should be reviewed bi-monthly by a designated person within each department.

5. At least every three years, or with major plan revisions, the Leadership Council will review this plan.

Approved/reviewed by:

Safety & Emergency Management Committee: Date: 7-18-14

Kurt Newman, MD, President and CEO Date

Original: June 1, 2007
Reviewed: June 26, 2008
Reviewed: Sept 22, 2009
Reviewed: Aug 19, 2011
Revised: July 1, 2014

Cross Reference:

Disaster Planning Policy; Base EOP, Code Orange (MCI); Code Brown (Campus Lockdown); Code Red; Code Black, Code Purple, Code White, Emergency Transportation Plan, Telephone Failure Emergency Communications Plan.

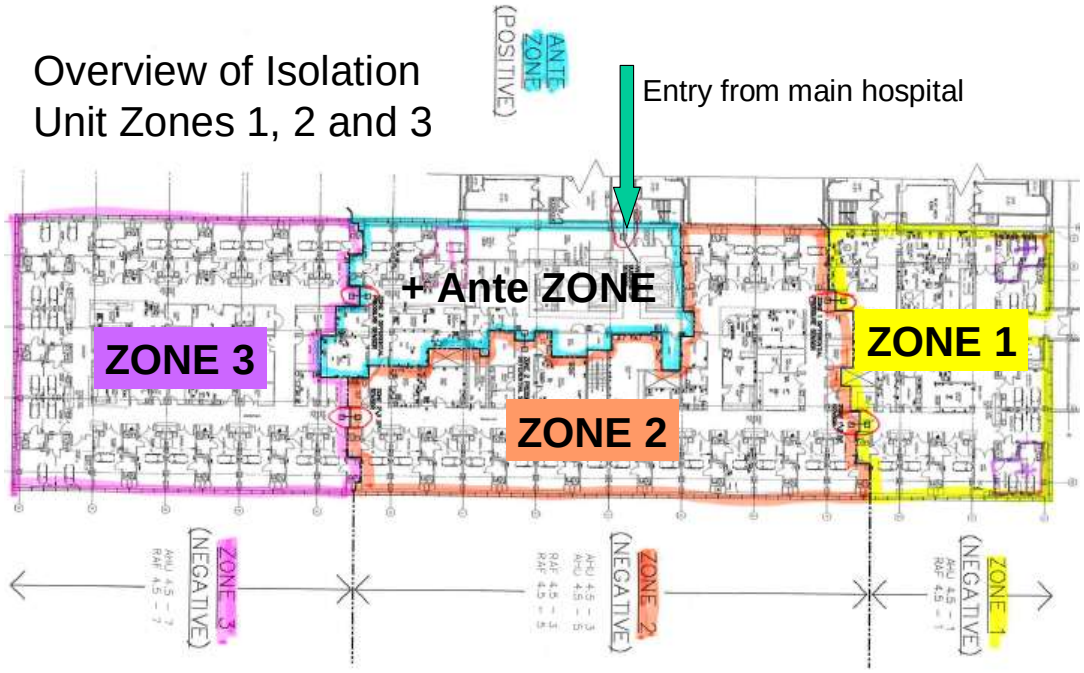
APPENDIX A, Code Navy Isolation Plan

Activation of the three isolation zones of negative pressure on 5 East is at the direction of the hospital Incident Commander (or designee) to the Facilities Control Room at ext 6040. The first zone to be activated is Zone 1. The facilities department will send a staff member up to smoke test all doors surrounding the zone to ensure it is in negative pressure. Staff on 5 East will close all doors to Zone 1, and flip all door signs to reveal isolation instructions. Central Supply will send the Isolation Cart up to Zone 1 upon announcement of "Code Navy Isolation Plan, Zone 1, is now in effect" as directed to the hospital operator by the Hospital Command Center (HCC).

The HCC will coordinate with nursing to relocate existing patients in Zone 1 to other beds within the hospital, or emergency discharge as appropriate. Nursing will also coordinate to redistribute staffing as needed to cover relocated patients and incoming isolation patients. Once confirmation is received in the HCC that current patients have been relocated, isolation patients arriving via negative pressure in decon showers can be brought to Zone 1 via the Decon elevators.

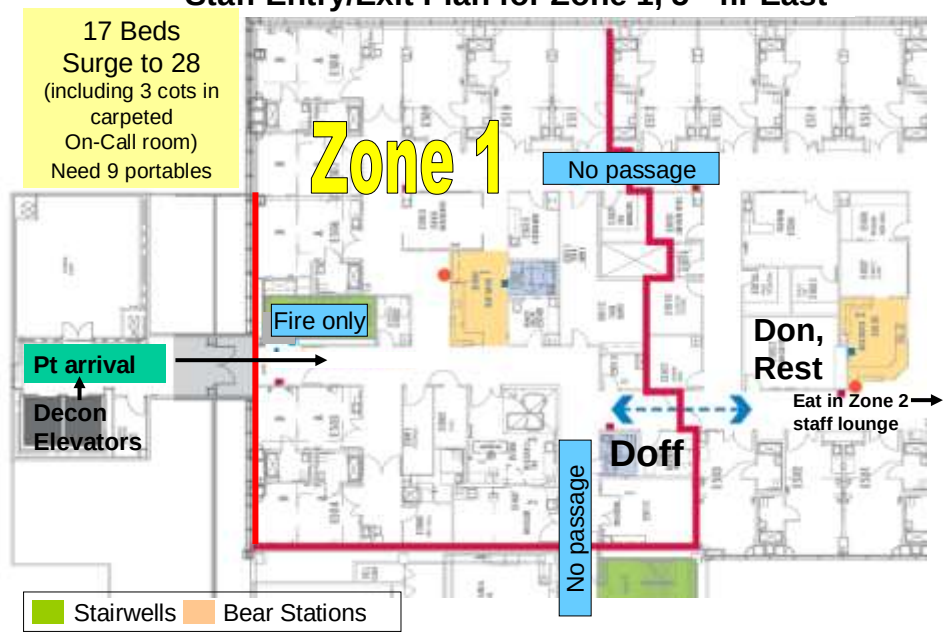
The above two paragraphs are repeated for activation of Zones 2 and 3 (respectively) as the volume of isolation patients arriving dictates.

The following floor plans show authorized entry/exit points, locations for staff to don and doff their PPE, locations for staff resting/eating/sleeping, and location for temporary isolation of any staff member who exhibits symptoms suspect of infection with the agent for which isolation is being conducted. Unless there is a fire in 5 East, the existing fire egress doors that are not indicated as primary entry/exit points should NOT be used as normal routes to and from the isolation units. Should a fire occur in the isolation unit, precautions to prevent the spread of infection should be taken as persons in the affected smoke compartment are evacuated to the adjacent smoke compartment under negative pressure. If evacuation due to a fire/smoke needs to occur vertically, precautions must be taken to prevent the spread of the infectious agent when moving to NON-isolation areas in the floors below 5 East.

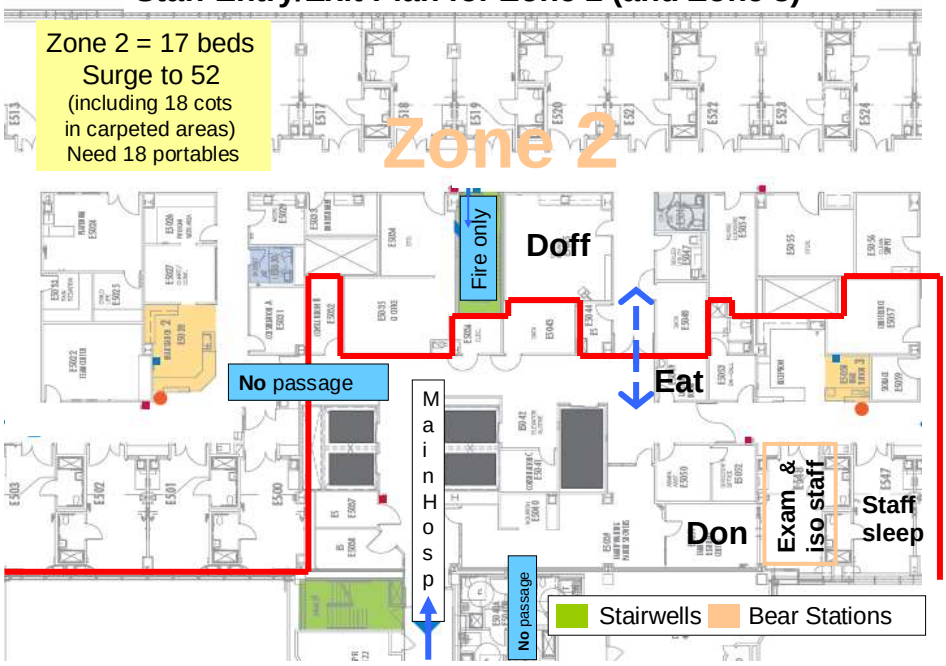


Note: Decon Building is adjacent to and below Zone 1, this is the point where patients enter the building under negative pressure, are screened by the ED for evidence of pandemic/epidemic illness, and if needed, then masked and transported to Isolation Zone 1 on 5 East.

Staff Entry/Exit Plan for Zone 1, 5th flr East

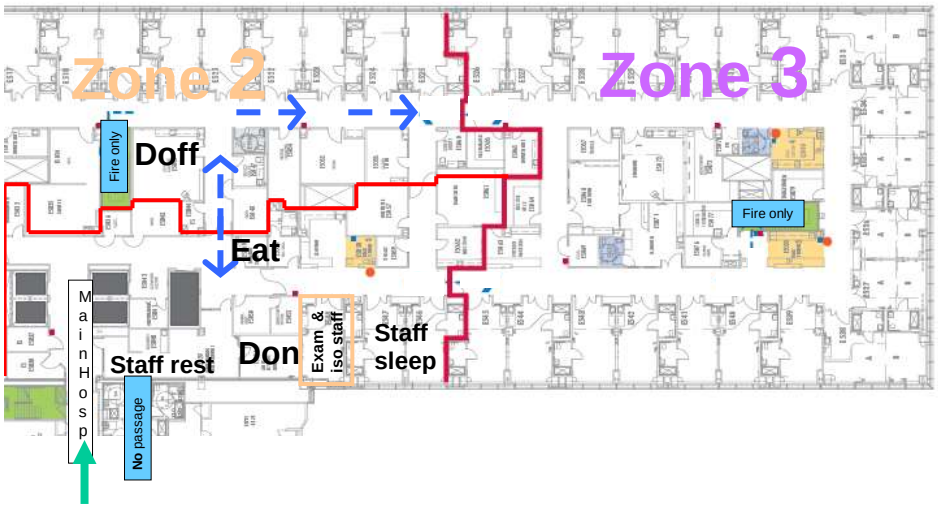


Staff Entry/Exit Plan for Zone 2 (and Zone 3)



Staff Entry/Exit Plan for Zone 2 & 3

Zone 3 = 26 beds
Surge to 52
(including 6 cots in carpeted areas)
Need 11 portables



Demobilization will occur at the order of the hospital Incident Commander as the volume of isolation patients decreases during response. Normally, this will occur by closure of Zone 3 for terminal cleaning followed by return of the air handling system to normal conditions. As patient volume further decreases Zone 2 will be closed, terminally cleaned and returned to normal conditions, then finally Zone 1 closes, is terminally cleaned and returned to normal conditions.