SAFETY POLICY AND PROCEDURE MANUAL

CATEGORY: Safety Practice **Policy No: DRAFT 11/30/01**

SUBJECT: MEDICAL DISASTER PLAN

I. POLICY

Johns Hopkins Community Physicians (JHCP) is committed to ensuring safe and effective care processes in the event of a disaster that affects JHCP patients, employees, the surrounding community, and/or Johns Hopkins Health Systems (JHHS) affiliates.

Role of JHCP in medical Disasters – In collaboration with JHHS and the Department of Health and Mental Hygiene (DHMH), JHCP will provide the following aspects of patient care during a medical disaster:

1. Disease Surveillance (attempt to provide early identification of trends or patterns of symptoms or diagnosis to alert public health officials of a possible biological or chemical terrorism event or outbreak of communicable disease)
2. Triage, basic decontamination, and symptomatic/supportive care of patients while awaiting transport to Designated Facilities via 911
3. Post exposure prophylaxis, treatment, and/or vaccination of patients and health care workers
4. Function as an ambulatory treatment center for less acute patients re-routed from other centers or the JHHS

During a Medical Disaster, all JHCP personnel are expected to remain on duty until otherwise notified. If not on duty personnel will remain available for assignment, and accept re-assignment as needed. Each staff member should have an emergency plan for dependent care situations.

II. PURPOSE

To outline the procedures for declaring Medical Disaster status, the roles and responsibilities of personnel, and the procedures to be followed during a medical disaster.

III. DEFINITIONS:

A. **Medical Disaster** - any occurrence in a JHCP practice site, the JHHS, or surrounding community that endangers patients or employees. A medical disaster requires evacuation or results in an influx of patients of such high volume, or so potentially hazardous to other patients and staff, that routine operations are disrupted. Examples include, but are not limited to, biological terrorism attack, influenza pandemic, mass inhalation of gases or chemicals, natural disaster, structural collapse, civil disturbance, acts of war.

B. **Bioterrorist Attack** - a deliberate act by a group or individual to disseminate an infectious agent to a large number of unsuspecting persons.

C. **Cohorting** – the act of grouping patients and/or healthcare workers with like syndromes or illness in geographical designated areas to limit spread of contagion.

D. **Covert Attack** – unannounced or concealed acts of terrorism resulting in persons presenting with nonspecific signs and symptoms.

E. **Overt Attack** – known acts of terrorism that result in large numbers of individuals requiring triage and possible treatment. Overt attacks are generally chemical or explosive in nature.

F. **JHCP Disaster Control Team (DCT)** – Coordinates response to Medical Disaster and is comprised of the following individuals or their designees:

-President / Chief Executive Officer
-Vice President of Medical Affairs
-Senior Director of Clinical Operations & Performance Improvement
-Director of Corporate Services

The Disaster Control Team (DCT) may be expanded to include representatives from various departments including but not limited to:

-Manager of Materials Management
-Manager of Facilities
-Corporate Safety Officer
-Director of Performance Improvement/Risk Management

III. PROCEDURE:

A. Administrative Coordination of Response

1. Recognition and Confirmation of Medical Disaster: It is the responsibility of all personnel to report any suspicion of a medical disaster to the Corporate leadership. A credible or confirmed notification made by law enforcement, government agent, or JHHS will provide verification that a medical disaster has occurred.

   Medical Disasters may include:

   a. Mass Trauma Casualties such as:

   - Explosion
   - Weather Emergencies
   - Large scale traffic Accidents
   - Earthquake

   b. Bioterrorism / Infectious Disease Epidemic

   Biological agents are usually not immediately detected. There is a delay between exposure and onset of illness known as the incubation period. The incubation period may range from several hours to a few weeks. Therefore, the initial response to a biological attack on civilians is likely to be made by direct patient care providers.

   1. Clinical indicators of a potential bioterrorism attack include:

   - Recognition of a suspect case of a highly infectious agent known to be associated with biological warfare (e.g. smallpox or pneumonic plague)
   - An unusual number of people seeking care, especially with fever, respiratory, or gastrointestinal complaints. A high level of suspicion will be maintained for cases of gastroenteritis, pneumonia with sudden demise in previously healthy adult, severe respiratory illness in young, previously healthy patients

     wide mediastinum on chest x-ray in a febrile patient with no other source, rashes of synchronous vesicular/pustular lesions, cranial nerve impairment with weakness, acute neurological illness with fever
   - An epidemiologically sound rationale (i.e. the presence of a larger epidemic, clusters of patients arriving from a single locale or more severe disease than would be expected in a given population)

providing suspicion that a bioterrorist attack has occurred

- Identification of a disease that is unusual for a given geographic area or seasonal pattern
- A more severe presentation of disease than would be expected for a given pathogen
- Failure of a common disease to respond to usual therapy

2. Environmental indicators can include:

- Spraying or suspicious devices or packages (see Attachment)

c. Chemical Terrorism Attack

Chemical agents will likely demand immediate reaction from EMS. Most chemical events will be localized and their effects will be evident within a few minutes.

1. Illness-related indicators of a chemical terrorism attack include:

- Large numbers of persons experiencing water-like blisters, weals or rashes
- Unexplained casualties: serious illness, nausea, vomiting, diarrhea, disorientation, difficulty breathing, convulsions
- Mass casualties without obvious trauma
- Odor on patient and/or obvious liquid contamination

2. Environmental indicators can include:

- Unusual occurrence of dead or dying insects or other animals
- Unscheduled spraying of an area
- Droplets, oily film, unexplained odor, low-lying clouds or fog unrelated to weather

- Unusual metal debris, abandoned spray devices, unexplained munitions

- Explosions

d. Radiation Exposures

.1 Nuclear Power Plant Accidents

.2 Nuclear Weapon Use

2. Activation of Medical Disaster Plan: Full activation of the Medical Disaster Plan will occur upon official notification from JHHS, or via the stepwise procedure below:

a. Administrative alert of DCT: Rule – out phase, clarification of the nature and scope of the disaster.

•Any JHCP employee suspecting that a potential previously unconfirmed Medical Disaster has occurred must notify the Senior Director of Clinical Operations and Performance Improvement or her designee at pager 410-283-2075 (24-hour coverage). The suspicion will be investigated to determine credibility. If the report appears credible the Disaster Control Team (DCT) will then be activated in collaboration with JHHS, Local Health Departments, and the FBI.

•A credible or confirmed notification made by law enforcement, government agent, or JHHS will verify that a medical disaster has occurred.

b. Full Activation of Medical Disaster Plan (agreement between JHCP Disaster Control Team, JHHS Disaster Control Administrator, DHMH, FBI, or other agencies as appropriate)

c. Emergency Telephone Chain: Once the Medical Disaster Plan has been fully activated, the Emergency Telephone Chain (alpha pager) will be initiated to notify all practice sites and departments. Confirmation of notification is required (see Attachment #). Upon notification that the disaster plan has been implemented, all Practices Administrators and Department Directors will maintain a dedicated PC for email communication & a dedicated phone extension for communication with the DCT. They must notify their staff as instructed, including those off duty if advised to do so by the DCT.

d. Command Center: The DCT will assemble in the Command Center which will be established at Wyman Park Medical

Center, 3rd floor, Office of the President, room 340. In the event that the disaster prohibits the use of this site, the Disaster Control Team (DCT) will designate an alternative location.

3. Leadership and Authority: The DCT will maintain authority in the execution and daily operation of the disaster plan throughout its duration in collaboration with JHHS, DHMH, and the Federal Bureau of Investigation (FBI).

   a. The Vice President of Medical Affairs and Senior Director of Clinical Operations & Performance Improvement or their designees will coordinate the clinical response to the disaster.

   b. The President and Chief Executive Officer and Director of Corporate Services or their designees will mobilize the non-clinical response to the disaster.

   c. Practice Administrators and Department Directors will provide leadership within the individual practices and departments under the authority of the DCT.

4. Staff Briefing:

   a. Multiple briefings will be sent from the DCT with priority status via email to MSCall to allow for continuity of information. Email communication may also be received from JHHS. The Practice Administrator is responsible for ensuring that all staff at his/her practice site are familiar with the information provided in the briefing. Department Directors are responsible for ensuring that all staff in their departments are familiar with the information provided in the briefing. If email communication is disrupted, staff briefings will be channeled through the leadership briefings as described below.

   b. Leadership briefings will be sent to all Regional Medical Directors (RMD's), Regional Directors of Operations (RDO's), Department Directors, Site Administrators, Practice Administrators and Office Medical Directors via priority status email or telephone and will occur based on the frequency of new information.

B. Roles and Responsibilities

1. President / Chief Executive Officer, Vice President of Medical Affairs , Senior Director of Clinical Operations & Performance Improvement, Director of Corporate Services: Serve as members or the DCT (see page).

2. RDO's, RMD's, Site Administators, Practice Administrators, Office Medical Directors and Department Directors will:

a. communicate information from the DCT, DHMH, or other resources to the staff at the practices and in the departments, including off duty staff if advised. Use "Health Department Advisory Documentation Form to ensure that specific, appropriate information is obtained – (Attachment # __).

b. assemble at practices as directed by the DCT.

c. prepare lists of available personnel, supplies, equipment, pharmaceuticals to be made available to the DCT, JHHS or DHMH or to indicate what is needed at the practice sites.

d. oversee infection control practices, including cohorting process. (Attachment #)

e. designate staff for the following roles and oversee the implementation of operational and clinical processes as directed by the DCT:

1. Patient Reassignment Personnel
   a. Clinical – Triage scheduled patients for cancellation, reappointment, or redirection to another practice, Emergency Department or Urgent Care Center.
   b. Clerical – Contacts patients for reappointment, redirection, or cancellation.
2. Triage Nurse
   a. Telephone
   b. Walk-In
3. Equipment & Supply Coordinator- Obtain needed equipment and supplies
4. Site Safety Officer – Coordinate security issues and Heating, Ventilation, and Air Conditioning (HVAC) issues.
5. Cohorting staff (see Attachment#)

3. <u>Site clinical personnel :</u>

a. MD's, PA's, CRNP's, RN's, LPN's, CMA's

1. Under the direction of the Practice Administrators and Office Medical Directors assume one of the following roles as appropriate to their credentials (see descriptions above):

   a. Clinical Patient Reassignment Personnel

   b. Telephone or Walk-In Triage Nurses

   c. Cohorted staff (see Attachment #)

   d. Equipment and Supply Coordinator

   e. Site Safety Officer

   f. Clinical Patient Care

2. Ensure appropriate infection control practices including cohorting (see Attachment #) process.

3. Inform Practice Administrators of personnel, supplies, equipment and pharmaceuticals that are available or may be needed.

b. Lab technicians, Radiology technicians

1. Assist in obtaining, preparing, and packaging specimens, perform testing as requested by providers. Maintain specimen cohorting and logging if necessary.

4. Site non-clinical personnel:

a. Medical Office Assistants (MOA's) – Act as Clerical Patient Reassignment Personnel, answer phones, provide information on appointment availability.

b. Social Workers - Assist in phone calls to patients and staff, be available to establish rest and recuperation areas for staff, coordinate crisis response efforts with JHHS Critical Incident Stress Services, Pastoral Care and Psychiatry. Provide staff, patients and family members with emotional support, demobilizations and disaster counseling.

c. Medical Records Staff - Arrange access to medical records and assist in transfer of records.

5. Non-clinical personnel, corporate

a. Marketing / Corporate Communications:

1. All outside requests for information will be routed to the JHCP Director of Marketing and Corporate Communications who will coordinate the public relations aspects of the disaster with JHHS. Corporate Communications staff will assist in supporting phone system changes as needed, such as re-routing Automated Call Distribution System, reprogramming recorded messages, forwarding lines to other locations, or setting up phone banks if necessary.

b. Information Systems: Provide necessary technological support.

c. Human Resources: Coordinate essential employee relations issues and workplace issues.

d. Corporate Services- provide and transport equipment, supplies, and pharmaceuticals as necessary. Transport staff as needed. Assess HVAC needs. Build barriers to

facilitate patient cohorting and decrease unauthorized access to practices.

e. Safety officer: Evaluate safety of environment including suspicious mail. Ensure appropriate use of personal protective equipment.

f. Clinical Operations: Assist in emergency contact chain, provide support to DCT.

g. Business Office: Be available to assist in making, receiving phone calls

h. Credentialling: Be available to assist in making, receiving phone calls

i. BayMeadow Groups:

- Customer Service
- Care Management
- Disease Management
- Contracts
- Provider Relations

6. Clinical personnel, not assigned to direct patient care

   a. RN's in Performance Improvement: Be available for phone bank, clinical duty as appropriate, Risk manager to communicate with JHH legal department as needed.

   b. After Hours Triage RN's: Be available for daytime telephone triage if necessary.

7. Security: Assist in evacuating patients, restrict access to authorized individuals, control traffic flow, ensure unidirectional flow in triage centers, support cohorting and quarantine efforts.

8. Employee Health: Coordinate general staff prophylaxis, post-exposure prophylaxis, treatment and vaccination for staff, liaison for staff infection control protection. Act as liaison with FASAP for employee emotional / mental health support.

9. Pharmacy Director: Coordinate pharmaceutical resources, act as resource to providers on pharmaceutical issues.

C. Operational and Clinical Response to Medical Disasters

1. Administrative Coordination of Response (see p.) includes recognition and confirmation of Disaster, notification of leadership and activation of the DCT.

2. Once activated, the Disaster Control Team (DCT) will:

a. activate the Emergency Contact Procedure (Attachment #)
b. assemble at the Command Center (see page)
c. initiate notification to the JHHS.
d. verify all necessary calls to DHMH, Centers for Disease Control (CDC), FBI, public relations, etc. have been made or make these call as appropriate
e. make decisions for operations based on collaboration with DHMH, JHHS, FBI or other agencies as appropriate.

- advise practices on reassignment of staff
- advise practices on reassignment of patients
- advise practices on operating hours

f. make decisions for clinical care guidelines if necessary based on collaboration with DHMH, JHHS, or other agencies as appropriate.

- advise providers on most current treatment guidelines, including prophylaxis for communicable diseases
- advise practices on surveillance activities
- advise practices on decontamination, triaging, and disposition of patients

g. determine "status" of practice sites based on nature, scope, and location of disaster in collaboration with JHHS, DHMH, and other appropriate organizations. Status designations include:

1. **Status RED Practices**: Practice Sites geographically located near the occurrence of the attack / event and expected to actually encounter victims of the disaster. These practices will have priority for resources and may be asked to redirect patients away from the practice site.
2. **Status GREEN Practices:** Practice Sites that will remain open but are not expected to encounter actual disaster victims. These practices will be on alert to possibly receive patients re-directed from Status RED or closed JHCP practices, from the JHHS affiliates, or other sources as designated by JHHS and DHMH. These sites may also be used to provide post exposure prophylaxis or vaccination to patients, health care workers and/or their families.
3. **Closed Practices:** Practice Sites located in an area too dangerous to remain open or so distant from the source of need that it is in the best interest of the public and staff to close and re-deploy staff and equipment elsewhere.

h. communicate decisions to RMD's, RDO's, Department Directors, Practice/Site Administrators, and Office Medical Directors
i. coordinate sharing of resources with JHHS, DHMH, and other appropriate organizations.

1. JHHS and/or DHMH may need to deploy clinical and support staff, supplies, equipment, and pharmaceuticals to assist JHCP practices in providing the predetermined level of care.
2. JHCP sites may need to provide clinical and support staff, supplies, equipment, and pharmaceuticals to assist JHHS and /or DHMH if necessary.
3. Shuttle transportation of personnel within JHHS will be arranged by JHHS affiliates.

j. prepare periodic reports to JHHS, DHMH, or other organizations.
k. coordinate security needs with Broadway Services, Inc. (BSI).
l. de-activate Medical Disaster Plan when indicated.

3. Patient Reassignment:

a. Status Red Practices and Closed Practices:

- To maximize resources available for treatment of disaster victims, these practices may need to evaluate and possibly re-direct patients who are not disaster victims, or in the case of Closed Practices, all patients.

- If the DCT determines patient reassignment to be necessary, all previously scheduled patients will be evaluated by Clinical Patient Reassignment Personnel and contacted by the Clerical Patient Reassignment Personnel.

- According to their medical needs, these patients may be redirected to other practices, Urgent Care Centers, or Emergency Rooms to be seen that day. Patients who do not need same day appointments will be advised to call for f/u within the clinically appropriate time frame. Alternative phone numbers may be provided for f/u at other practice sites.

- Phone re-routing or changes in messages should be employed to assist in automating the operational management of incoming calls.

- If patients are redirected to designated centers either via 911 or their own transport, be advised of the appropriate infection control practices that must be employed during transfer (see attachment)

Emergency transport personnel and the receiving facility must be notified that the patients are being sent.

- Documentation regarding redirected or reassigned pts must be maintained.

If Bioterrorism Event or Contagious Disease Epidemic:

If the disaster involves communicable disease victims, immediately remove all patients without symptoms of the disease out of the practice, if medically appropriate, prior to the arrival of any victims. If potentially contagious disaster victims have already arrived, other patients and staff at the practice may need prophylaxis or quarantine. The DCT and DHMH will provide guidance in this

situation. Access to the practice must be strictly limited, signs placed on the doors, and phone systems modified to inform patients of the situation.

Status GREEN Practices:

- Practices not expected to receive disaster victims may need to prepare to treat non-disaster victims re-directed from **Status RED** Practices, **Closed Practices** or from the JHHS affiliates.
- If the DCT confirms that redirecting patients is necessary, existing pt schedules must be immediately evaluated and patients reassigned based on medical need by **Clinical Patient Reassignment Personnel**. Patients will be contacted by **Clerical Patient Reassignment Personnel** and informed of reassignment.
- If patients are redirected to designated centers either via 911 or their own transport, be advised of the appropriate infection control practices that must be employed during transfer. (see attachment)

Emergency transport personnel and the receiving facility must be notified that the patients are being sent.

- Documentation regarding redirected or reassigned pts must be maintained

4. Infection Control Practices

Standard precautions shall be utilized with initial contact of all patients, regardless of the nature of the disaster. When in doubt, use maximum protective apparel.

In the event of a bioterrorism attack or epidemic the following should also be observed:

- Any patient with respiratory symptoms or vesicular rash shall be placed in a surgical mask Biological agents requiring ONLY standard precautions include anthrax, botulism, brucellosis, Q-fever, tularemia

- Biological agents requiring mandatory masks, gloves, and gowns, isolation of waste and no sharing of patient equipment include plague, smallpox. (See Attachment # [table from JHH's policy])

- Cohorting / If the suspected agent is contagious (i.e. smallpox, viral hemorrhagic fevers [Ebola or Marburg], pneumonic plague), it is imperative that patients be cohorted geographically and isolated appropriately. See attachment #

5. Triage

Patients will be triaged either in person or by telephone, per JHCP policies, in keeping with the nature and scope of practice within our organization, patients requiring care beyond the scope of JHCP should be given basic supportive care and be quickly transferred to a facility capable of managing the patient. In the event of a Medical Disaster, these standards may be altered based on feedback from DHMH or other.

In the event of a bioterrorism attack, contagious disease epidemic, chemical or radioactive material exposures the following procedures may be required:

1. Walk-In Triage: Status RED Practices: Practices expected to encounter victims of contagious diseases should be prepared to implement the following process if directed by the DCT:

- A Walk –In Triage Nurse with the appropriate personal protective equipment (PPE) will await patients outside the main entry door, decontaminate if appropriate, and redirect them to the appropriate level of care (see Attachment # for personal protective equipment). If suspect symptoms indicate a potentially contagious disease a surgical mask is immediately placed on the patient by the Walk-In Triage Nurse outside of the practice site and will be transferred to an appropriate facility.

If the scope of the disaster is so large that these facilities or the resources to transfer patients to these facilities are overwhelmed it may be necessary to provide some further level of care to these patients. In this extreme scenario a cohorting system would need to be implemented at our Status Red Practices (see Attachment #).

2. **Telephone Triage:** Telephone triage guidelines will be provided to all practices and to the After Hours Triage Department by the DCT. Re-routing of incoming calls to phone banks, status green practices or modification of phone messages may be required.

6. <u>Decontamination:</u>

1. **Bioterrorism:**

•Victims of overt exposure to a bioterrorism event will need decontamination. If a patient has come in contact with a powdery substance or spray that give reasonable suspicion of being a bioterrorism exposure, they should be considered contaminated and an exposure risk to staff. If their medical needs are not urgent or emergent, if possible, they should be kept outside of the practice site and decontamination should not be attempted in this case. These patients should be re-directed to a designated facility as directed by DHMH and DCT. Law enforcement and the receiving facility must be notified.

•Victims of overt exposures to bioterrorism events are considered decontaminated if they have showered and are wearing clothing that was not involved in the exposure or that has been laundered since the exposure. These patients pose no contamination risk to staff.

• Victims of covert exposures to bioterrorism events are considered decontaminated if they have showered within the past 48 hours and are wearing clothing that has been laundered since last worn. These patients pose no contamination risk to staff.

• If a patient potentially contaminated with a bioterrorist agent does present to a practice site in need of urgent or emergent care, decontamination will be necessary:

1. If possible, the patient should be kept outside of the practice site while decontamination takes place

2. Full personal protective equipment should be worn by staff, including N95 respirator at minimum, and impervious gowns and gloves and face shields
3. All clothing should be removed from the patient and placed in a hazardous waste bag.
4. The patient should be irrigated with clean water. A clean, large trash bag may be used to cover the patient during this process.
5. All trash should be double bagged and handled in a way that minimizes aerosolization. Wear a mask when tying full bags.

2. **Chemical incidents:**

a. Keep pt outside to decontaminate – vapors could pose a hazard to staff and patients inside. Liquid or aerosolized chemicals can pose a dermal threat and must be removed from the patient rapidly. Consider airflow – staff should remain upwind.

b. Use impervious gowns, face shields, heavy-duty chemical gloves and masks. Staff should avoid contact with any liquid contamination – standard gloves may not provide protection.

c. Remove patient clothing and seal in plastic bag. Decontaminate patient with water. DO NOT use bleach or other caustic substances on the skin.

d. Isolate any body fluids in closed containers (toxic vapors could be emitted)

3. **Radiological incidents:**

Patients who have been exposed to radioactive material can safely be decontaminated in the same manner as for a chemical exposure. Once decontamination has taken place the patient poses no risk to staff. Patient's bodies will not be radioactive after decontamination.

7. <u>Treatment of Patients</u>

a. Patients will be provided with symptomatic, supportive care within the scope of practice at JHCP under the direction of the DHMH. Patients in need of care outside of this scope will be re-directed, under the guidance of DHMH, to the appropriate facility. For detailed medical management of victims of bioterrorist events or chemical events refer to USAMRIID handbooks. A summary of treatment guidelines for bioterrorism events is included in attachment # . A summary treatment guide for victims of radiological events is found in Attachment # .

b. Specimen Handling: Diagnostic specimens as determined by DHMH shall be sent to the appropriate facility to confirm the suspected diagnosis and determine antimicrobial susceptibilities when appropriate. Follow health department directions on obtaining, preparing, and transporting diagnostic samples. (Attachment#---- documentation guidelines) In general, all specimens should be placed in double

bags, transport personnel and the receiving laboratory must be notified. For on-site waived testing, contact Disaster control Team for guidelines. The Disaster Control Team will provide information on priorities regarding antibiotic prescribing.

3. Management of Deceased: Contact the Disaster Control Team or DHMH for specific guidelines

8. Staff prophylaxis

Occupational Health will direct any immunization or prophylaxis of staff based on priorities set by DHMH and JHHS (likely to include all staff, not only those cohorted). See Attachments ___ & ___ for disease specific isolation guidelines and prophylaxis. Rest breaks will be provided but staff may not leave cohorted area.

9. Cleaning, Disinfection and Sterilization of Equipment and Environment.

1.Standard procedures shall be used to clean and sterilize patient-care equipment and environmental control of the organism (see Attachment #). Surfaces shall be wiped down with bleach solution. Consult DCT or DHMH for questions.

2. Medical Waste Management

All medical waste will require incineration and shall not be crushed to limit the possibility of aerosolization of disease particles. Once an organism has been identified further waste management instructions will be given. Consult DCT or DHMH for questions.

COHORTING

In the case of a bioterrorism attack, if the suspected agent is contagious (i.e. smallpox, viral hemorrhagic fevers [Ebola or Marburg], pneumonic plague), it is in the best interest of our staff and the public to have the patient re-directed to a facility capable implementing the appropriate infection control measures. This may involve the need for HEPA N100 filter respirators, staff properly fitted and trained in the use of these respirators, negative air flow rooms, and cohorting facilities.

If the scope of the disaster is so large that these facilities or the resources to transfer patients to these facilities are overwhelmed it may be necessary to implement a cohorting system at our Code Red Practices. The following are guidelines of how to set up cohorting at a practice site. Guidance in these cases will be provided by the DCT and DHMH.

If Cohorting of patients is necessary the practice should be closed to all other patients. Only one entry to the practice from the outside should be accessible.

Cohort patients who present with similar syndromes, i.e., group affected patients into a designated section of the practice site. All healthcare workers caring for these individuals and the equipment /supplies used on them shall also be cohorted.

All communication to and from this area should be made via telephone so that the door is opened as little as possible. An area distant from the Cohorted Area should be designated for non-cohorted staff to assemble. HVAC systems must be turned off to lessen potential spread of the infectious agent.

Appropriate protective equipment, including fitting and training on use of respirators is necessary. Safety officer will provide “just-in-time” training if necessary.

Cohorting Areas ideally would have the following capabilities:

- closed off to the rest of the practice site
- located near an outside door which shall be used for egress of those patients
- have a restroom
- have a telephone

The following Designated Staff roles will be necessary:

- **Walk –In Triage Nurse** - will await patients outside the main entry door, place a surgical mask on the patient and decontaminate if necessary (see Attachment #)
- **Cohorted Provider & Support Staff** – Remain in cohorted area to treat contagious patients.

- **Cohort Circulator** – Remains immediately available by telephone to the cohorted staff to provide communication and transport equipment and supplies. A predetermined phone extension should be identified for this purpose.

- **Cohort Escort** – Escorts potentially contagious patients from outside triage station to Cohorting Area.