

Minimum Care Facility
Concept of Operations
North Dakota Department of Health
MINIMUM CARE FACILITIES CONCEPT OF OPERATIONS
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I. Purpose:

- To define a model for alternative inpatient care for short term use in the setting of pandemic influenza
- To provide a guide for community planning for implementation of the alternative model
- To identify resources likely to be needed during the operation of a minimum care facility.

II. Definitions:

Minimum Care: Minimum care includes hygiene, nutrition and hydration, if necessary by use of minimally invasive procedures including intravenous fluids or nasogastric tubes for hydration.

Minimum Care Facility: A minimum care facility (MCF) is defined, for purposes of this document, as a community operated inpatient facility for contagious patients which provides supportive care for patients requiring hospitalization, for whom no hospital access is available. Care will be consistent with minimum care as defined above. In addition, care above and beyond minimum care will be provided as time, expertise and resources permit. An MCF is not a substitute for a hospital, but an ancillary site that provides such care as it can until the private health care system is able to resume all care.

Maximum surge: Hospital surge above maximum capacity achieved by compromise of quality of care, up to the point at which further compromises in quality will result in approximating minimum care.

Professional Health Care Staff: Physicians, physician assistants, registered nurses, licensed practical nurses or paramedics acting as medical care supervisors within an MCF.

III. Indications for use:

An MCF will be opened during a sustained pandemic when the number of persons requiring inpatient care exceeds hospital maximum surge capacity. In a non-generalized disaster in which the re-distribution of excess inpatients outside the community or outside the state was possible, an MCF will not be indicated. The facility will only be open long enough to provide care until the private medical care system can absorb all inpatient care. An MCF will supplement hospital care, not replace it. During the time that an MCF is open, hospitals will continue to operate at maximum surge capacity.

IV. Authority:

An MCF is expected to only be operational during a state emergency declaration (ND 37-17.1). Provisions of a state emergency declaration include:

All functions hereunder and all other activities relating to emergency management are hereby declared to be governmental functions. Neither the state nor any county or city or its departments and agencies, or any disaster or emergency worker complying with or reasonably attempting to comply with this chapter, or any executive order or disaster or emergency operational plan pursuant to the provisions of this chapter, or pursuant to any ordinance relating to any precautionary measures enacted by any county or city of the state, except in case of willful misconduct, gross negligence, or bad faith, is liable for the death of or injury to persons, or for damage to property, as a result of any such activity. This section does not affect the right of any person to receive benefits to which that person will otherwise be entitled under this chapter, or under workforce safety and insurance law, or under any pension law, nor the right of any such person to receive any benefits or compensation under any Act of Congress.

An MCF will be established under the authority of the state. The conditions under which the NDDoH DOC will authorize the opening of an MCF in a local area are stringent since the quality of care in such a facility will be much below the care offered by a hospital, even during maximum surge conditions. According to criteria defined in other state planning documents, before an MCF will be considered a viable option, health care facilities must have done everything reasonably possible to accommodate all healthcare needs, including

compromising quality of care in order to expand the number of patients receiving care. The exception to this is the opening of a facility specifically for the provision of assisted care to open up additional space in a hospital for the acutely ill.

In an MCF organized under the authority of the DOC, all persons working in the facility will be considered to be working under the authority of the State of North Dakota and covered by state tort protections. Although a decision by the DOC not to open an MCF would not legally preclude local government authorities from opening a facility independently, since state resources will be expected to support an MCF (e.g., medical supply cache), it is expected that all MCFs will be operated with the mutual agreement of state and local incident command under the authority of the NDDoH DOC.

V. Hospital Responsibility for MCF Management

A hospital will not be responsible for managing or staffing an MCF; however, at the time a new MCF is opened, the DOC will associate the facility with a single nearby hospital solely for the purposes of patient allocation between hospital and MCF. The medical director of the MCF will receive patients from the hospital or transfer patients to the hospital according to the direction of the incident commander for the hospital (or designee). In turn, the incident command of the hospital will depend on the medical director of the MCF to:

- Determine which patients in the MCF will benefit from movement from the MCF to a hospital bed when space became available;
- Evaluate patients for admission to the MCF who arrived at the MCF from the community;
- Discharge from the MCF to the community; and,
- Brief the incident commander for the hospital (or designee) on the availability of space within the MCF on a regular basis so that priority for beds in the MCF will go to patients being transferred from the hospital.

If additional minimum care space is needed, the hospital will contact the DOC and request to move patients to an MCF not affiliated with that hospital.

VI. Planning Scope:

The planning scope for this document is to provide for accessory inpatient care for 5000 patients in multiple facilities of varying sized dispersed across the state.

VII. Community and State Dependencies:

An MCF is a collaborative effort between community, hospital, and state and local public health; NDDoH will not attempt to open and operate an MCF in the absence of support from local hospitals and community. No single agency will have the capacity or expertise to manage an MCF without the assistance of partners.

VIII. Command and Control:

Command and control of the MCF will be dependent on three levels of supervisory authority as follows:

- NDDoH Department Operations Center
 - Authority to open or close and MCF facility
 - Establishment of parameters of expected care
 - Provision of medical supplies
- Local hospital Operations Center
 - Allocation of inpatients between hospital and MCF
- Local emergency operations center
 - Logistical support
 - Operational support, including staffing

It is not intended that these represent distinct, non-overlapping authorities; rather they indicate the source of primary or first responsibility.

IX. Staffing of an MCF:

An MCF will have minimal professional health care staffing. It is recommended that for a facility with 120 patients, two professional health care staff be assigned (MD, PA, ARNP, RN, LPN, Dentist, Paramedic), to rotate 12 hour shifts (with a third professional available for substitution). Where possible, it is recommended that at least one health care professional be a physician. Professional staffing should not be drawn from the hospital; all hospital care providers will be used to maximally expand care in the hospital where care will be superior to that provided in an MCF. Sources of professional staff include licensed personnel who are retired, in administrative roles or who are not employees of a hospital. In addition, the MCF should have an arrangement with the hospital to use ER medical staff on a consultative basis as needed.

All other staff at an MCF can be non-professional staff. The number of non-professional staff needed will depend on the patient load, but must be sufficient to provide care consistent with minimum ethical standards. Volunteers working in pairs will be expected to care for 40 individuals per two person team (staffing ratio 1:20). This will require a minimum of 12 volunteers per 24 hours (plus alternates), with all staff working 12 hour shifts. The facility director will communicate with incident command and the local hospital regarding his or her assessment of the facilities capability of exceeding the 1:20 ratio. In the absence of any alternative (e.g., no additional MCF can be used or created), the director may expand care to greater than 1:20, but must determine the point at which the facility can no longer expand care.

In order to provide state tort coverage, all volunteers need to be registered with the Public Health Emergency Volunteer Reserve (PHEVR) and rosters of workers working each shift would need to be maintained. All volunteers should also be registered with state workers compensation.

X. Scope of Care:

An MCF will potentially admit any patient who requires inpatient care, regardless of severity; however, the threshold for admission may vary during the course of the pandemic as pressure for care increases.

An MCF will not accept:

- 1) Patients who have a home care provider and are able to take fluids orally;
- 2) Patients without pandemic influenza;
- 3) Patients with low probability of survival if bed space is limited; or,
- 4) Patients from a long term care facility.

Patients might enter the MCF by:

- 1) Transfer from a hospital;
- 2) Referral from clinic;
- 3) Arrival by ambulance; or,
- 4) Arrival by private vehicle.

Admission to the MCF will not be based on a patient's or family's gender, creed, nationality, religion, documentation status, economic status or any other socio-economic status.

Care provided by an MCF will include:

- Hydration, orally if possible, otherwise by nasogastric tube or IV;
- Hygiene including regular patient cleaning and changing of linen;
- Medication administration limited to drugs which were critical to life (e.g., insulin, anti-hypertensives) as determined by the medical director.
- Nutrition provided by mouth (Note: NG feedings will not be routinely provided. The facility will not have the capability of placing feeding tubes and risk of aspiration pneumonia with an NG tube)

makes NG feeding inadvisable. However, NG feeding may be provided at the discretion of the medical director.)

Care provided by an MCF will not include:

- Imaging or other advanced diagnostics;
- Laboratory services (exception will be glucometer);
- Resuscitation (CPR).

If a patient presents for admission with a medical condition for which the facility cannot provide services (e.g., dialysis), such that failure to provide the service is likely to result in the patient's death, the director will consult with the hospital about alternatives for care. If no other alternative exists, the medical director may elect to decline admission if beds are limited. In any circumstance where the facility is full and no other alternatives for care exist in other facilities, the medical director may select those patients for admission most likely to benefit from care. Changes in criteria for admission should be communicated to the public and to the ethic board overseeing the facility, including a description of the types of patients who will or will not be admitted.

If a patient who does not meet admission criteria is dropped off at the facility without authorization, the patient may be cared for as long as they have influenza until such time as a more suitable disposition can be found. Patients who do not have influenza may not be cared for at the facility and will need to go to the hospital or to a shelter for care.

XI. Admission and Discharge Procedures

Procedures for processing incoming patients will depend on the location from which the patient arrives. A hospital, a clinic, or an EMS can request admission in accordance with guidelines provided by the MCF. Hospitals clinics and EMS services will need to be updated on the types of patients that the facility can receive (e.g., severity of illness).

Elements of a standard brief history and physical will be expected from all qualified providers. Any critical information not available should be collected at the facility from family members before transfer. For persons brought to the facility by family, the person will be assessed for admission and, if admitted, a brief history and physical will be completed. Each patient must receive an identification bracelet and triage tag at the time of admission. Family members will be provided with an information sheet discussing the care provided at the MCF site and will be verbally told the expectations regarding discharge care and restriction from visitation at the MCF, including the possibility of not seeing the patient alive again should they die in the facility. Translation services when required will be provided over the phone through a translations service (see crisis communications plan).

Each patient admitted will be assigned a triage tag if they do not already have one. These will be supplied from the state cache. This tag will remain with the patient on transfer or discharge to morgue. When discharged home, the tag may be destroyed. The number on the triage tag will become the patient ID number. This number should also be put on the patient ID wrist band. The triage tag may be placed in the chart rather than tied to the body. The family should be provided the triage tag number and given a family information sheet which will explain how to use the patient number to access information about their family member. For each patient admitted, the following needs to be completed:

- Triage and admission record
- Patient admission orders
- Update of the master patient record
- Update of website for patient conditions

The triage unit leader, if available, may complete the initial intake evaluation then discuss the patient's history with the medical director. The medical director will perform a physical assessment on each patient admitted and determine the need for any deviation from standard orders. The medical director may give the triage unit leader discretion of refuse admission to persons who do not meet written, protocol-driven admission criteria. The triage unit leader may not refuse admission to a patient based on a decision that they will not survive. Only the medical director may do this, and only when that restriction on admission has been approved by the medical branch director of the DOC.

When a patient is to be discharged home, the facility will make contact with family and attempt to assess the ability of caregivers to resume care of the patient. Discharge will be delayed for persons who were too weak to provide care for themselves if they have no one to assist them. It is assumed that many of the persons in the facility will fall into this category. If admission pressure on the facility is high, the facility may choose to move the patient to another part of the facility (e.g., a school classroom rather than the gymnasium) where a single worker can provide assisted living type care to a large number of persons.

The facility will discharge patients when:

- 1) Deceased;
- 2) When able to take fluids orally if assisted by an available home care provider;
- 3) When patient has been hydrated and home care provider is willing and able to provide hydration through an NGT at home;
- 4) When able to care for self if no home care provider is available; or,
- 5) To a hospital to receive a higher level of care;

Criteria for discharge to a home care provider will be:

- 1) Patient is clinically recovering and afebrile;
- 2) Patient is able to take food, fluids and usual medications by mouth (or NGT); and,
- 3) Patient has a place to go with suitable care.

Upon discharge, the triage unit leader will provide to the patient or caregiver written instructions on additional care and signs of secondary complications or reasons to bring the patient back to a medical facility.

A patient may be discharged at the request of next of kin regardless of their physical status (i.e., patients will not be held against their will or against the will of their next of kin). Infectivity with the pandemic agent is not a criterion for either admission or discharge to an MCF.

XII. Patient Transfer Procedures

Before a patient is transferred between facilities, confirmation of acceptance by the receiving facility is required. If the MCF wishes to transfer a patient to the hospital, the medical director for the hospital must approve the transfer. An MCF will accept transfers as long as there is staffed space available to receive the additional patients; however, the medical director for the hospital should confirm with the medical director of the MCF before sending a patient to the MCF.

Transportation of the patient between facilities will be the responsibility of the sending entity. Ambulance transport, while preferred, is unlikely to be available to the extent needed. Family members should be requested to move the patient; however, if the family is unable or unwilling, any climate controlled vehicle driven by a volunteer in which the patient may be recumbent will be suitable. A vehicle suitable for patient transport may be requested from the local EOC if necessary.

Documentation accompanying the patient on transfer should include history and physical, a transfer sheet briefly describing hospital course, current medications being administered as well as those usually taken,

personal items and personal care items, medications from home (if available), routine care appliances (foley catheter, IV or heparin lock). Patients with ET tubes or central lines will not be accepted by the MCF. If the family does not transport, the family should be notified, if possible, of the transfer. The patient location should be updated in the patient tracking system.

Patients being transferred from a hospital to an MCF must have pandemic influenza. Because of the minimal staffing, patients who are agitated, combative, or seriously mentally ill should not be transferred to an MCF. An MCF will not routinely administer medications; consequently patients who require regular medication are not the best candidates for transfer. Essential medication will be given as necessary. Hospitals should transfer adult patients before pediatric patients (patients 12 or under). Patients with influenza who are dying may be transferred to the MCF for palliative care unless the MCF has had to quit taking palliative care patients due to over crowded conditions. Patients who are past their pandemic infection crisis but cannot go home due to lack of a caregiver at home, may be transferred to an MCF; however, if beds in the MCF are tight, attempts should be made to transfer the patient to an MCF which has physical space for an assisted living area away from the acute care floor.

Each shift, the medical director of the MCF going off service should review with the incoming medical director the list of patients which he or she believes are the best candidates for transfer to the hospital. At least once per day, the MCF medical director should discuss these patients with the hospital medical director and request next available bed for these patients. Patients who will be considered optimal candidates for transfer are those who will be expected to have a substantially increased likelihood of survival if admitted to the hospital (e.g., post-influenza pneumonia). This assessment may take into account a patient's underlying medical conditions, age, and nutritional status in assessing survival chances (see section on ethics). If the hospital has adults with uncomplicated influenza, the MCF may arrange a swap of patients.

XIII. Assisted Living

The facility floor plan may have much to do with how the assisted living area is structured. If a school is used, it may that classrooms holding several beds are used for persons who are recovering. Bedside toileting will likely be needed since communal toilets may be a long way from the patient rooms. Patients will be alert and more sensitive to their surroundings, so patient rooms should be segregated by sex and privacy screens should be available. Patients with a similar level of debility might be cohorted together to ease the burden of care givers. That is, some persons who can get up to a commode on their own and feed themselves might be placed in rooms together, while persons who need more assistance might be placed in rooms together. Providing some sort of self entertainment (books, radios, television) may be necessary as patients become more self capable. The patients would not be expected to have family available or they would be discharged home; hence, opportunity for socializing will become important.

While all patients will be treated with the utmost care and respect, the MCF will not be able to adhere to specific cultural or religious practices of the patients. Individual attention accommodation will continue to be limited in the assisted care area of the facility.

XIV. Personnel Functions

The following functions are defined for an MCF. Consistent with incident command, positions may be collapsed as needed.

COMMAND

1. MCF Site Commander – this person will supervise the facility;
2. Safety and Security – this person will be responsible for safety procedures, including proper infection control procedures, and will oversee security;
3. Security worker – this person will assist with security functions.

4. Liaison – this person will assist the site commander by handling incoming calls, communicating with external entities and tracking activity in the facility. The liaison will be responsible for forwarding rosters and status of all patients to the supervising operations center and maintain any required reporting into HC Standard;
5. Medical director – this person must be a licensed health care provider who will act as a medical care consultant. This person will be responsible for any invasive care procedures (IV, NGT, Foley catheter) which might be needed, assess patient status (palliative care designation, hydration status), admissions, discharges and transfers.

OPERATIONS

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| <ol style="list-style-type: none"> 6. Operations Chief – this person will oversee all aspects of caring for patients and staff. 7. Triage Unit Leader – this person will make an initial assessment of patient suitability for admission or discharge, collect intake information, assign patients to specific locations in the facility, maintain master rosters which included location and patient status, collect surveillance information, and update patient tracking software. 8. Morgue Unit Leader – this person will collect bodies from the patient care area and move them to a holding area, request body pickup from teams, complete initial paperwork and triage unit leader of the deceased status entry. 9. Staff Support Unit Leader – this person that needs of staff were met (e.g., logistical) and remove workers from showed undue signs of stress or fatigue. 10. General Nursing Care Unit Leader – this oversee all patient care responsibilities, workers provide assistance to each other and ensure that all patients received care appropriate for their situation. 11. Patient care providers – these persons basic nursing services to the ill including hygiene, and monitoring. Specific providers can be designated as unit section of the facility’s patients, supervision and assistance to care assigned to that section and serving as less experienced volunteers. 12. Pharmacy Unit Leader – this person will procurement, storage and allocation of 13. Dependent Care Unit Leader – this perform social work functions required adequate outcomes when a person leaves and ensure that patients can be quickly as possible once they were well to leave. | <p style="text-align: center;">PERSONNEL</p> <p>COMMAND</p> <ol style="list-style-type: none"> 1. MCF site commander 2. Safety and security 3. Security worker 4. Liaison 5. Medical director <p>OPERATIONS</p> <ol style="list-style-type: none"> 6. Operations chief 7. Triage unit leader 8. Morgue unit leader 9. Staff support unit leader 10. General nursing care leader 11. Patient care providers 12. Pharmacy unit leader 13. Dependent care unit leader <p>LOGISTICS</p> <ol style="list-style-type: none"> 14. Logistics chief 15. Facility unit leader 16. Maintenance officer 17. Sanitation systems officer 18. Laundry worker 19. Janitorial worker 20. Materials supply unit leader 21. Communications unit leader 22. Transportation unit leader 23. Transport workers 24. Nutritional support unit leader <p>PLANNING</p> <ol style="list-style-type: none"> 25. Planning chief 26. Labor pool unit leader 27. Situation unit leader | <p>morgue notify the for computer</p> <p>will ensure emotional, duty who</p> <p>person will ensure that as needed equitable</p> <p>will provide feeding, patient care leaders for a providing providers mentors for</p> <p>oversee the medication. person will to ensure the facility discharged as sufficiently</p> |
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LOGISTICS

14. Logistics Chief – this person will supervise all logistical operations dealing with the facility, supplies, IT, transportation, and resources
15. Facility Unit Leader –this person will oversee all aspects of facility management including sanitation and maintenance.

16. Maintenance Officer– this person will maintain critical utilities (water, sewage, electricity, HVAC). This role should be filled by someone who knows the building, preferably a person responsible for maintenance during normal building operation.
17. Sanitation Systems Officer – this position will oversee all laundry and janitorial functions (cleaning and disposing of waste, including hazardous waste);
18. Laundry worker – this person will launder clothing;
19. Janitorial worker – this person will clean the physical space and dispose of waste.
20. Materials Supply Unit Leader – this person will be responsible for all supplies and equipment;
21. Communications Unit Leader – this person will be responsible for all IT functions
22. Transportation Unit Leader – this person will oversee all transportation functions, both manual and vehicular.
23. Transport workers – this person will physically move patients, materiel, and corpses.
24. Nutritional Support Unit Leader – this person will ensure that food and drink were available for staff, and for patients as needed.

PLANNING

25. Planning Chief – this person will oversee the planning section, including documentation, personnel management, and situation assessment.
26. Labor Pool Unit Leader – this person will be responsible for scheduling and tracking personnel, assigning new personnel to work areas and mentors, credentialing and volunteer recruitment;
27. Situation Unit Leader – this person will be responsible for meeting minutes, all maintaining, filing, retrieving, and quality assurance of documentation including patient care documentation, supplies, and costs.

A diagram appended to this document demonstrates the command structure for these positions. The reality of staffing shortages likely to occur in an MCF will mean that many of these position functions will be collapsed into a few positions; this will necessitate increased reliance on the community EOC incident command system. A second diagram represents a possible structure with most positions collapsed and only three senior level command staff. Based on the second diagram (the mostly likely scenario), the following staffing is likely for a facility with 120 patients is:

Position	Positions Assigned	Shift 1	Shift 2	Alternates
Site Commander	1,4,14,25, 27	1	1	1
Medical Director/Ops Chief	5,6,12	1	1	1
Safety and Security Officer	2	1	1	1
Patient Care Volunteer Leader	7,9,10,13	1	1	1
Patient Care Volunteers	11	6	6	3
Patient Transportation Volunteer Leader	8,22	1	1	1
Patient Transporters	23	1	1	1
Support And Resource Volunteer Leader	20,21,24,26	1	1	1
Resource Assistant		1	1	1
Infrastructure Volunteer Leader	15,16,17	1	1	1

Infrastructure Assistant	3,18,19	2	2	1
Total		17	17	13

An additional presence in the MCF may be a chaplain. The chaplain should spend no more time in contagious areas than necessary, and should receive adequate training to ensure he or she is protected. The site commander or medical director may wish to try to tap the chaplain for assistance with meeting the emotional needs of staff.

XV. Pharmacy Operations

It is not expected that an actual pharmacy would operate, although that is a possibility in the large facilities. Generally the low use of medication, will permit each patient’s medication to be stored at the bedside (likely in two labeled clear plastic bags under the bed – one holding those medications which are in use and the other holding medications which are not in use. Controlled substances should not be retained in the facility. Although facilities may vary in their implementation plan for this, it would be logical to designate three times of day (not falling at a time immediately after shift change) when staff would know to administer that medication which has been prescribed. If the volume of medication being administered is large, the facility may choose to set up a pharmacy location which manages all medication. A pharmacy job action sheet is provided for situations in which a pharmacy is provided.

XVI. Relationship between MCF and Hospital and Community EOC

At this time, a one-to-one relationship between hospital and MCF is anticipated for most facilities for purposes of allocation of patients. The relationship will not extend to administrative or logistical management of the MCF.

[NOTE: Legal review of potential liability to hospital based on gatekeeping role is pending.]

Patients may be transferred from the hospital to an MCF. Each shift, the MCF will provide an update to the hospital (and to the DOC, through WebEOC assuming the MCF site has Internet access) regarding the status of the facility, particularly bed availability. A patient can be moved from a hospital to the MCF at the request of the medical director for the hospital (or designee), assuming the MCF has space and staff to receive additional patients. A transfer might occur because of

- Additional loss of hospital staff due to illness;
- Displacement of pandemic influenza patients by non-pandemic patients requiring care;
- Step down of patients who are past their crisis but are too sick to go home; or,
- Arrival of pandemic influenza patients at the hospital from the community who require admission but for whom no bed is available.

If a hospital’s assigned MCF is full, the hospital may request movement of patients to space available in a nearby facility by contacting the DOC.

Patients may also be moved from the MCF to the hospital. The medical director for the MCF should have a list of patients who will benefit most from admission (e.g., patients with treatable secondary complications who are likely to survive with treatment). The MCF medical director will request space at the hospital for those patients as soon as space becomes available. It will be up to the Medical Director of the hospital to determine which patients should be utilizing the available space in the hospital, but it would be assumed that patients identified at the MCF with treatable conditions would go to a hospital bed in preference to newly arriving pandemic patients who need supportive care.

Requests for assistance required by the MCF will be directed first to the local EOC. If this can not be met by the local EOC it will be forwarded to the state. It will be expected that most supplies that are non-medical in

nature will be identified and supplied by the local EOC; whereas, medical supplies will need to be released by the DOC from the state cache.

XVII. Training

For each MCF, sufficient staff to fill the positions of site commander and medical director, 24/7, for a two to three week period should be identified prior to the event. To the extent possible, it is recommended that the site commander role be assigned to a person with appropriate experience (e.g., persons with shelter management experience).

Each supervisor will ensure that his/her staff is adequately instructed when the facility opens. Replacement staff will need to work with an assigned mentor filling the roles to which they are to be assigned, before assuming independent duties. The mentor will let the supervisor know when the new staff member is ready for independent action. Each worker will be provided with the appropriate job action sheets and the key documents which need to be read (e.g., rules for personal protection). (See Attachment)

Mandatory just-in-time training must include

- Risk of working in an MCF
- Facility orientation
- Infection control
- Correct use of PPE
- Staying well
- Watching out for other workers
- Death management
- Task assignments available
- Specific guidance for:
 - Patient care
 - Logistical support
 - Infrastructure support
 - Transportation
- Unit leadership
- Mentorship
- Stress expectations and stress management
- Shift scheduling
- Protecting family at home
- Ethics
- Patient privacy
- Respectful care of the living and dead

XVIII. Space requirements

Patient care area: Beds should be in a single room where large numbers of patients can be cared for by as few staff as possible. A twin bed is approximate 42"x78" and facilities will require aisles between beds which are 2.5 feet wide (just wide enough to accommodate a stretcher or wheelchair). This will require about 40 square feet per bed (about 72 inches from bed center to bed center). A typical gymnasium style room should be about 8000 to 10,000 square feet minimum. If patients occupied space approximately 100 feet by 80 feet which had five five-foot walk aisles (for two stretchers to pass), it should hold seven rows of beds with 17 beds per row (119 patients).

Additional minimum space requirements:

Additional space needed to accommodate 16 workers would include

- Patient receiving and admission triage area;

- Male and female locker rooms with restroom facilities;
- Equipment storage area;
- Single office area;
- Mortuary holding area;
- Staff rest areas;
- Equipment cleaning area;
- Dining area;
- Food preparation area (if food is to be prepared on site).

Additional space will be desirable for an assisted living area to which patients can be moved when they no longer need to be on the acute care floor, but cannot be discharged home. However, a large number of patients in assisted living will require increased staff. If patients are no longer contagious, they may be able to go to a medical shelter if an appropriate facility is set up. Alternatively, an MCF facility could initially be established to provide assisted living only, in order to unload convalescing patients from the hospital who cannot go home. Acute care would be added when necessary, and the assisted living area might continue to operate for a period of time after the acute care ward is closed.

XIX. Equipment and supply requirements

Quantities assume a 120 bed unit which operated for two weeks, caring for a total of 200 different persons. See Attachment.

XX. Disinfection

A clean area within each MCF will be designated to include offices, eating areas, and some restroom facilities. Removal of exterior patient care protective clothing (e.g., gown) and thorough hand cleaning will be needed to move from the patient care area to the clean area. Because of the risk of contagion from a co-worker who appears well, workers should be instructed to wear respiratory protection when in close proximity (e.g., same desk or table) of others. Eating will be a solo activity.

Disinfection of surfaces will be part of regular cleaning. A dilute bleach solution (commercial bleach at 1:100 concentration) should be used on all handled environmental surfaces (e.g., door knobs, telephone receivers). (NOTE: staff assigned to cleaning should be provided with instructions on preparation of bleach solution (see Attachment) instructed when to use detergent and when to use bleach, and warned against the mixing of ammonia containing products in the bleach solution.) Environmental cleaning will occur once per day for all areas in addition to clean up of spills or body fluids. Cleaning will include wipe down of patient care areas daily and between patients. Although the risk of pandemic influenza transmission between patients will not exist, the risk of transmission of other agents needs to be minimized to the extent possible. To avoid risk to the public, a perimeter will be established around the facility, especially around doors and ventilation units, to protect persons outside the building from exposure to the virus. This will be posted with signs and periodically patrolled by the safety security officer.

XXI. Worker protection/Infection control

All persons will be required to wear N95 or equivalent respiratory protection in contaminated areas, and will be encouraged to wear it when around other staff in clean areas. Fit testing should be performed to ensure all workers have adequate respiratory protection; however, universal fit testing may not be feasible, so persons working in an MCF without being fit tested need to know the potential increased risk should their N95 not fit. During orientation, the assigned mask should appear to fit and form a suction seal when covered on inhalation. If a seal is not reliably being formed with available N95 masks, the person should be issued an N100 mask or a PAPR. Masks should be marked for personal use with a permanent marker to permit re-use until too soiled or worn to wear. Masks should be rotated off every 4-6 hours and allowed to dry thoroughly

before re-use. Each person will be assigned three masks which are to remain in the facility and rotated during the shift.

In a contaminated area, workers must wear an exterior protective garment which can be removed and re-used, gloves, and respiratory protection. Face shields are necessary if splattering is likely. Great care must be taken by all workers to avoid touching the eyes, since this is the second most common portal of entry after the respiratory tract. If eyes must be touched, hands should be thoroughly washed.

When moving from a contaminated to a clean area, all persons must remove exterior garments used for patient care (e.g., Tyvex covers) and gloves. N95 masks should be removed before going into the clean if the person expects to eat or drink anything. Hands should be washed after touching any protective clothing or equipment.

Disposable gloves must be changed between patients. Gloves must be removed when going to the restroom. Frequent hand washing is required even with glove use. Because a shortage of personal protective equipment is likely during a severe pandemic, facility personnel will be expected to comply with state issued guidelines for conservation of PPE.

In addition to wearing gloves when having contact with patients, all persons will be expect to wash hands or used alcohol based hand rubs with great frequency. Because the location of most facilities is likely to be in a gymnasium type setting, hand sanitation is likely to depend heavily on hand wipes and alcohol rubs; however, periodic washing with soap and water is recommended. If facilities are available for showering, it is recommended that all workers shower and change clothes when going off duty. If this is not possible, the worker should shower and change clothes immediately upon returning home.

Workers may wear scrubs for patient care, but not as exterior dress in the contaminated area since they may not be readily removed. They should be treated as any other clothing – covered with a gown and changed as soon as possible after duty. Laundering of all items which have been used for direct patient care (including at home) should be done while wearing gloves. Private changing areas and lockers for storing assigned personal protective equipment will be necessary.

All workers should be assessed for illness when they report for duty. Should a worker report to duty sick or become sick during the course of the work period, it will be the responsibility of the safety/security officer to assess whether that person is too sick to continue to work or whether their continued work might place co-workers at increased risk.

XXII. Communications

All communication will be routed through the supervising operations center. This will include requests for resources, and patient status information. The facility will need to maintain HC Standard data reporting number of beds open and filled. The facility may use forms provided by the EOC or forms provided in this document Attachment.

Available communication links may depend on location of the facility. If a school is used, then ground line telephone, cell phone, Internet, and Stagenet should be available at a minimum. Portable radio communications equipment should be secured if resources permit. Requests for communications equipment should be directed first to the local EOC. The site commander, medical director and safety/security officer should carry walkie-talkies. Additional walkie-talkies should be provided to supervisory staff for infrastructure, logistics, transportation and patient care if available.

XXIII. Ethics

Community Ethic Review

The community should designate an ethics panel to oversee the care of patients by an MCF. Although a community could arrange with the local hospital to assume this function, persons on hospital ethics committees may be too engaged in patient care to take on additional duties for the MCF. This group could be the planning committee members who set up the MCF, a board of health or some other committee selected for this purpose. Inclusion of a priest or pastor is recommended and should include three to five people total.

The ethics committee may function by meeting with a medical director to discuss policies (e.g., for refusing admission), deal with complaints of citizens, and review master patient lists to identify patients placed on palliative care with review of the indications in each case. Because of the pressure of other duties plus the emotional and physical fatigue of the medical directors, the committee should keep its time demands focused and brief, even if the meeting is scheduled during non-shift hours for the medical director. Potential questions for the review committee include:

- Are patients treated respectfully?
- If admissions to the MCF are restricted, is admission based on medical need only?
- If palliative care designations are used, is the designation applied fairly based on established written criteria, and are designations reviewed between medical directors at change of shift?

The ethics committee may also be asked by the MCF to provide input on policies or deal with difficult family situations. The ethics committee is not asked to be ethical experts, but to use their good sense to ensure the equitable treatment of all persons.

Access to MCF

Access to the MCF must be based solely on medical need. If the MCF is full and no alternative sites are available, the medical director may take such steps as he or she thinks necessary to maximize patient survival (e.g., discharge of palliative patients to families, movement of palliative patients off the acute care floor, or lowering the threshold for being designated as a palliative patient). The director may selectively admit patients based on survival likelihood, but this should only be done after consultation with the site commander and discussion with the DOC. The DOC will provide information to the facility regarding facilities in the area which have available space to which the family may take the patient, as well as consider the feasibility of opening an additional MCF in the community.

Palliative Care

Use of palliative (“comfort”) care designation is permissible if required to prioritize limited personnel or physical resources toward those patients most likely to survive. If sufficient staff and equipment are available to care for all patients, palliative care designations should be avoided. Only the medical director on duty can place someone on the palliative care list. At change of shift, the medical director going off service should review with the incoming medical director any additional patients placed on the palliative list during the previous shift and the rationale for the action in each case. Medical directors may wish to designate palliative care status only at change of shift after consultation together. Initial criteria for considering a person to be palliative include:

- Marked hypotension (systolic BP less than 70 mm Hg) after adequate hydration;
- No urine output or minimal urine output for 24 hours in non-obstructed patient;
- Severe cyanosis;
- Severely disordered breathing (Cheyne-Stokes, apnea, agonal breathing)
- Signs indicative of severe neurologic injury (e.g., decorticate or decerebrate posturing)

Criteria for designating people as palliative care may change if MCFs are full and additional MCF space is unavailable.

Patients placed on palliative care will be left in their current place on the acute care floor, but will receive care only after other patients who are more likely to survive have been cared for. The medical director

should continue to round on these patients and assess these patients to determine if there has been any change that would warrant removing any patient from the palliative care list.

Because of the restricted access by family members, when a patient is placed on palliative care, an MCF should attempt to contact the family and let them know that the patient is likely to die. If they family would like to be with the patient, that they will need to take them home. Patients brought to the facility for admission by family who meet criteria for being designated as palliative care may reasonably be refused admission if there is family available to care for their hygiene needs, keeping in mind that some criteria listed above cannot be assessed without admission.

Not only patients, but also staff, will require humane treatment. Staff may have family or friends in the facility that die or are dying. Staffing patterns will need to be altered to allow staff to grieve and to spend time with those who are dying or dead. Referral to chaplaincy services is encouraged for staff who are grieving; or, if this is not acceptable, visiting with a counselor. Supervisors should decide whether it is in the best interest of the staff member to attempt to continue to render care in the face of a close personal lose.

Access to Patients by Community Members

MCF are closed facilities (i.e., not accessible to the family, media or public) which poses substantial strain on the family. The closure of the facility is for two reasons:

- To protect the public from exposure to a highly contagious environment;
- To make it possible for the facility to function without having to meet the demands of anxious family members wanting more attention to their loved one.

Even if a community member who is not volunteering at the site has an N95 mask of their own or is a community VIP, they should not be allowed into the facility. This policy will minimize risk, ensure fairness, and prevent disruption to the facility operations. The only non-staff member permitted in the facility should be a member of the clergy who has been asked to provide chaplaincy care in the facility.

Obviously one of the benefits of working in the facility is the opportunity to see family members who may be patients in the facility. However, a volunteer may be assigned to care for patients other than their own family member. If a volunteer should be providing care for their own family member, he or she will be expected to care for all patients equally without preference for any.

Circumstances may arise in which a family member wishes to remove the patient from the facility against the recommendation of the medical director. It is permissible for the patient to be discharged against medical advice, but the person requesting discharge must be a spouse, or other first degree relative (parent, sibling or adult child) and must be accepting the responsibility of personally providing for the care of the patient.

Care for Children

The needs of children are unique. Fluid management and family management are both more complicated for children. It is not feasible to separate parents from small children, but it is also not possible to provide adequate PPE protection for all parents who may want to be with an admitted child. Because of the special needs of children, hospitals should retain patients who are 12 years or less in preference to older patients with pandemic disease. If children must be moved to the MCF, older children should be moved before younger children. Children 12 or less who must be admitted to the MCF should be placed in a separate area of the acute care floor (pediatric “ward”).

Most children who are admitted to an MCF are expected to be unresponsive¹; consequently, provision for parental access is often more a recognition of the parent’s need to be with the child, rather than the child’s need to have a parent present. If it is necessary for a child age 12 or younger to be admitted to the MCF and

¹ Most patients who are responsive should be able to take fluids by mouth and can remain home with a parent providing care.

a parent wants to be with the child, the parent must become a volunteer and assist with the care of other patients with as much attention as they give their own child.

XXIV. Fatality Management

When a patient care worker thinks a patient has passed away, he or she will contact the medical director. Only the medical director can pronounce a patient dead. Once the patient has been pronounced, transport workers will move the body to a morgue holding area and call the designated hotline number for requesting a community morgue team. The triage tag should be attached to the body before it goes to the morgue. The wrist ID should remain in place. Nasogastric tubes, IVs and foley catheters may be removed. The transporters should have all the patient care records and patient's personal effects moved to the holding area as well. The medical records will be available for review by the morgue team, but they are not to leave the facility. The morgue team should take all the patient's personal effects to the morgue with the body. The medical director should make an attempt to contact the family at this time; however, if time pressures are too great, he or she may request that the transporters attempt to notify family. The medical director should ensure that the patient status is updated on the master patient form and that that information is provided to the person responsible for updating the patient tracking system through HC standard. The Morgue Unit Leader will complete required paperwork per protocol before the unit is discharged to the morgue.

XXV. Public Website

When a patient is admitted to the MCF, their tag number will be recorded on the website with a statement of the patient's condition. This site should be updated each shift and is the primary method by which family members will know about the condition of those they care about in the facility. The web site will open to the public, but because information will be recorded by patient number only, as long as there are ten or more patients in the facility, additional information of a confidential nature may be included. If fact of death is updated on the web site, the reference should include the patient's name to ensure that no error is made in assigning death to the wrong patient number. Fact of death is not considered confidential information.

XXVI. Medication Management

Routine administration of medication is not part of the expected service provision by the MCF. At the time of admission, the medical director on duty will determine the absolute necessity of administering any medication that the patient is on. For example, if a patient taking digitalis and warfarin for atrial fibrillation and insulin for type II diabetes, the medical director may elect to continue or discontinue any or all of the medications based on his or her assessment of the risk. Given a limited caloric intake (due to an altered mental status of most patients) and lack of laboratory monitoring, it may be safer to discontinue even seemingly critical medications. Certain medications must be continued, albeit an altered dose may be indicated (e.g., insulin for diabetes).

The MCF will not stock a pharmacy; however, a regular staff member may need to be assigned pharmacy duty if a substantial number of patients are receiving medication. Although a physician director may be able to prescribe a drug and obtain it from an area pharmacy, the usual policy will be that drugs brought by the patient's family with the patient may be administered at the discretion of the medical director on duty. If the medical director needs a medication not available among the patient's medications, he or she should attempt to obtain it from a local pharmacy; however, the medical director may use his or her personal judgment regarding accessing medications needed to save a life. If a patient is receiving a medication which runs out, the staff responsible for pharmacy operations should call the pharmacy and request a refill.

In most patients it is expected that medications will have to be administered down an NG tube after being crushed. This will pose special problems when the medication is in a controlled release form which must not be crushed. The medical director may attempt to substitute an alternative formulation or drug if the treatment is necessary. It is anticipated that insulin will be the only drug administered by injection. No use of IV drugs is anticipated.

It is not anticipated that oxygen will be available. Should it be available, the facility will need to coordinate with the department operation center of NDDoH through the local EOC to obtain supplies for oxygen administration. Oxygen will be administered at the discretion of the medical director, if available.

XXVII. Public Information

Media Access

Although the public has a compelling interest in knowing the conditions inside an MCF, it is not considered feasible to allow the media into the facility. It will not be possible to provide respiratory protection to the media. Even if media representatives wished to take the risk and enter the facility without adequate protection, this is unwise and will increase the risk of having additional patients for which care must be provided. In addition, from a public relations perspective, it makes little sense to allow media into the facility when families cannot enter to visit patients. Consequently, the site will remain closed to the media, although every attempt will be made to meet the request of media for interviews outside the facility.

Public Communication Concepts

- General
 - The MCF concept needs to be introduced to the public before MCF use becomes necessary.
 - An MCF's operation and capacity will be dependent on the availability of volunteers.
 - An MCF is a high contagion area, and even with personal protective equipment, risk of illness may be increased by volunteering at such a site.
 - Families should bring the following items to the facility with the patient
 - Medications (except controlled substances)
 - Medication administration materials (e.g., insulin syringes)
 - Mobility aids
 - Family contact information
 - Family should not bring the following items:
 - Personal items (The facility will permit limited religious items (bible, rosary), but cannot guarantee their return.)
 - Cell phones
 - An FAQ will be developed and posted online.
 - Informational documents will be provided to family at the time of admission and at the time of discharge.
 - Numbers to call if one wishes to volunteer, the requirements to be a volunteer and types of duties of volunteers will be asked to perform will be publicized.
 - Directions for access to the MCF for evaluation will be publicized.
- Services Offered
 - An MCF is a contagion facility.
 - An MCF does not dispense antivirals or provide outpatient care.
 - MCF patients will only receive medication at the discretion of the medical director on duty.
 - An MCF does not keep antivirals, vaccine or controlled substances on hand.
 - MCF personnel will not be able to answer the phone. Phone use is limited to emergency communications only.
 - An MCF does not charge for patient care.
 - Persons needing care by an MCF should go their local or nearest MCF facility.
 - Spiritual care available cannot guarantee any denomination affiliation, or religious affiliation.
 - Only patients meeting certain conditions will be eligible for admission (publicized); patients who can be cared for at home will be better off there if hydration can be maintained.
 - Families will be expected to resume care when the patient is ready for discharge.

- An MCF is not a hospital and does not offer the services of a hospital. An MCF is only operational under conditions of disaster medical care.
- If an MCF is full and can not accept additional patients, its closure to new patients will be publicized.
- An MCF is a restricted access facility; only persons working in the facility will be granted admission.
- When a patient is left at an MCF, it may be the last time the family sees the person alive. Family members should be prepared to take permanent leave of family members when they are admitted.
- Pediatric patients will be accepted if necessary, but will be preferentially admitted to the hospital. Provisions for a parent to be with a child in the MCF can only be made if the parent is willing to volunteer to work in the MCF helping to care for others.
- Definitions will be publicized for terms used to describe patient condition according to AHA guidelines as follows:
 - **Undetermined** - Patient is awaiting physician and/or assessment.
 - **Good** - Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.
 - **Fair** - Vital signs are stable and within normal limits. Patient is conscious, but may be uncomfortable. Indicators are favorable.
 - **Serious** - Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.
 - **Critical** - Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.
- Patient management
 - Patients may be transferred to or from an MCF without consultation with family. General criteria for transfer will be communicated as public information.
 - Patients with a low probability of survival may be assigned to comfort care only at the discretion of the medical director of the MCF.
 - Admission to an MCF does not imply that the patient's condition is poor. Admission is based on space availability in the hospital.
 - Patients may be discharged while still contagious.
 - A patient may be taken from the facility by an immediate family member who provides reasonable documentation of their relationship to the patient and who is prepared to personally provide for the care of the patient. Immediate family member includes spouse, sibling, parent or child.
 - It may not be possible to individually notify families when a patient dies.
 - A patient who dies will be sent to the nearest community morgue capable of accepting the remains.

XXVIII. Forms and Documents

The following forms will be needed. See Attachment.

- History and physical form
- Master patient list for shift
- Chart note form
- Vital sign form
- Scheduling form
- Worker sign in form
- Incident/Injury form
- Procurement request form
- Confidentiality policy

Following the patient's discharge or demise, all records for that patient will be put in a folder in a file cabinet or file box. Records will not be discarded. Following shutdown of the facility, all facility documents will be

gathered and filed, including master patient lists. The records will belong to the state and must be forwarded to the DOC for long term storage.

XXIX. Medical Rounds

At the beginning of each shift, the medical director coming on duty will:

- Discuss specific patients with the off shift medical director
- Discuss patients on the priority list for transfer to hospital if beds become available
- Round on each patient including
 - Review of daily record
 - Physical assessment
 - Brief note
 - Change in orders
 - Update patient status

Patient rounds on all patients will occur every 12 hours. Patient documentation will be at the bedside and include:

- A brief history and physical at admission
- Daily vital signs record
- Orders
- Brief note once per shift including at a minimum:
 - Date and time
 - Patient hydration status
 - Patient condition change or status change (e.g., designation as palliative care only)
 - Any medication to be administered during the shift and reason

During rounds, the medical director will update a master list of each patient with the patient's condition (good, fair, serious, critical, deceased). At the end of the rounds, this information must be entered into the patient tracking system. If an action must be taken during the course of the shift, the medical director will amend the daily note, which needs to be communicated to the person coming on shift. Should the patient die during the shift, the master patient list for the shift and patient tracking system must be updated.

XXX. Security and Safety

A single person will be assigned safety/security duty to keep the perimeters of the site clear and ensure the physical safety of person working at the site. Law enforcement will may be called (via 911) to assist with any incident which pose a risk to staff or patients. The Safety and Security officer will also make sure that workers at the facility follow procedures which reduce the risk of disease transmission to themselves or others (e.g., hygiene, PPE, clothing, not touching eyes with hands) and will observe workers for signs of excessive stress, fatigue or illness and remove them from duty if needed.

If patient movement is required, the safety/security officer will enforce having sufficient persons move the patient to avoid individual injury. The safety/security officer will also observe the care of patients ensuring that patients and human remains are treated respectfully at all times. Although volunteers who are known or believed to pose a risk may be excluded from the facility, no background checks will be required for a person to work in an MCF. Workers will be asked to wear two-badge identification (personal government issued ID plus disaster response ID issued on arrival). When a person checks in for duty, they will be issued a badge with an ID number, and surrender the badge when leaving the facility. Only persons currently staffing the facility will be allowed into the facility.

Each facility will need a fire and evacuation plan, the preparation of which will be the responsibility of the safety/security officer. The safety/security officer will patrol the premises and call the fire department (via

911) if needed. The acting site commander will be in charge of evacuation procedures if that becomes necessary.

XXXI. Contracting Services

It may be possible to contract out some services such as laundry and food preparation, as long as it is recognized that contracting entities may, due to illness or cash flow limitations, be unable to fulfill obligations during a pandemic. If a contractor is used, they will need to use appropriate personal protective equipment (e.g., N95 mask if handling laundry) and should be excluded from the facility by transfer of material (food, laundry) outside the facility. Janitorial services should not be contracted out, but can be performed by a volunteer willing to work in the facility.

XXXII. Returning Control of the Facility to Community Use

During or after pandemic influenza when the facility shuts down, it should be thoroughly cleaned with quarternary disinfectant and water and aired out. Influenza is not a durable organism in the environment and will be inactivated by the environment in a short period. However, influenza will not be the only organism present, and thorough cleaning is required. No restrictions on returning the building to normal use exist following pandemic influenza. Following an influenza pandemic, the organism will have been present in every building, private and public, in the community. The site used for the MCF will pose no different risk (i.e., zero) than any other building in the community.

ATTACHMENT A
MCF Activation Sequence

Definitions:

Lead agency for planning: That agency which develops the plans and protocols for local MCF operation within a community.

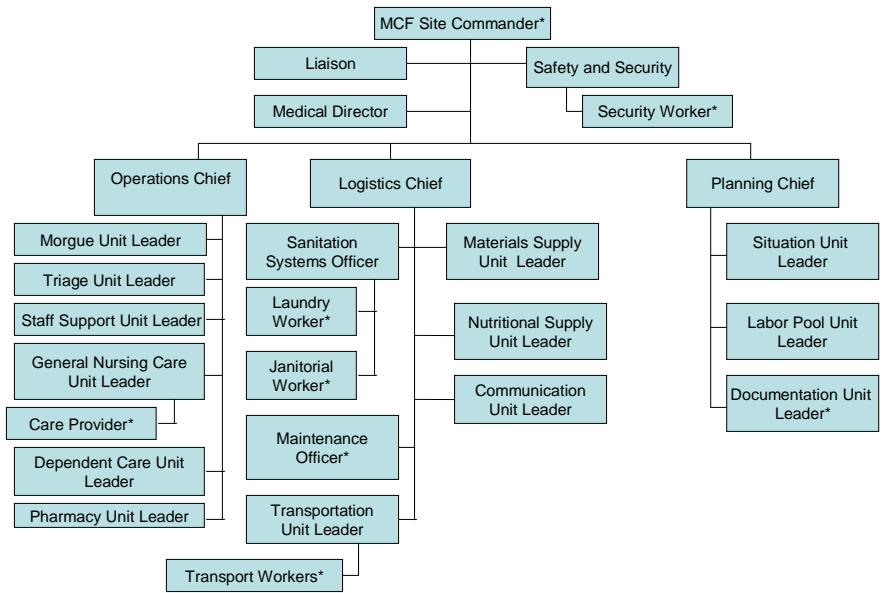
Lead agency for activation: That agency that takes on management responsibility once an MCF is opened.

1. NDDoH DOC approves Standard of Care Level III (or specific hospital requests community access to assisted living function (for recovering pandemic patients without home care provider) in order to delay movement to Stage III care).
2. NDDoH DOC notifies regional EPRs that community preparations should be initiated for opening MCFs.
3. Designated lead agency for planning* for each MCF meets with identified site commanders* to plan local community actions.
4. A facility setup lead person is assigned responsibility for setup of facility.
5. Site commanders work with lead agency for activation to define minimal management staffing and to prioritize additional management positions to fill in order to reach desired fixed staffing level for each MCF. Lead agency for planning will serve as a technical consultant.
6. Specific individuals are assigned into management staff positions, but a specific staffing schedule is not developed until first date of operation is determined.
NOTE: For minimum staffing, because of training requirements and need for daily continuity of operations, seven management positions should be assigned three deep (site commander, medical director, safety and security, patient care coordinator, patient transportation coordinator, support and resource leader, infrastructure leader). All other positions can be filled by rotating volunteers.
7. Identify chaplaincy services.
8. Site management personnel are trained by pre-designated training agent* using management training curricula*.
9. Public request is released for lay volunteers needed to perform patient care and management support staffing. Facility staffing may be light initially and increased as patient load increases.
10. Building MOU* is activated.
11. Site is setup including:
 - a. Acquisitions and staging of beds
 - b. Setup of IT, communications and office space
 - c. Receipt and storage of supplies
 - d. Designation and labeling of room functions
 - e. Labeling of patient flow, entrance and exit sites
 - f. Duplication of forms
12. Facility setup lead notifies local DOC that it is ready to receive MCF setup shipment of medical supplies. Local DOC notifies the NDDoH DOC.
13. Initially required quantities of resources to be obtained locally are secured and setup of facility is initiated using both local and state resources.
14. Facility setup lead notifies NDDoH DOC that facility is ready to receive patients.
15. Hospital provides 24 hour lead time before MCF is needed.
16. Facility setup lead or designee sets up initial week staffing schedule for all positions and notifies all individuals (all management staff and volunteers) of when they are scheduled to work.
17. Volunteer staff are trained in duties prior to receipt of first patient.
18. Designated lead agency designates oversight group that will periodically review care and ensure ethical treatment of patients.
19. Contract services* are activated.
20. First patient arrives.

* Planning step which needs to be completed pre-pandemic

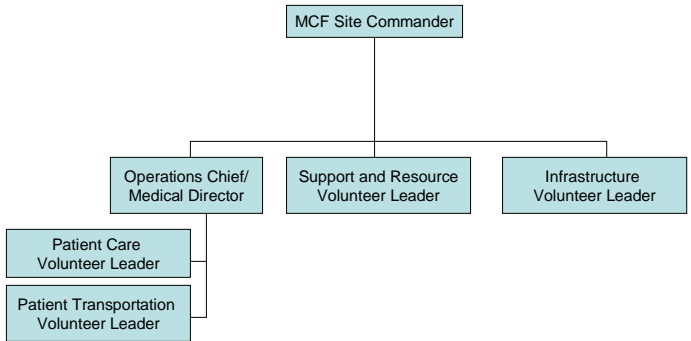
ATTACHMENT B MINIMUM CARE FACILITY INCIDENT COMMAND STRUCTURE

MCF Incident Command Structure



*Not a HEICS defined position

MCF Incident Command Structure



MINIMUM CARE FACILITY CONCEPT OF OPERATIONS

ATTACHMENT C

FORMS

Forms for death processing can be found at: <http://www.ndhealth.gov/vital/EVERS.htm>

TRIAGE AND ADMISSION RECORD

Date:

Time:

Triage Officer:					
Last Name		First Name		MI	
Age	Date of Birth	Home Address		Triage Tag #	
Name of Person Requesting Admission		Relation to Patient	Address		Phone
Next of Kin Name		Relation to Patient	Address		Phone
Why was the person brought in?					
Illness History					
Past Medical History					
Allergies					
CURRENT MEDICATIONS <input type="checkbox"/> List Continued on Back					
Medication Name		Dosage	Frequency	Reason for Use	
Medical Director:					
Blood Pressure		Pulse	Respiration	Temperature	
Physical Exam					
Mental Status			Hydration		
Summary Assessment					
<input type="checkbox"/> Good		<input type="checkbox"/> Fair		<input type="checkbox"/> Serious	
<input type="checkbox"/> Good		<input type="checkbox"/> Fair		<input type="checkbox"/> Serious	
Disposition			Medical Officer Signature		

Bedside Progress Notes

Patient Name:

Bed Number:

Date and Time	Medical Director Notes	Date and Time	Nursing Notes
			<input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Poorly responsive <input type="checkbox"/> Unresponsive Number times water passed this shift: Number of bowel movements this shift: Temp Pulse Resp BP
			Notes:
			<input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Poorly responsive <input type="checkbox"/> Unresponsive Number of times water passed this shift: Number of bowel movements this shift: Temp Pulse Resp BP
			Notes:

Master Patient Record

Date:

Shift:

Bed	Name	Notes	Status
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical
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			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical

Good – indicators excellent **Fair** - indicators favorable **Serious** - indicators questionable **Critical** - indicators unfavorable.

North Dakota Minimum Care Facility Confidentiality Statement

I understand that as a volunteer in a minimum care facility, that I will have access to personal and health information which must not be disclosed to any person not authorized to receive the information in accordance with the laws of North Dakota.

I understand that any information that I learn about any patient in the facility, past or present, regardless of the nature of that information, is to be treated as confidential, and my obligation to maintain the confidentiality of that information will continue as long as I live.

I will not discuss or reveal any information about any patient, past or present, when outside the facility, even at the request of family members, unless authorized to do so as part of my duties in this facility.

I will not view any records about any patient, past or present, except as it relates to my assigned job duties in the facility.

I will not remove any records from the facility.

I understand that if I disclose confidential information, I may be subject to civil or criminal penalties in accordance with the laws of North Dakota.

It is access to confidential information, and not the existence of this document that legally binds me to protect patient confidentiality; however, there is nothing in this policy or in the laws of North Dakota that prevents me from sharing confidential information about a patient with other persons providing medical care for that the patient who need to know the information.

By signing this, I acknowledge that I have read, understand and will comply with this statement.

Volunteer's name (print or type)

Volunteer's signature

Date

Witness

Date

TRANSFER RECORD

Date:

Last Name		First Name		MI
Age	Date of Birth	Home Address		Triage Tag #
Next of Kin Name		Relation to Patient	Address	Phone
Past Medical History				
Allergies				
MEDICATIONS ON ADMISSION TO MCF <input type="checkbox"/> List Continued on Back				
				RECEIVEING NOW
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
Blood Pressure		Pulse	Respiration	Temperature
History and Hospital Course				
Reason for Transfer				
Medical Officer Signature				

Staff – Emergency Information

Date:

Personal Information	
NAME:	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home address	
Home phone	
Cellular phone	
Home e-mail address	
Birthday (MM/DD/YYYY)	
Professional certification or license (List license type or none)	
Medical Information	
Phone number	
Medical conditions	
Allergies	
Current medications	
Doctor's name	
Clinic	
Address	
Emergency Contact Information	
Emergency contact's name	
Relationship	
Address	
Phone Numbers	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other

Incident/Injury Report

<input type="checkbox"/>	An incident is an event that caused injury to a person or damage to equipment, facilities, or materials.				
<input type="checkbox"/>	A near miss is an event that potentially could have caused injury to a person or damage to equipment, facilities, or materials.				
Form completed by:			Person involved in incident:		
Witness(es):					
Date of incident:	Time of incident:	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.	Date reported:	
Department and location where incident occurred:					
Nature of injury (such as strain, cut, or bruise):					
Body parts affected (such as left hand or right ankle):					
Medical treatment required:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did employee leave work because of the injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Employee signature:				Date:	
Supervisor signature:				Date:	

NOTE:

This form is for tracking purposes.
 This form does not constitute a complete report for purposes of worker's compensation.
 A complete report should be made within 24 hours using and appropriate form.

MCF Sign-In

Date:

	Name	ID Card #	Signature	Time In	Time Out
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

MEDICAL MATERIAL TRACKING			
Supply Item	Description	Quantity Remaining	Estimated Daily Use Rate
DIAGNOSTICS			
Glucometer Strips			
Tongue blades			
Thermometer probe covers			
Syringes with Luer lock			
Needles (sizes)			
Pulse Oximeter			
Glucometer			
Adult BP cuffs			
Child BP cuffs			
Infant BP cuffs			
Thermometers			
Stethoscopes – BP			
Stethoscope – Cardiology			
Flashlight and batteries			
HYDRATION			
IV stand			
IVF – NS			
IVF - D5NS			
IVF – D5¼NS			
Tourniquet			
IV catheters 20g			
IV tubing			
Alcohol preps			
Tape (plastic, IV)			
Sharps container, gallon			
Hydration salts			
Feeding/fluid tubing and bags and connectors			

MEDICAL MATERIAL TRACKING			
Supply Item	Description	Quantity Remaining	Estimated Daily Use Rate
NG tubes			
Irrigation syringes			
KY jelly			
RESPIRATORY			
Nasal trumpets (various sizes)			
Airways (various sizes)			
Suction tips			
Suction device			
MEDICATION			
Script pad			
Mortar and pestle			
Insulin syringes and needles			
URINARY AND GI			
Foley catheter/tube/bag			
Emesis basin			
Urinals			
Bedside commodes			
HYGIENE			
Body lotion			
Chux			
Toothbrush			
Toothpaste			
Bedpans			
Towels			
Wash clothes			
Diapers (various sizes)			
Bath basin			
Bath wipes			

MEDICAL MATERIAL TRACKING			
Supply Item	Description	Quantity Remaining	Estimated Daily Use Rate
PPE			
Gowns (provider medium)			
Gowns (provider large)			
N95 masks (various sizes)			
Gloves – non-sterile			
Gloves – Sterile (various sizes)			
Face shields			
Surgical masks			
Gloves – rubber kitchen			
OTHER PATIENT CARE ITEMS			
Identification bracelets			
Obstetrical kit			
Mortuary bags			
Patient lift			
Accessory lighting			
Scissors (bandage)			
Band-aids			
FACILITY ITEMS			
Bleach (gallon)			
Liquid soap			
Toilet paper			
Paper plates			
Napkins			
Plastic tableware			
Plastic cups			
Paper towels			
Permanent markers			
Pens			

MEDICAL MATERIAL TRACKING			
Supply Item	Description	Quantity Remaining	Estimated Daily Use Rate
Stapler and staples			
Tape – cellophane			
Paper clips			
Hole punch			
Binders (3 ring)			
Clipboards			
Ziplock bags (sizes)			
AED (?)			
Ambu bag and mask			
Industrial mop and bucket			
Trashcans			
Desk			
Table			
Office chair			
Supply cart			
FORMS AND PAPER			
History and physical form			
Physician order forms			
Progress notes			
Admission forms			
Patient rosters and status			
Volunteer roster forms			
Workers comp forms			
Volunteer schedule forms			
Plain paper			
Cots, beds or			

MEDICAL MATERIAL TRACKING			
Supply Item	Description	Quantity Remaining	Estimated Daily Use Rate
mattresses			
Sheets			
Pillows			
Pillow cases			
Privacy screens			
TRANSPORTATION			
Stretcher			
COMMUNICATION AND IT			
Extension cords			
Radio			
Television			
Computer			
Ethernet cable			
Printer			
Telephone			
Walkie-talkies			
WASTE			
Trash bags			
Medical waste bags			

MCF SITE REVIEW
QUALITY IMPROVEMENT ASSESSMENT

Assessment Date: _____

Yes	No	Unk	TRIAGE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patients are evaluated for admission according to written triage procedures.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reasons for admission or refusal of admission are documented for each patient seen in triage.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family members are either given literature about care provided in the MCF or literature about how to care for patients at home if the person is not admitted.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No controlled substances are being retained in the facility.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adequate records arrive from the hospital for transfers.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patients arriving from the hospital are appropriate for transfer to this facility.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient condition is updated on the web site daily from the Master Patient Record.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Master Patient Record is kept up-to-date with a fresh printed copy available before rounds each shift.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patient are routinely admitted and begin care within two hours of presentation.

MEDICAL DIRECTORS

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Directors evaluate each patient presenting for admission and complete the triage/history and physical form regardless of whether they are admitted or not.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Only patients meeting triage criteria for pandemic influenza are admitted to the facility
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recovering patients who are discharged leave in a condition and to a destination in which they can be expected to do well.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical rounds are completed on each patient each shift by the medical director, including both the acute care area and the assisted living area.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Directors assign priority for transfer to the hospital each shift, and communicate priority to hospital medical director at least once daily.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	All required records are complete at admission.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Directors chart on each patient each shift and update status designation on the Master Patient Record.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Directors supervise the patient care services provided and ensures the quality of care being provided.

- All decisions regarding admission, to admit or not to admit, are driven by written protocol. Changes in protocol are written and approved by the Site Commander.
- All decisions regarding no admission due to palliative status are made by the Medical Director and based on written triage protocol approved by the Site Commander.
- When a patient dies, family is notified immediately.
- Positioning of NG tubes which are placed or require partial re-insertion ALWAYS have their position checked before NG fluid or feeding.
- Medical Directors make all decisions regarding palliative status according to protocol and reason for palliative status is documented.
- When a patient is put on palliative status, family is notified and given the option of taking the patient home to care for them
- Medical Directors authorize all transfers to the assisted living area on the order sheet.
- A transfer summary is completed on every patient transferred to the hospital. Family is notified of the transfer.

STAFF

- Volunteers report that they receive adequate instruction and mentoring in order to execute their assigned duties.
- All staff sign-in daily.
- All volunteers are registered in the PHEVR system.
- Schedules are always complete at least three days in advance and volunteers know when they are next expected to work.
- All staff meticulously follow patient confidentiality requirements and all volunteers sign a confidentiality agreement before they begin working in the facility.
- Needs of staff are met including rest, hydration, nutrition, personal and emotional.
- Staff are given an opportunity to grieve and referral to counseling as needed
- Over stressed, exhausted or ill staff are removed from duty

PATIENT CARE

- Staffing is adequate to ensure that patients are cleaned in a timely manner.
- Patients are provided chaplaincy services in a timely manner.
- Fluid bags are changed daily and filling of bags is done with washed, freshly gloved hands.

- Living and deceased are treated respectfully at all times.
- Privacy is preserved to the extent possible.
- Patients requiring medication administration receive it on schedule, and Medical Directors are notified when they must administer a medication
- Ethics committee makes periodic review of facility operations.
- Transportation of patients occurs in a timely manner.
- Personal effects are moved with patients, whether to morgue, another facility or home.
- Appropriate documents are sent to the morgue or hospital on transfer and medical records are retained in the facility.
- Patients are treated ethically and equally.
- Access to morgue area is controlled.

SAFETY AND INFECTION CONTROL

- Procedures for maintaining the clean area clean are followed.
- Staff following procedures for staying well.
- Safety officer periodically checks with workers that N95 is worn correctly and is changed every four to six hours.
- Staff are screened for illness before being allowed to work.
- Patients in assisted living are cohorted by sex.
- Volunteers who have on the job incidents complete an incident report form and follow-up filing with WSI is completed as indicated/
- Building perimeters are periodically monitored and warning signs are posted near all exits and air exchange units.
- No unauthorized persons are permitted to enter the building. Only registered staff and approved chaplains may enter.
- Techniques used for patient movement do not put the patient or the care giver at risk.
- Patients in assisted living are consistently assisted with ambulation or movements (e.g., to commodes or chairs) to prevent falls
- Falls rarely or ever occur.
- Containers of patient medications are clearly labeled and patient medication is positioned in relation to the correct patient and returned after use.
- Staff wash hands regularly and use hand rubs between each patient.
- Staff wear PPE appropriately in all circumstances.
- Sharps containers are used for all sharps.

- Body fluids are cleaned up appropriately and safely.
- Containers with electrolyte mixture for feedings are always correctly and clearly label.

SUPPLIES

- Supplies are maintained to prevent shortages.
- Reusable supplies are cleaned thoroughly and according to protocols and returned to the supply area in a timely manner.
- Laundry is returned clean and is available is sufficient quantities.
- Supply issuing is controlled.

RECORDS

- Administrative documentation is maintained and delivered for filing every shift.
- Patient records are maintained and retained, including triage records of those who are not admitted.
- Expenditures are tracked and documentation is maintained.
- Access to filed medical records is controlled.

FACILITY

- Patient care areas are kept clean.
- Staff areas are clean.
- Toilet areas are clean and well supplied.
- Food is available, nutritious and palatable.
- Hazardous waste is kept separate, in biohazard bags, from non-hazardous waste.
- Waste receptacles are emptied regularly and waste is disposed of properly.
- Sharps containers are available.
- Physical plant functioning is maintained including HVAC, and temperature is in comfortable zone.
- IT equipment is functional.

MINIMUM CARE FACILITY CONCEPT OF OPERATIONS SUPPLY LIST

ATTACHMENT D				
Supply Item	Total Use Calculation	Initial (Total)	Reuse	Source
DIAGNOSTICS				
Glucometer Strips	20 patients*3/day*14 days	100 (840)	No	State
Tongue blades	200 patients * 1/day*14 days	1000 (2800)	No	State
Thermometer probe covers	200 patients * 1/day*14 days	500 (2800)	No	State
Syringes with Luer lock	200 patients * 1/day*14 days	2800	No	State
Needles (sizes)	200 patients * 1/day*14 days	2800	No	State
Pulse Oximeter	1 per facility	1	Durable	State
Glucometer	1 per facility	1	Durable	State
Adult BP cuffs	3 per facility	3	Durable	State
Child BP cuffs	1 per facility	1	Durable	State
Infant BP cuffs	1 per facility	1	Durable	State
Thermometers	3 per facility	3	Durable	State
Stethoscopes – BP	3 per facility	3	Durable	State
Stethoscope – Cardiology	1 per facility	1	Durable	State
Flashlight and batteries	3 per facility	3	Durable	Local
HYDRATION				
IV stand	One per 4 patients	10 (30)	Durable	State
IVF – NS	1/day for 10% *200*14 days	20 (280)	No	State
IVF - D5NS	1/day for 25%*200*14 days	50 (700)	No	State
IVF – D5¼NS	2/day for 25%*200	100 (1400)	No	State
Tourniquet	5 per facility	5	Multiuse	State
IV catheters 20g	0.5/day for 25% * 200*14 days	100 (350)	No	State
IV tubing	0.5/day for 25%*200*14 days	100 (350)	No	State
Alcohol preps	0.5/day for 30%*200*14 days	150 (420)	No	State

ATTACHMENT D				
Supply Item	Total Use Calculation	Initial (Total)	Reuse	Source
Tape (plastic, IV)	0.5/day for 30%*200*14 days	150 (420)	Multiuse	State
Sharps container, gallon	4 per facility	4 (4)	No	State
Hydration salts(commercial or home prepared)	120 patients*2/day*14 days+200*3*1	1000 (3960)	No	State
Feeding/fluid tubing and bags and connectors	0.5/day for 70%*200*14 days	200 (980)	Washable	State
NG tubes	2/patient for 70%*200	100 (280)	No	State
Irrigation syringes	2/patient for 70%*200	100 (280)	No	State
KY jelly	1 tube per 10 NGT	10 (28)	Multiuse	State
RESPIRATORY				
Nasal trumpets (various sizes)	2/patient*200	100 (400)	No	State
Airways (various sizes)	0.1 per patient*200	10 (20)	No	State
Suction tips	200 patients*1 per patient	50 (200)	No	State
Suction device	200 patients*1 per patient	50 (200)	Durable	State
MEDICATION				
Script pad	1 per facility	1	Multiuse	Local
Mortar and pestle	3 per facility	3	Durable	State
Insulin syringes and needles	20 patients*3/day*14 days	200 (840)	No	State
URINARY AND GI				
Foley catheter/tube/bag	20 patients	5 (20)	No	State
Emesis basin	Washable	20 (50)	Washable	State
Urinals	Washable	20 (50)	Washable	State
Bedside commodes	7 per facility	3 (7)	Washable	State
HYGIENE				
Body lotion	200 patients*1 per patient	200	Multiuse	Local
Chux	5/day*200*14	3000 (14,000)	No	State

ATTACHMENT D

Supply Item	Total Use Calculation	Initial (Total)	Reuse	Source
Toothbrush	200 patients*1 per patient	200	No	State
Toothpaste	200 patients*1 per patient	200	Multiuse	State
Bedpans	1/patient for 20%*200	20 (40)	Washable	State
Towels	1 per patient per day	200	Washable	Local
Wash clothes	1 per patient per day	200	Washable	Local
Diapers (various sizes)	6/day for 5%*200*14	100 (840)	No	Local
Bath basin	1 per 20 patients	5 (10)	Washable	State
Bath wipes			No	State
PPE				
Gowns (provider medium)	16 workers/shift* 2 per shift*2 shifts*14	250 (896)	Type Dependent	State
Gowns (provider large)	16 workers/shift* 2/shifts*14 d	250 (896)	Type Dependent	State
N95 masks (various sizes)	3 assigned per worker * 60 workers+50% replacement	100 (270)	Multiuse	State
Gloves – non-sterile	8/day*200*14 days	5,000 (22,400)	No	State
Gloves – Sterile (various sizes)	1/day for 5%*200*14	20 (140)	No	State
Face shields	5 per facility	5	Durable	State
Surgical masks	1 per worker per day*44 workers*14	200 (616)	No	State
Gloves – rubber kitchen	2 workers *1/day*14 days	10 (28)	Multiuse	State
OTHER PATIENT CARE ITEMS				
Identification bracelets	200 patients	100 (200)	No	State
Triage tags	200 patients	100 (200)		
Obstetrical kit	2 patients	1 (2)	No	State
Mortuary bags	TBD	2	No	State
Patient lift	2 per facility	2	Durable	State
Accessory lighting	1 per patient row*7 rows	7	Durable	Local

ATTACHMENT D

Supply Item	Total Use Calculation	Initial (Total)	Reuse	Source
Scissors (bandage)	3 per facility	3	Durable	State
Band-aids	0.5/day for 30% *200*14day	100 (420)	No	State
FACILITY ITEMS				
Bleach (gallon)	2 gallons per week*2	1 (4)	Multiuse	Local
Liquid soap	2 gallons per week*2	1 (4)	Multiuse	Local
Toilet paper	2 rolls per day*14	12 (28)	No	Local
Paper plates	3 per worker per day*14*60	1000 (2520)	No	Local
Napkins	3 per worker per day*14*60	1000 (2520)	No	Local
Plastic tableware	6 per worker per day*14*60	2000 (5040)	No	Local
Plastic cups	6 per worker per day*14*60	2000 (5040)	Multi-unit	Local
Paper towels	1 roll per day*14	3 (14)	No	Local
Permanent markers	5 per facility	5	Multiuse	Local
Pens	1 per worker per week*2*60	120	Multiuse	Local
Stapler and staples	1 per facility	1	Multiuse	Local
Tape – cellophane	1 roll with dispenser	1	No	Local
Paper clips	1 box	1	Multiuse	Local
Hole punch	1 per facility	1	Durable	Local
Binders (3 ring)	5 per facility	5	Multiuse	Local
Clipboards	1 per bed +10%	50 (132)	Durable	Local
Ziplock bags (sizes)	1 box quart, 1 box gallon	2	No	Local
AED	1 per facility	1	Durable	State
Ambu bag and mask	1 per facility	1	Washable	State
Industrial mop and bucket	1 per facility	1	Durable	Local
Washtub	6 per facility	6	Durable	Local
Trashcans	1 medical waste+1 regular waste/row	14	Durable	Local
Desk	2 per facility	2	Durable	Local

ATTACHMENT D				
Supply Item	Total Use Calculation	Initial (Total)	Reuse	Source
Table	3 per facility	3	Durable	Local
Office chair	2 per facility	2	Durable	Local
Supply cart	1 per 2 patient rows	3	Durable	Local
History and physical form	1 packet per patient	200	No	Local
Physician order forms	1 per patient	200	No	Local
Progress notes	3 per patient	600	No	Local
Admission forms	1 set per patient	200	No	Local
Patient rosters and status	1 per shift*2*14	28	No	Local
Volunteer roster forms	1 per shift*2*14	28	No	Local
Workers comp forms	20 copies	20	No	Local
Volunteer schedule forms	1 per shift*2*14	28	No	Local
Stretcher	2 per facility	2	Durable	State
Extension cords	1 per patient row*7 rows	7	Durable	Local
Plain paper	1 ream	1 ream	No	Local
Privacy screens	2 per patient row*7 rows	14	Durable	State
COMMUNICATIONS AND IT				
Printer	1 per facility	1	Durable	Local
Telephone	2 per facility	2	Durable	Local
Walkie-talkies	6 per facility	6	Durable	Local
Radio	1 per facility	1	Durable	Local
Television	1 per facility	1	Durable	Local
Computer	1 per facility	1	Durable	Local
Ethernet cable	1 per facility	1	Durable	Local
BEDDING				
Cots, beds or mattresses	1 per patient	120	Durable	Local
Sheets	3 sets per patient +50%	100 (540)	Washable	Local
Plastic sheets	1 per bed, sized by	120	Multiuse	Local

ATTACHMENT D

Supply Item	Total Use Calculation	Initial (Total)	Reuse	Source
	mattress sizes available (twin 96x66, double 96x81)			
Pillows	1 per patient + 10%	132	Multiuse	Local
Pillow cases	3 sets per patient +50%	100 (540)	Washable	Local
WASTE				
Trash bags	4 trash cans*1/day*14 days	56	No	Local
Medical waste bags	4 medical waste cans*2/day*14 days	112	No	State

ATTACHMENT E
SITE SELECTION TOOL FOR MINIMUM CARE FACILITY

Grading: A (best) to D (unacceptable)

Priority Level	Domain	Characteristic	Grade
1	Facility	Flooring	A. Concrete, tile, vinyl, rubber B. Wood D. Carpet
1	Facility	Site acquisition	A. Public building closed due to influenza B. Private building closed due to influenza or public building closed for this use C. Private building closed for this use
1	Facility	Acute care space	A. Single room large enough for all beds B. Two rooms will hold all beds D. Multiple small rooms
1	Facility	Assisted care space	A. Rooms holding from two to six beds B. Single rooms C. Two large rooms (male and female) D. Single large room without sex cohorting
1	Facility	Triage space	A. Separate room proximal to acute care area, with external door opening onto driveway or parking lot B. Distance to external door or distance to acute care area requires transport through non-clean area D. Room not separate or transport through clean area required.
1	Facility	Morgue space	Separate room with solid door required
1	Facility	Ancillary space	A. Separate room for staff rest, eating area, offices, supply storage, counseling, pharmacy (if used) B. Multi-function rooms due to limited space D. No space for all above functions
1	Facility	Halls and Doors	Adequate for gurneys and wheelchairs
1	Facility	Sinks and Toilets	A. Sinks within acute care area and nearby toilets B. Sinks located in nearby toilets only C. Toilets distant
1	Facility	Locker rooms	A. At least two rooms with individual lockers, showers and toilets (male and

			female) B. At least two rooms with lockers (male and female) C. Two rooms with space for staff changing and place to hang clothing and PPE to dry D. Less than C
1	Facility	Communications	A. Internet access, Stagenet access, telephone lines B. No Stagenet access C. No Internet access D. No phone lines
1	Facility	Utilities	A. Hot water, heating, cooling, sewage, electrical power with regular outlets C. Electrical outlets distant
1	Facility	Services	A. Facility provides security staff B. Contracted security staff C. Volunteers provide all security
1	Facility	Services	A. Facility provides laundry services B. Contracted laundry services C. Volunteers provide laundry services
1	Facility	Services	A. Facility provides janitorial services B. Contract or volunteer janitorial services
1	Facility	Services	A. Facility provides food services B. Contracted food services D. Volunteers prepare food
1	Facility	Services	A. Facility provides administrative staff B. Administrative staff assigned to rotating volunteers D. Administrative staff assigned to random volunteers daily
1	Supplies	Bed acquisition	A. Facility provides B. Available from other public facility C. Mixed acquisition (private source, purchase, donated) D. Unsecured supply (e.g., 100% donated at time of event)
1	Supplies	Beds	A. Twin B. Double beds, cots D. Mattress or mat on floor
1	Supplies	Mattresses	A. Vinyl cover, impervious B. Cloth with plastic sheet underlayment
1	Supplies	Refrigeration	A. At least two refrigerators – meds and food B. One medication refrigerator

			C. Refrigeration dependant on ice
2	Facility	Generator	A. Backup generator on site which can run all services B. Backup generator on site can maintain lights and HVAC C. No backup power
2	Facility	Lighting	A. Lighting adequate without supplementation C. Lighting requires supplemental lamps D. Supplemental lighting required without proximal electrical outlets
2	Supplies	Office equipment	A. Fax, computers, copiers, printers available for use B. Some office equipment must be brought in C. All office equipment must be brought in
2	Facility	Ancillary space	Loading dock
2	Facility	Ancillary space	On-site parking

ATTACHMENT F
EXECUTIVE ORDER 2008-0

WHEREAS, the potential for an outbreak of pandemic flu is occurring according to index information reported to me by the state health officer and index information received from the Centers for Disease Control and the State Health Officer and Local Health Officers indicates a severe threat to public health and the potential for large number of serious influenza cases; and

WHEREAS, issuance of an Executive Order to implement North Dakota's **all hazards plan, its appendices and annexes** will automatically implement procedures contained in that plan to reduce the spread of infectious influenza, severe illness, and possible loss of life; and

[Optional] *WHEREAS*, several local subdivisions have declared a local disaster or emergency in accordance with North Dakota Century Code 37-17.1-10, instituting isolation, quarantine, and other measures; and

WHEREAS, pursuant to the provisions of the North Dakota Disaster Act (Chapter 37-17.1, North Dakota Century Code) this executive order;

NOW THEREFORE, I, John Hoeven, Governor of the State of North Dakota, by the authority vested in me, do hereby order that the pandemic flu mitigation actions as listed in the North Dakota **all hazards plan, its appendices and annexes applicable to a pandemic flu** be extended to all lands both public and private; and

I further order that –

All laws under title 43 of North Dakota Century Code, and any other law **or any administrative rule** regarding the licensing, certification, and scope of practice of any health care provider, are suspended during the for the duration of this executive order, **to the extent an exception from any licensing, certification, and scope of practice requirement is permitted under the North Dakota all hazards plan, or order of the state health officer.**

All laws under title 23 North Dakota Century Code and any other law **or any administrative rule** relating to the licensing and certification of hospitals and other health care facilities, including bed capacity, staffing ratios, life safety code, and other similar requirements are suspended for the duration of this executive order, **to the extent an exception from any licensing, certification, bed capacity, staffing ratio, life safety code, and other similar requirement is permitted under the North Dakota all hazards plan, or order of the state health officer.**

All laws under title 23 North Dakota Century Code and any other law **or any administrative rule** relating to ambulance transportation, burial time of the deceased, requirements for corners to examine bodies, mandatory reporting of disease and death, and patient tracking are suspended for the duration of this Executive Order, **to the extent an exception from any ambulance transportation, burial time, corner examination, disease and**

death reporting, and patient tracking requirement is permitted under the North Dakota all hazards plan, or order of the state health officer.

I further order that all state departments and administrators maintain pandemic flu response resources and capabilities at high levels of readiness to executive responsibilities pursuant to the State all hazards plan, its appendices and annexes applicable to a pandemic flu; and

This order is issued upon the following basis and for the following reasons:

1. The governor is vested with the executive authority pursuant to Article V, Section 1 or North Dakota Constitution; and
2. The governor is vested with statutory authority to issue an executive order to minimize or avert the effects of a disaster or emergency pursuant to Chapter 37-17.1 of the North Dakota Century Code; and
3. The governor is vested with statutory authority to issue an executive order that suspends or modifies any otherwise applicable statute or administrative rule pursuant to N.D.C.C. § 37-17.1-05(6)(a); and
4. A coordinated and effective effort of all state departments is required to minimize or avert the effects of disasters and emergencies in this state; and

5. An outbreak of pandemic flu is occurring according to index information reported to me by the state health officer and index information received from the Centers for Disease Control and the State Health Officer and Local Health Officers indicates a severe threat to public health.

Executed at Bismarck, North Dakota, this ___ day of _____ 2008.

/s/
John Hoeven
Governor

Attest:
/s/
Alvin A. Jaeger
Secretary of State

ATTACHMENT G
SUPPLY AND ENVIRONMENTAL CLEANING PROTOCOLS

SUPPLY ITEM CLEANING:

The following items have been designated as washable and would be processed by the supply area.

Category A (Bleachable)

- Emesis basin
- Urinals
- Bedside commodes
- Bedpans
- Bath basin

Category B (Non-Bleachable)

- Feeding/fluid tubing and bags and connectors
- Ambu bag mask

Category A (Bleachable)

1. Rubber gloves should be worn at all times.
2. In a wash tub or separate sink, wash items in hot, soapy water removing all visible soilage.
3. In a separate wash tub or sink, rewash items in hot, soapy water and rinse.
4. In a separate wash tub, wash items using solution of 1-2 tablespoons of bleach per gallon of cool water.
5. Rinse in clean water and allow to air dry completely.

Category B (Non-bleachable)

1. Rubber gloves should be worn at all times.
2. In a wash tub or separate sink, wash items in hot, soapy water removing all visible soilage.
3. In a separate wash tub or sink, rewash items in hot, soapy water and rinse.
4. In a separate wash tub, wash items using solution of 1 cup of white vinegar per three cups of water.
5. Rinse in clean water and allow to air dry completely.

Items may be restocked after they have air dried completely.

In the event of serious supply shortage, other items may need to be washed for re-use. As a rule of thumb, items made of hard plastic or metal may be final-washed in bleach. Soft plastic items should be final-washed in vinegar rinse.

**Recipe for Bleach Disinfecting Solution
Environmental Surfaces**

1/4 cup bleach
1 gallon of cool water

OR

1 tablespoon bleach
1 quart cool water

Add the household bleach (5.25%
sodium hypochlorite) to the water.

**Recipe for Weaker
Bleach Disinfecting Solution
(Use on sensitive objects)**

1 tablespoon bleach
1 gallon cool water

DANGER: DO NOT MIX AMMONIA CONTAINING SOLUTIONS WITH BLEACH

Attachment H

JOB ACTION SHEETS

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MCF Job Action Sheet
Site Commander
Copies: 3

Section assignment: Command Staff	
Report to: Local EOC	
Supervise: Safety Officer, Liaison Officer, Operations Chief, Logistics Chief, Medical Director	
Mission	<ul style="list-style-type: none"> • Direct all operation at MCF • Maintain communications with local EOC and DOC • Ensure MCF is prepared to receive and care for patients
Equipment	<ul style="list-style-type: none"> • Cellular telephone • Walkie-talkie • Full access to command office and equipment • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Familiarize self with job duties of all staff in the facility;
- Appoint command staff directly supervised by this position and orient staff to their responsibilities;
- Establish command center on-site and develop incident action plan with assistance of staff;
- Establish communication protocols;
- Re-enforce role and authority of Safety Officer;
- Review MCF planning documents;
- Delegate responsibilities to command staff and assume responsibility for all tasks not assigned.

Ongoing Duties

- Obtain full briefing from off-shift Site Commander when coming on shift;
- Wear appropriate identification and safety equipment at all times;
- Brief all supervised staff on duties and self-protective actions;
- Brief and de-brief supervised command staff as needed;
- Support decision making of command staff and make decisions as necessary;
- Maintain communication with local EOC and NDDoH DOC;
- Interact with media as necessary and approve release of media information;
- Approve resource acquisitions and ascertain from staff resource immediate and future resource needs;
- Anticipate and complete all tasks not assigned to others to complete;
- Perform site review for quality improvement on regular schedule;
- Remain in the facility throughout assigned shift and reachable;
- Supervise demobilization of facility when no longer needed;
- Prepare off-shift report and fully brief replacement at change of shift;
- Document any decisions, incidents, actions taken or change of procedures;

- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Ensure smooth shift transition for command staff;
- Remain accessible when off shift;

MCF Job Action Sheet
 Medical Director
 Copies: 3

Section assignment: Command Staff	
Report to: Site Commander	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Medical and ethical decision making • Admission and discharge of patients • Regular assessment of all patients
Equipment	<ul style="list-style-type: none"> • Cellular telephone • Walkie-talkie • Full access to command office and equipment • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Familiarize self with job duties of all patient management positions.
- Review MCF planning documents
- Familiarize self with available medical supplies and adequacy

Ongoing Duties

- Brief Site Commander regarding global issues related to patient care needs
- Wear appropriate identification and safety equipment at all times;
- Update Site Commander on request, and update Ops Chief regularly;
- Coordinate patient management with Operations Chief;
- Obtain full briefing from Medical Director going off shift, including any changes to policy;
- Interact with media as necessary;
- Establish, confirm or modify written criteria for admission, discharge, medication use, designation of palliative care and other patient management policies in incident action plans;
- Ensure that only patients who meet the criteria for influenza are admitted to the facility;
- Assess patients and apply current written patient management policies;
- Perform needed vital signs not obtainable by patient care staff;
- Perform rounds on each patient during each 12 hour shift, assessing patient status and needs and documenting in progress notes;
- Update master patient status form during rounds;
- Respond to all requests for medical assistance from patient care providers;
- Perform all invasive medical interventions (IV, NG tube, foley);
- Make a determination of death;
- Develop a list of patients for priority transfer to the hospital and ensure that this is communicated to the medical director of the hospital at least once per day along with bed status (filled and open);

- Determine when a patient are ready for discharge or move from the acute care floor to assisted care area;
- Identify resource needs for patient care and communicate them to the Material Supply Unit Leader;
- Remain in the facility throughout assigned shift;
- Ensure all patients have appropriate dispositions during demobilization of site;
- Prepare off-shift report and fully brief replacement at change of shift;
- Document any decisions, incidents, actions taken or change of procedures;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Ensure smooth shift transition for command staff
- Remain accessible when off shift

MCF Job Action Sheet
Liaison Officer
Copies: 3

Section assignment: Command Staff	
Report to: Site Commander	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Establish communications with all outside entities • Manage all media responses relayed by the local EOC or DOC • Relay information to media for release to public regarding MCF • Manage and relay important information to staff • Be familiar with facility statistics which may be requested
Equipment	<ul style="list-style-type: none"> • Cellular telephone • Walkie-talkie • Full access to command office and equipment • N95 mask (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Familiarize self with job duties of all supervisory positions;
- Review MCF planning documents;
- Secure contact information for local EOC, NDDoH DOC, local hospital, EMS, media and other key partners;

Ongoing Duties

- Obtain briefing from Liaison Officer going off shift;
- Wear appropriate identification and safety equipment at all times;
- Act in assistant role to Site Commander;
- Update Site Commander regularly;
- Establish contact with outside supporting entities and maintain contact data
- Take incoming calls and direct necessary calls or information to appropriate staff;
- Log all communications;
- Maintain ongoing awareness of situations, activity and policies in the institution;
- Assist medical director with documentation which tracks current facility policy related to patient care;
- Review with Site Commander information to be released to the public;
- Make requests for assistance which are approved by the incident commander;
- Request information and maintain records needed by the site commander;
- Anticipate intra-organization problems;
- Establish an area outside the facility where media questions can be answered and notify media of access restriction;
- Assist Site commander with preparation of media briefings;
- Remain in the facility throughout assigned shift and reachable;
- Prepare off-shift report and fully brief replacement at change of shift;
- Document actions and decisions;

- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Remain accessible when off shift;

MCF Job Action Sheet
Safety and Security Officer

Copies: 3

Section assignment: Command Staff	
Report to: Site Commander	
Supervise: Security worker	
Mission	<ul style="list-style-type: none"> • Establish and enforce safety procedures • Establish and enforce security procedures • Immediately terminate any activity which poses a risk for staff or patients
Equipment	<ul style="list-style-type: none"> • Cellular telephone • Walkie-talkie • Full access to command office and equipment • N95 mask (3)

Initial Duties

- Wear appropriate identification and safety equipment at all times;
- Be familiar with all responsibilities described on this sheet;
- Review MCF planning documents;
- Establish safety procedures related to infection control, physical management of space inside and outside the facility, and material/equipment handling;
- Establish security procedures for worker entry and exit from the building, worker identification, access to building and security of valuable equipment;
- Establish procedures for patient privacy and confidentiality including personal privacy, protection of health information and respect for human remains;
- Review procedures with Site Commander and obtain approval or modification;
- Appoint additional security workers required.
- Assume all duties related to safety and security not assigned to supervised personnel.

Ongoing Duties

- Obtain briefing from Safety/Security Officer going off shift;
- Update Site Commander regularly;
- Conduct a safety briefing at the beginning of each shift;
- Brief all new staff on safety and security procedures;
- Brief all supervised staff on duties and self-protective actions;
- Ensure all staff log in an out of facility;
- Ensure that PPE is not removed from the facility at checkout;
- Observe staff and patients to ensure safety and security procedures are followed;
- Ensure that only identified staff have access to the building;
- Establish entry and exit sites, control access points and ensure safe vehicle movement outside the premises;
- Work with transportation leader to establish patient and remains transportation procedures to ensure the safety of patients and workers;

- Remove unauthorized personnel from the premises;
- Immediately terminate any activity which may pose a threat to staff or patients;
- Obtain signed privacy agreements from all staff at initial orientation;
- Establish and mark external areas for appropriate vehicle use;
- Monitor physical facility for hazards, physical or infectious;
- Call for emergency assistance (fire, police) if needed;
- Monitor staff for illness, stress or fatigue and remove staff from duty as needed;
- Ensure that all staff off duty leave the facility within two hours of end of shift;
- Remain in the facility throughout assigned shift and reachable;
- Prepare off-shift report and fully brief replacement at change of shift;
- Document actions and decisions;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Remain accessible when off shift;

MCF Job Action Sheet
 Security Worker
 Copies: 3

Section assignment: Command Staff	
Report to: Safety and Security officer	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Enforce safety procedures • Enforce security procedures • Immediately terminate any activity which poses a risk for staff or patients
Equipment	<ul style="list-style-type: none"> • Walkie-talkie • N95 mask (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Know all safety, security and privacy procedures established by supervisor

Ongoing Duties

- Wear appropriate identification and safety equipment at all times;
- Manage safety, security and privacy roles assigned by supervisor;
- Observe staff and patients to ensure safety and security procedures are followed;
- Ensure that only identified staff have access to the building;
- Immediately terminate any activity which may pose a threat to staff or patients;
- Monitor physical facility for hazards, physical or infectious;
- Notify Safety and Security Officer of impending hazards;
- Monitor staff for illness, stress or fatigue and report concerns to safety and security officer;
- Remain in the facility throughout assigned shift and reachable;
- Prepare off-shift report and fully brief replacement at change of shift;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Remain accessible when off shift;

MCF Job Action Sheet
 Logistics Chief
 Copies: 3

Section assignment: Command Staff	
Report to: Site Commander	
Supervise: Facility Unit Leader, Materials Supply Unit Leader, Nutritional Supply Unit Leader, Communications Unit Leader, Transportation Unit Leader	
Mission	<ul style="list-style-type: none"> • Supervise Logistics Section • Ensure all needs related to materiel, physical facility, communication services and transportation services are met • Request additional resources
Equipment	<ul style="list-style-type: none"> • Walkie-talkie • Cellular telephone • Full access to command office and equipment • N95 mask (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Familiarize self with job duties of all positions with section ;
- Review MCF planning documents;
- Appoint persons to unfilled supervised positions;
- Assume all logistical tasks not assigned to other persons.

Ongoing Duties

- Update Site Commander regularly;
- Obtain briefing from Logistics Officer going off shift;
- Wear appropriate identification and safety equipment at all times;
- Provide briefing to Logistics Section Staff at the beginning of each shift;
- Meet with staff regularly to assess needs;
- Brief all supervised staff on duties and self-protective actions;
- Prepare requests for resources for approval by the Site Commander;
- Work with Liaison Officer to identify and secure additional resources;
- Work with Safety/Security Officer to establish safe procedures for receiving and storing resources;
- Attempt to improvise resource procurement or resource modification if needed materiel is not available;
- Ensure that resources are managed, allocated, tracked and recovered when no longer needed;
- Track expenditures;
- Activate contracted services;
- Remain in the facility throughout assigned shift and reachable;
- Prepare off-shift report and fully brief replacement at change of shift;
- Document actions and decisions;

- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Remain accessible when off shift;

MCF Job Action Sheet
 Facility Unit Leader
 Copies: 3

Section assignment: Logistics	
Report to: Logistics Chief	
Supervise: Maintenance Officer, Sanitations Systems Officer	
Mission	<ul style="list-style-type: none"> • Oversee all aspects of building management • Ensure adequate material and personnel resources are available for building management
Equipment	<ul style="list-style-type: none"> • N95 masks (3) • Walkie-Talkie

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Familiarize self with job duties of all positions with section
- Review MCF planning documents
- Work with Safety and Security Officer establish protocols for cleaning and disinfection of building, safe clean-up of spills and linen cleaning
- Appoint persons to unfilled supervised positions
- Assume all tasks related to maintenance and sanitation not assigned to other persons

Ongoing Duties

- Obtain briefing from Facility Unit Leader going off shift
- Wear appropriate identification and safety equipment at all times;
- Brief all supervised staff on duties and self-protective actions
- Allocate locker space for worker property and equipment
- Establish schedules for cleaning of various areas of facility
- Monitor facility cleanliness
- Ensure all sanitation materiel is accessible for use at all times
- Monitor linen supplies and ensure adequate supplies
- Assist supervised staff with cleaning duties
- Remain in the facility throughout assigned shift and reachable
- Prepare off-shift report and fully brief replacement at change of shift
- Document actions and decisions;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Remain accessible when off shift;

MCF Job Action Sheet
Sanitation Systems Officer
Copies: 3

Section assignment: Logistics	
Report to: Logistics Chief	
Supervise: Laundry Workers, Sanitation Workers	
Mission	<ul style="list-style-type: none"> • Ensure patient linen is appropriately cleaned • Ensure all physical areas of facility are clean • Clean up spills and body fluids • Ensure disposal of waste including infectious waste • Ensure all persons in unit wear appropriate protective equipment
Equipment	<ul style="list-style-type: none"> • N95 masks (3) • Walkie-Talkie

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Familiarize self with job duties of all positions with section;
- Review MCF planning documents;
- Work with Safety and Security Officer establish protocols for cleaning and disinfection of building, safe clean-up of spills and linen cleaning;
- Appoint persons to unfilled supervised positions;
- Assume all logistical tasks not assigned to other persons.

Ongoing Duties

- Obtain brief from sanitation office going off shift;
- Brief all supervised staff on duties and self-protective actions;
- Wear appropriate identification and safety equipment at all times;
- Allocate locker space for worker property and equipment;
- Establish schedules for cleaning of various areas of facility;
- Monitor facility cleanliness;
- Inspect waste receptacles and ensure hazardous and non-hazardous waste is being correctly separated;
- Ensure sanitation resources needed for body fluid cleanup are accessible to all staff;
- Ensure hand cleansers and hand washing material are always accessible;
- Monitor linen supplies and ensure adequate supplies;
- Assist supervised staff with cleaning duties;
- Remain in the facility throughout assigned shift and reachable;
- Prepare off-shift report and fully brief replacement at change of shift;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Remain accessible when off shift;

MCF Job Action Sheet
 Laundry Worker
 Copies: 3

Section assignment: Logistics	
Report to: Sanitation Systems Officer	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Retrieve dirty linen from collection points • Wash and fold linen for re-use • Restock clean linen in storage area
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Complete orientation

Ongoing Duties

- Obtain briefing from linen worker going off shift
- Wear appropriate identification and safety equipment at all times;
- Retrieve linen from collection areas and replace empty collection container
- Coordinate with supervisor for obtaining laundry supplies and any money needed for machine operation
- Wash and bleach linen using external facilities if necessary
- Fold linen;
- Restock clean linen storage;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;

MCF Job Action Sheet

Janitorial Worker

Copies: 3

Section assignment: Logistics	
Report to: Sanitation Systems Officer	
Supervise: None	
Mission	<ul style="list-style-type: none">• Prepare cleaning solutions and supplies• Clean facility daily and restroom areas twice daily• Collect and appropriately dispose of waste including hazardous waste• Clean spills and body fluids
Equipment	<ul style="list-style-type: none">• N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Complete orientation

Ongoing Duties

- Obtain briefing from janitorial worker going off shift
- Wear appropriate identification and safety equipment at all times;
- Ensure adequate cleaning supplies are available
- Store and prepare cleaning solutions safely
- Clean restroom areas twice per 24 hour period
- Mop floors in all use areas daily
- Clean patient care area daily and between patients
- Clean up spills, including body fluid spills, safely
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
Maintenance Officer
Copies: 3

Section assignment: Logistics	
Report to: Facility Unit Leader	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Ensure physical plant functions are operation • Ensure necessary supplies or parts are available to maintain physical plant
Equipment	<ul style="list-style-type: none"> • N95 masks (3) • Walkie-talkie

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Complete orientation
- If unfamiliar with building, conduct facility review and functional assessment

Ongoing Duties

- Obtain briefing from maintenance officer going off shift
- Wear appropriate identification and safety equipment at all times;
- Confirm the functioning of all utilities at least once per shift
- Complete a walk through of the physical plant to identify damage, functional problems or hazards
- Review content of supply and spare part inventory and obtain additional items needed or anticipated to be needed soon
- Track expenditures
- Correct any physical plant problems identified
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
Materials Supply Unit Leader
Copies: 3

Section assignment: Logistic	
Report to: Logistics Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Manage disposable and durable equipment and supplies (for patient care and administration) • Maintain adequacy of supplies • Maximize supply usage efficiency • Ensure all reusable supplies are cleaned and re-stocked for use
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Complete orientation
- Inventory supplies and storage facilities

Ongoing Duties

- Obtain briefing from Materials Supply Unit Leader going off shift;
 - Wear appropriate identification and safety equipment at all times;
- Receive and store materials required for patient care and administration of site;
- Duplicate forms as needed;
- Track material usage and request additional supplies as needed through logistics chief, ensuring adequate time for re-supply before shortage occurs;
- Ensure supplies are in a storage site that can be secured;
- Control access to sensitive or tightly limited supplies, and issue medical supplies to workers;
- Identify approaches to improve conservation where possible, reviewing safety of any proposed re-use procedure change with safety officer;
- Track and document expenditures;
- Train staff in conservation and re-use procedures;
- Clean re-usable items according to protocol before restocking;
- Recover durable and unused supplies and equipment at the time of facility closure, making material disposition according to instructions received at that time;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Nutritional Supply Unit Leader
 Copies: 3

Section assignment: Logistics	
Report to: Logistics Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Ensure access of staff to food and beverage • Ensure patients are fed according to medical orders • Ensure safe food handling and disposal • Maintain food service area • Clean and store food service items
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Complete orientation
- Obtain needed food service supplies and equipment
- Set up food service area including physical site and needed supplies
- Ensure adequate plans for acquisition of food are in place
- Identify safe storage location for food
- Ensure adequate supplies of water are available on-site at all times

Ongoing Duties

- Obtain briefing from Nutrition Supply Unit Leader going off shift
- Wear appropriate identification and safety equipment at all times;
- Wash hands frequently and thoroughly
- Track expenditures
- Follow safe food handling procedures
- Manage food and beverage contractors
- Receive and store food, beverage and food service items
- Ensure sanitary food, beverage and solution preparation and storage
- Ensure food accessibility
- Clean food service area
- Prepare and deliver food for assisted living patients with help of assigned care provider
- Prepare nasogastric solutions under supervision of medical director
- Recover and clean food service items
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Communications Unit Leader
 Copies: 3

Section assignment: Logistics	
Report to: Logistics Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Provide IT support to users • Provide for setup and troubleshooting of hardware and software • Distribute and recover communications and IT equipment
Equipment	<ul style="list-style-type: none"> • N95 masks (3) • Walkie-Talkie

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Complete orientation

Ongoing Duties

- Obtain briefing from Communications Unit Leader going off shift;
- Wear appropriate identification and safety equipment at all times;
- Maintain all communications equipment in working order;
- Setup IT equipment and troubleshoot user, hardware and software problems;
- Distribute portable communication equipment as needed, and ensure all users are familiar with usage and common frequencies;
- Maintain supply of IT equipment not in current use;
- Recovery IT equipment when no longer needed;
- Document expenditures;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any actions or decisions;

MCF Job Action Sheet
 Transportation Unit Leader
 Copies: 3

Section assignment: Logistics	
Report to: Logistics Chief	
Supervise: Transport workers	
Mission	<ul style="list-style-type: none"> • Manage movement of patients and remains within the facility; • Arrange travel from the facility.
Equipment	<ul style="list-style-type: none"> • N95 masks (3) • Walkie-Talkie

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;
- Assess resources and physical condition of resources.
- Assign sufficient transportation workers to cover need;
- Assume responsibility for all responsibilities within unit which are not assigned to supervised personnel.

Ongoing Duties

- Obtain briefing from Transportation Unit Leader going off shift
- Wear appropriate identification and safety equipment at all times;
- Work with Safety/Security Officer to establish transportation protocols, including safe lifting, safe patient movement, release of patients or remains to receiving care giver, respectful treatment of patients and remains, loading and unloading areas for external transportation;
- Orient supervised workers to task and self-protection measures;
- Ensure transport workers follow all transportation protocols;
- Assess transportation resources and transportation needs;
- Maintain transportation resource area for unused gurneys and wheelchairs;
- Assist transportation workers with patient movement;
- Work with Liaison Officer to secure needed external transportation resources;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Transport Workers
 Copies: 3

Section assignment: Logistics	
Report to: Transportation Unit Leader	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Move patients within the facility; • Load and unload patients from external transportation vehicles; • Move human remains; • Move supplies and equipment as needed.
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Complete orientation

Ongoing Duties

- Obtain briefing from Transport Workers going off shift
- Wear appropriate identification and safety equipment at all times;
- Follow all transportation protocols;
- Load onto or unload patients from gurney or wheelchair while ensuring their safety;
- Ensure all personal effects accompany patient;
- Move patients within the facility;
- Move human remains to morgue area with personal effects;
- Move human remains from morgue to external transportation vehicle;
- Assist patient care givers with patient movement in bed or into and out of bed;
- Unload supplies and equipment and move to appropriate storage areas;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Planning Chief
 Copies: 3

Section assignment: Planning	
Report to: Site Commander	
Supervise: Situation Unit Leader, Labor Pool Unit Leader	
Mission	<ul style="list-style-type: none"> • Situational assessment • Situational projections • Action planning
Equipment	<ul style="list-style-type: none"> • Cellular telephone • Walkie-talkie • Full access to command office and equipment • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;
- Assign all supervised positions which are unassigned;
- Assume all duties within section not assigned to supervised personnel.
- Develop working knowledge of all planning documents;

Ongoing Duties

- Obtain briefing from Planning Section Chief going off shift;
- Wear appropriate identification and safety equipment at all times;
- Brief Site Commander regularly;
- Attend section briefings and identify needed actions;
- Discuss and validate situation projections developed previous shift at section brief;
- Provide briefing to Planning Section Staff at the beginning of each shift;
- Complete proposed action plan after the section briefing, confirm actions with Site Commander and disseminate to staff;
- Supervise work of assigned staff;
- Work with Liaison Officer to remain informed on all incoming information and situation of all sections as shift progresses;
- Develop situation projections for 12, 24 and 48 hours post shift and review with incoming planning chief at change of shift;
- Prepare any required situation reports for Site Commander;
- Manage all statistical data and prepare it for use by those needing it;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Situation Unit Leader
 Copies: 3

Section assignment: Planning	
Report to: Planning Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Retrieve and file all management documents • Retrieve and file patient records • Duplication
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet
- Complete orientation

Ongoing Duties

- Obtain briefing from Situation Unit Leader going off shift
- Wear appropriate identification and safety equipment at all times;
- Take minutes for daily briefings and other meetings as assigned;
- Retrieve all management forms, costs records, briefings, situation reports or other records from staff before they leave;
- Perform any needed duplication including blank forms and patient records at transfer or final disposition;
- Assist Planning Chief with preparation of reports;
- Recover patient records when patient is discharged and file;
- Provide for confidentiality of all patient records;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Labor Pool Unit Leader
 Copies: 3

Section assignment: Planning	
Report to: Planning Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Recruit, credential and schedule staff for duty • Log staff in and out of building • Provide of needs of staff while on duty
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;
- Assign all supervised positions which are unassigned;
- Assume all duties within section not assigned to supervised personnel.

Ongoing Duties

- Obtain briefing from Labor Pool Unit Leader going off shift;
- Wear appropriate identification and safety equipment at all times;
- Keep supervisor up-to-date on staffing;
- Track location of staff, logging staff in and out of building;
- Observe staff for signs of illness when reporting for duty;
- Upon recruitment, confirm licensure status of medical director and any other staff acting under a professional health care license;
- Assist Staff Support Unit Leader with meeting needs of staff;
- Schedule staff for duty in advance and provide schedule to all staff;
- Fill gaps in staffing;
- Work with Liaison to recruit additional volunteers to expand available staffing;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Operations Chief
 Copies: 3

Section assignment: Operations	
Report to: Site Commander	
Supervise: Morgue Unit Leader, Triage Unit Leader, Staff Support Unit Leader, General Nursing Care Unit Leader, Dependent Care Unit Leader, Pharmacy Unit Leader	
Mission	<ul style="list-style-type: none"> • Supervise Operations Unit Leaders • Ensure ethical treatment of patients • Project and communicate resource needs for operations section
Equipment	<ul style="list-style-type: none"> • Cellular telephone • Walkie-talkie • Full access to command office and equipment • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;
- Keep Site Commander updated on status of operations;
- Assign all supervised positions which are unassigned;
- Assume all duties within section not assigned to supervised personnel.

Ongoing Duties

- Obtain briefing from Operations Chief going off shift;
- Wear appropriate identification and safety equipment at all times;
- Brief Site Commander regularly;
- Attend section briefings and identify needed actions;
- Provide briefing to Operations Section Staff at the beginning of each shift;
- Ensure the ethical treatment of all patients;
- Work with Medical Director to assess facility needs for patient care;
- Work with Planning Chief to make projections on facility usage, including expansion and contraction of bed space;
- Work with Logistics Chief to obtain needed resources to maintain patient care;
- Assist unit leaders with problem solving and situational assessment;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
Morgue Unit Leader
Copies: 3

Section assignment: Operations	
Report to: Operations Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Assist with movement of remains to morgue area • Manage morgue • Ensure correct identification stays with body • Complete death registration documentation • Arrange of pickup of bodies by morgue team
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;

Ongoing Duties

- Obtain briefing from Morgue Unit Leader going off shift;
- Wear appropriate identification and safety equipment at all times;
- Track location of all remains that are in the facility;
- Assist Transport Workers with movement of remains to morgue area;
- Ensure that each body moves retains identification and correct paper work accompanies remains from facility;
- Complete death documentation;
- Assist medical director with notification of families and track date/time and family member to whom notification is given;
- Provide information to families regarding community policies for access to remains;
- Ensure all personal belongings accompany remains from facility;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Ensure respectful treatment of remains throughout the facility;
- Keep remains covered and out of view;
- Restrict access to morgue to senior staff and transport workers;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
Triage Unit Leader
Copies: 3

Section assignment: Operations	
Report to: Operations Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Assess each patient that presents for admission criteria • Ensure all needed records and medications are obtained for each patient at time of admission; • Perform preliminary completion of documentation • Provide admission information and assistance to Medical Director
Equipment	<ul style="list-style-type: none"> • N95 masks (3) • Walkie-talkie

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;

Ongoing Duties

- Obtain briefing from Triage Unit Leader going off shift;
- Wear appropriate identification and safety equipment at all times;
- Work with Medical Director to establish protocols for patient assessment specific to current triage criteria;
- Ensure triage criteria and admission access is applied without prejudice or preference;
- Ensure triage is setup near entry area and away from acute care area with all needed documents, assessment tools and patient care items;
- Contact security or any other available staff for support in dealing with aggressive or threatening situations;
- Educate families bringing patients for care regarding facility policies and limitations;
- Contact Transport Workers and supervise safe transfer of patient from arriving vehicle;
- Assess each patient presenting to the facility from the community for admission criteria including obtaining and documenting history and vital signs;
- Make additional contacts regarding patient if needed to complete assessment;
- Ensure all needed medical records and patients personnel medication are available at admission;
- Consult with Medical Director regarding each patient presenting for admission.
- Assist Medical Director with his or her physical exam, admission documentation and any invasive procedures;
- Keep Master Patient Record updated, with patient bed assignments;
- Ensure discharged patients or family receive instructions for continuing care;

- Prepare updated printed copy of Master Patient Record (bed number and Name) for use by Medical Director on shift rounds and update patient status in patient tracking system.
- Ensure chart accompanies patient to care site;
- Notify Pharmacy Unit Leader of admission orders for medication and deliver medication brought in by family;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Staff Support Unit Leader
 Copies: 3

Section assignment: Operations	
Report to: Operations Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Assessment mental, emotional and physical condition of staff • Remove impaired staff from duty • Ensure that staff have adequate rest breaks and take nutrition and hydration; • Observe staff for compliance with personal protection • Provide opportunity for staff to discuss feelings, stress and needs
Equipment	<ul style="list-style-type: none"> • N95 masks (3) • Walkie-talkie

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;

Ongoing Duties

- Obtain briefing from Staff Support Unit Leader going off shift;
- Wear appropriate identification and safety equipment at all times;
- Keep Labor Pool Unit Leader notified of staff who become unable to work;
- Observe staff for signs of illness and observe them for compliance with use of personal protective equipment and behaviors;
- Assess physical, emotional and mental well being of staff and remove staff from duty if impaired;
- Ensure staff take adequate breaks, nutrition and hydration;
- Meet the mental, emotional and physical needs of staff to the extent possible;
- Assess staff for stress arising from presence of family members in MCF and advise Labor Pool Unit Leader and General Nursing Care Unit Leader regarding assignment;
- Assess staff for stress related to family at home and assess for grief related to family or friend death;
- Observe interaction and seek to maintain interpersonal communication at a constructive level;
- Mediate conflict and defuse abnormal or inappropriate interactions between staff, including working with Labor Pool Unit Leader to ensure reassignment;
- Provide opportunity for staff to discuss feelings, stresses and needs in a confidential setting, and in a group setting if needed;
- Refer staff to professional assistance such as MCF chaplain or professional mental health worker;
- Maintain confidentiality of all staff communications unless there is danger to the staff member, other staff or patients;

- Work with supervisory staff to develop atmosphere of mutual support and concern of staff for each other;
- Maintain awareness of staff of availability of chaplaincy assistance for patients, other staff members or self, and work with liaison to arrange chaplain access;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Maintain a level of external world awareness and provide guidance to Operations Chief regarding information which should be communicated to all staff;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 General Nursing Care Unit Leader
 Copies: 3

Section assignment: Operations	
Report to: Operations Chief	
Supervise: Care Providers	
Mission	<ul style="list-style-type: none"> • Manage acute patient care area • Make assignments of care providers to patients • Assess adequacy of staffing to provide minimal acceptable care • Allocate provide care time to palliative patients as available or necessary • Maintain situational awareness of all patients in acute care area and possible status change • Maintain situational awareness of all patient care staff in acute care area
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;
- Assign all supervised positions which are unassigned;
- Assume all duties within unit not assigned to supervised personnel.

Ongoing Duties

- Obtain briefing from General Nursing Care Unit Leader going off shift;
- Wear appropriate identification and safety equipment at all times;
- Assess staffing adequacy and keep Operations Chief and Labor Pool Unit Leader up-to-date;
- Determine frequency of some types of care, such as bathing, based on staffing capacity;
- Assess residual capacity to care for additional patients and communicate needs to Operations Chief regarding resources needed for expansion;
- Assist Medical Director with rounds, completing documentation of each patients as they are seen and tracking actions which Medical Director needs to follow-up with for specific patients;
- Notify Pharmacy Unit Leader of any changes in orders that affect medication;
- Assign Care Providers in teams to two to patients;
- Assign inexperienced staff to mentorship training by most capable staff;
- Assess capability of staff ensuring at least one member of each team is well trained and performs well;
- Observe staff for signs of illness;
- Observe staff for correct use of personal protective equipment and application of self-protective behaviors include safe lifting and avoiding contamination of self;
- Ensure procedures are followed which fulfill infection control policy;

- Supervise administration of medication, discussing any concerns with Medical Director or notify Medical Director when it is time for him or her to administer medication;
- Ensure all patients are treated ethically and without prejudice or preference;
- Maintain situational awareness of all acute floor patients including acute needs and change in status;
- Notify Medical Director regarding any suspected change in status of patients in the acute care area;
- Notify Medical Director of death then arrange transport of remains to morgue area after death is pronounced;
- Assist Staff Support Unit Leader with staff assessment and with meeting needs of patient care staff;
- Work with Staff Support Unit Leader to intervene and troubleshoot problematic or inappropriate staff interactions;
- Assist patient care staff with duties as time permits;
- Provide encouragement and feedback to patient care staff, radiating sense of calm and satisfaction with providing the best care that resources permit;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Dependent Care Unit Leader
 Copies: 3

Section assignment: Operations	
Report to: Operations Chief	
Supervise: Care Providers as needed	
Mission	<ul style="list-style-type: none"> • Manage assisted living area • Assist patients in assigned area and obtain additional care staff if needed • Maintain situational awareness of all patients in assisted living area and possible status change • Periodically assess social situation and function status for discharge
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;
- Assign all supervised positions which are unassigned;
- Assume all duties within unit not assigned to supervised personnel.

Ongoing Duties

- Obtain briefing from Dependent Care Unit Leader going off shift;
- Wear appropriate identification and safety equipment at all times;
- Assess staffing adequacy and keep Operations Chief and Labor Pool Unit Leader up-to-date;
- Assess residual capacity to care for additional patients and communicate needs to Operations Chief regarding resources needed for expansion;
- Assist Medical Director with rounds, completing documentation of each patients as they are seen and tracking actions which Medical Director needs to follow-up with for specific patients;
- Assist patients with personnel care including physical, mental and emotional needs;
- Supervise at least one Care Provider and request assignment of additional staff if needed;
- Observe staff for signs of illness;
- Observe staff for correct use of personal protective equipment and application of self-protective behaviors include safe lifting and avoiding contamination of self;
- Ensure procedures are followed which fulfill infection control policy;
- Supervise administration of medication, discussing any concerns with Medical Director or notify Medical Director when it is time for him or her to administer medication;
- Ensure all patients are treated ethically and without prejudice or preference;
- Maintain situational awareness of all assisted care patients including acute needs and change in status;

- Notify Medical Director regarding any suspected change in status of patients in the assisted care area;
- Assist Staff Support Unit Leader with staff assessment and with meeting needs of patient care staff;
- Work with Staff Support Unit Leader to intervene and troubleshoot problematic or inappropriate staff interactions;
- Provide encouragement and feedback to patient care staff, radiating sense of calm and satisfaction with providing the best care that resources permit;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

MCF Job Action Sheet
 Care Provider
 Copies: 3

Section assignment: Operations	
Report to: General Nursing Care Unit Leader or Dependent Care Unit Leader as assigned	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Provide care to assigned patients • Maintain hydration, nutrition and hygiene • Turn patients every two hours who cannot move themselves
Equipment	<ul style="list-style-type: none"> • N95 masks (3)

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;

Ongoing Duties

- Wear appropriate identification and safety equipment at all times
- Follow procedures for self protection;
- Notify supervisor regarding any concerns about the patient, their status or their invasive equipment;
- If in doubt about any situation, condition, or procedure ask supervisor;
- Follow infection control procedures
- Maintain privacy of patient when exposing them;
- Maintain confidentiality of patients in facility;
- Change bedding when soiled, cleaning patient as instructed;
- Bathe patients on a schedule determined by supervisor;
- Ensure fluids, whether IV, NG or oral are given as scheduled
- Provide nutrition as indicated by orders;
- Administer medication under supervision of supervisor;
- Discuss any staffing concerns with supervisor;
- Work with other staff as a team member;

MCF Job Action Sheet
 Pharmacy Unit Leader
 Copies: 3

Section assignment: Operations	
Report to: Operations Chief	
Supervise: None	
Mission	<ul style="list-style-type: none"> • Acquire, store and provide medications needed by patients
Equipment	<ul style="list-style-type: none"> • N95 masks (3) • Walkie-talkie

Initial Duties

- Be familiar with all responsibilities described on this sheet;
- Complete orientation;

Ongoing Duties

- Obtain briefing from Pharmacy Unit Leader going off shift;
- Wear appropriate identification and safety equipment at all times;
- Acquire medications ordered, obtaining physician prescription if necessary;
- Organize and maintain medication for each patient separately;
- Maintain a medication sheet for each patient listing the medications ordered, dose and time of administration;
- For those patients with medication prescribed, prepare a small cup labeled with patient name and medication(s) containing the appropriate dosages (crushed if necessary) to be delivered at the appropriate time;
- Compulsively ensure that medication is prepared for the correct patient in the correct dosage and correctly label, as ordered by Medical Director;
- Place medication for bank of patients in order on tray for pickup by patient care staff;
- Ensure complete cleaning of mortar and pestle after crushing medication for a given patient dosage;
- Ensure documentation is complete and filed with Situation Unit when no longer needed;
- Work with other staff as a team member;
- Document any change of procedures;

Attachment I

Minimum Care Facility

Just in Time Training for Volunteer Care Providers

Thank you for volunteering to help care for your sick friends and neighbors. A licensed health care worker will be in charge of the care provided in this facility. That person is your “medical director”.

MALPRACTICE PROTECTION

The work you are doing to help others is protected under the North Dakota Disaster Act. The language of the disaster act includes the following:

An emergency worker complying with or reasonably attempting to comply with the North Dakota Disaster Act, or any executive order or disaster or emergency operational plan pursuant to the provisions of the Disaster Act of is not liable for the death of or injury to persons, or for damage to property, as a result of any such activity, except in case of willful misconduct, gross negligence, or bad faith. N.D.C.C. § 37-17.1-16(1).

Any requirement for a license to practice any professional, mechanical, or other skill does not apply to any authorized disaster or emergency worker who, in the course of performing their duties, practices such professional, mechanical, or other skill during a disaster or emergency. N.D.C.C. § 37-17.1-16(2).

"Disaster or emergency worker" means any person performing disaster or emergency responsibilities or duties at any place in this state subject to the order or control of, or pursuant to a request of, the state government or any political subdivision. N.D.C.C. § 37-17.1-04(2).

KEEPING YOURSELF WELL

It is important to recognize that you are working in a facility providing care for patients with a contagious disease. Even though you will be supplied with protective equipment to help you stay well, you may be at increased risk of becoming ill. **ALWAYS PROTECT YOURSELF FIRST.** If you are hurt or sick, you cannot help others and someone will need to care for you. There are several things you can do to prevent spreading infection to yourself or those around you and things you can do to keep from becoming injured.

If you begin to **feel sick** while you are working in the minimum care facility, notify the medical director right away.

Hand washing and wearing personal protective equipment are the most effective things you can do to keep from getting sick.

Clean your hands with either soap and water or an alcohol based hand cleaner frequently but at least:

- When you arrive at the facility for your shift;
- Anytime hands are visibly dirty;
- Before and after providing any care for each patient;
- After removing personal protective equipment such as gown, gloves, or masks;
- After using the restroom;
- Before and after eating meals; and,
- Before leaving the facility at the end of your shift.

Hand washing should be thorough. Use plenty of soap. Lather at least 20 seconds and clean under the nails.

Avoid touching your face, eyes, nose, or mouth at anytime while providing care to patients unless you wash your hands first.

Wear protective gear as directed by the facility medical director. You should always wear gown, gloves, and a mask when caring for patients in the minimum care facility; however, the number of times you will be able to change gowns and masks will depend on the supplies that are available.

- Masks should fit tightly over your face to prevent you from breathing in germs in the air. When you have the mask on, use one hand to cover the mask without pressing it into your face. Now inhale. The mask should draw in slightly toward your face. Now place both hands around the edges of the mask (don't try to hold the mask against your face) and breath normally noting if there is any air leaking around the mask. If air is leaking around the mask, you may need to adjust the nose clamp and the position of the mask on your face. If air continues to leak around the mask, you may need a different size or shape mask. Recheck any new mask you try. If you cannot fit the mask with out noticeable air leaks you may not be able to work in this facility. Talk to the facility medical director.
- Take your mask off only if you are away from the sick people in an area where you may eat, drink, and rest. Even then, keep a distance of 3 feet or more between you and others in the rest area. Influenza can be spread by people who have become infected but don't have symptoms.
- Change gloves after each contact with a patient. If gloves are in short supply you will be instructed to use gloves when handling body fluids such as blood and to wash your hands carefully for all other patient care activities. Always wash your hands after taking gloves off. Wearing gloves does not mean you don't have to wash your hands!
- Gowns should be changed when they are visibly dirty such as if something has spilled on the gown. When changing your gowns handle the gown as described below for handling dirty linen. Take off a dirty gown before going to any clean areas such as the area where care providers may eat and rest.

To avoid becoming injured or injuring someone else:

- Use good judgment and listen to the instructions of your supervisors, Medical Director and the Safety Officer. Use the techniques you have been taught.

- Don't try to move something too heavy for you. This includes patients. Patient care requires moving heavy people in sometimes awkward positions. This requires more than one person to avoid injury. For especially large persons, a special lift may be needed.
- Unlike hospital beds, the beds you will be working around don't have rails. It is easy to roll a patient out of bed on the floor and seriously injure them. Someone will need to be on the each side of a patient when they are rolled over.
- If you see a sharp object, such as a needle that has not been properly disposed of, notify your supervisor or medical director who has been trained in sharps disposal. Do not put caps back on needles.
- When you become fatigued, you will be more prone to injury. Be aware of this and stop and think. If you become too fatigued, rest.
- If you become emotionally distressed, take the time needed to recover and speak to a chaplain, staff member or co-worker to work through feelings.

Working in this facility will be stressful. Remember that there is only so much you can do. Try to keep a positive attitude—you are making a difference—and work as a team with other care providers in the facility. Make sure that you eat healthy meals, drink plenty of water, and try to get eight hours of sleep a day.

Feelings of strong emotion in this setting is normal. Talk to others working in the facility with you about what you see and how you feel. You can talk to your family about your feelings, but remember to not talk with them about the patients. If you have a family member or friend in the facility you will be able to participate in their care, but you will be expected to give equal time and care to all patients.

If you make a mistake that is detrimental to a patient, notify your supervisor or the Medical Director immediately. They can ensure that the patient is assessed and helped. Learn from your mistakes, but avoid guilt. You are not and are not expected to be a licensed health care provider (who also make mistakes). You are willing and loving hands and heart doing the best you can for those in need in a terrible situation.

LINEN

Separate dirty linens, supplies and equipment from clean linens, supplies and equipment. You will be given a tour of the facility which will include where clean supplies are kept and where to store dirty linen, where to deposit garbage, how to separate regular garbage from medical waste, and where to clean dirty equipment. Always transport dirty linen, garbage, dirty supplies and equipment by carrying them away from your body. Dirty things should not be held against your body as they can transfer germs to your clothing. Never “shake out” or “drag” dirty items because this allows some types of germs to float through the air.

PATIENT PRIVACY

When people are sick enough to be at this facility they will need someone to help them with almost every personal activity such as eating, changing position, and toileting. It is important to provide privacy when possible and to demonstrate respect for the individual when helping with these personal tasks. Try to offer the privacy that you would want if you were a patient here.

It is very tempting to relieve stress through joking; however, some kinds of joking are inappropriate. Make no fun of a patient. Say nothing negative about a patient. Even though many of the patients may appear to be unconscious, assume every patient can hear you. Sometimes they really can. It feels degrading to be dependent on others for help. We want each patient to know that it is OK to be sick, and that everybody needs help sometimes. This is an opportunity for you to express kindness to those who are sick and to be an example to those you with whom you work.

You may know some of the patients in the facility. Some you may like; some you may not like. Make sure it makes no difference to the care you provide. Care for all the same.

PATIENT IDENTIFICATION

All patients in the facility will be wearing an **ID bracelet**. Always check the bracelet to make sure you have the right patient when you are giving any medications, transferring patients, or writing information on the patient's papers or "chart".

CHARTING

What you do for the patient and how the patient reacts is **documented** on the patient's chart at least once during each shift (the time you are assigned to work at the facility). The patient's chart is a legal record. Write on the chart only what you personally have done or have seen. Each note must include the date and time the note is written. Sign your name to each note you put on the record.

All documentation is done in ink. If you need to correct something you have written, do not scribble it out. Instead, draw a single horizontal line through the incorrect entry and write your initials and date next to the deletion. Correct language can now be added. (Example: John has a ~~brown~~^{SPP 2/13/07} grey horse.) Although you are protected from malpractice by state tort protection, the state may be challenged regarding care that was delivered, and these medical records are legal documents. Information which is scribbled out can be "assumed" by attorneys to be anything. Something that has been incorrectly written but properly corrected is always better than what is unknown because it can't be read.

GIVING FLUIDS

To **give fluids by mouth** raise the head of the bed or assist the patient to sit up in bed. Assist the patient to sip small amounts of fluids. Offer fluids frequently. If the patient is not conscious and cannot swallow, do not try to give fluids by mouth. Notify the medical director so that other treatment measures can be considered.

When a patient is not conscious and can not take fluids by mouth they still need the mouth cleaned and moistened. To provide this **oral care** you can mix mouthwash with water and use special sponges or soft toothbrushes to clean the mouth and teeth. Carefully clean the roof of the mouth, tongue, gums, inside of the cheeks, and teeth. If necessary a clean gauze pad can also be used to clean the mouth. If the patient has dentures remove them prior to providing oral care. You should always wear gloves when providing oral care.

Sometimes for patients that can not swallow fluids, a **naso-gastric tube** (NG tube) will be used. Usually the tube going through the patient's nose into the stomach will be connected to a bag of fluids which slowly drip into the stomach. Be careful to not pull the tube out. The tube will be taped to the nose to make sure it stays in the stomach. Before putting fluids down the tube, check it to see if is firmly secured in the tape to the nose. If you think the tube could have pulled part of the way out, stop any fluids and notify the medical director. Do not attempt to push the tube back in yourself. A tube which has come too far out and is put back, could end up in the lung instead of the stomach.

Once per day, you will need to replace the fluid bag with a clean one. If you notice that a bag is empty and do not have instructions for additional fluids, notify the medical director. Sometimes the naso-gastric tube is not connected to a bag, however; at regular intervals a large syringe is attached to the tube and fluids are allowed to slowly drip into the stomach. The syringe is then removed until the next time that fluids are given to the patient. Some patients may need important medications that they cannot swallow. Some pills can be crushed and given through the naso-gastric tube. If you are to give fluids or medications through the naso-gastric tube using a large syringe, someone will show you how to do it.

The fluids being given through the naso-gastric tube are a mixture of water, salts and sugar. Sugar solutions can grow bacteria which can make the patients sick, so care must be used. When mixing or adding fluids, make sure your hands are very clean and freshly gloved. Do not touch the liquid or the inside of the bag. Unless given instructions to the contrary, the fluids will be mixed in the bag. Turn off the flow of fluids. Add one quart of water to the bag and then add the contents of one packet or baggie of the solution mix. (If alternative instructions should be followed, they will be provided to you at the time.) Make sure everything is well dissolved and mixed before starting the solution flow again. The sugar and salt mixture may come in a commercial packet or may be prepared in the kitchen or pharmacy area. Make sure you are using the correct mixture. Never use a mixture from an unlabeled package or baggie.

Patients that are not able to keep fluids down when given through the stomach may need **intravenous fluids or an “IV”**. The medical director or another medical provider will place a small flexible tube into a blood vessel and special fluids in a bag will be connected to the “IV” to slowly drip into the blood stream. You won’t need to manage an IV other than notifying the medical director if you are concerned about it (see below). You will want to take care not to put tension on the tube or accidentally pull it out.

Notify the medical director or medical provider if you observe any of the following:

- An IV bag is empty;
- Skin around the IV is swollen, hard, or red;
- IV is not dripping;
- Patient complains of pain around the IV site;
- Blood is flowing up into the line (Sometimes you will see blood in the IV line that has been there awhile; if the line is dripping, this is not a problem);
- IV catheter pulls out of the skin. If the patient is bleeding from the site, use a piece of gauze while wearing gloves to hold pressure on the site until it quits bleeding, then notify the medical director.

TOILETING

Most of our patient will not be able to get out of bed to go to the bathroom. Many will not even be able to tell you that they have to pass their water or move their bowels.

If the patient is able to tell you their **toileting needs** you can either assist them to a nearby **bathroom**, assist them to use a **bedside commode**, or assist them to use a **bedpan**. When a bedside commode or bed pan is used they should be emptied right away in the nearest bathroom. A bedpan will be used for only one patient and should be rinsed clean and returned to the patient’s bedside. A commode may be used for many patients and should therefore be cleaned between patients. For those patients that can not tell you of their toileting needs you will use disposable pads on the bed or disposable underpants. These should be checked frequently and changed when wet or soiled. Wear gloves when changing clothing or linen of soiled patients.

In rare cases a patient may have a soft flexible tube known as a “**foley catheter**” placed into the bladder to drain urine into a bag. Keep the urine bag hanging from the bed frame below the level of the patient. Do not leave the bag lying on the floor. Take care not to put tension on the catheter or pull the catheter out. As the bag becomes full you will drain the bag into another container and empty the urine into the toilet in the nearest bathroom.

MOVING PATIENTS

Patients that are very sick and weak often are not able to turn over in bed or **re-position** themselves. Patients should be carefully turned from back to side to side every 2 hours or as often as possible to prevent “bed sores” caused from pressure of lying in the same position for too long. Reach across the patient grasping the blankets or sheets that are under the patient and pull them toward you to roll the patient on his side. When you turn

patients, it is helpful to use pillows or folded blankets to help “prop” the patient into the desired position if possible. Position the arms and legs in a way that looks comfortable to you, and so that they are not pinned under the patient or causing bony areas to rest against other bony areas. Look for areas of severe redness or open sores and report these to the medical director or medical provider. The usual areas for bed sores to occur are the heels of the feet, the buttocks, back, hips, shoulders, and back of the head.

Transferring patients from their bed to a transfer cart or cart to bed will require several people. Get help. Use blankets under the patient to help lift the patient from a bed to a transfer cart or cart to bed. Staff people on both sides of the patient will take a hold of the blanket with both hands. One person will give the instruction to transfer the patient on the count of three. As the counter says “three” lift and move the patient. Lift with your legs and arms taking care not to strain your back. A “**patient lift**” may be available to help transfer exceptionally heavy patients. This mechanical piece of equipment uses a sling and frame and a hydraulic mechanism to allow one person to safely transfer a patient. Someone will show you how to use the lift. Never leave a patient alone while in the lift.

VITAL SIGNS

You may be asked to measure a temperature, pulse (heart beats each minute), respiratory rate (breaths each minute), or blood pressure. These measurements are commonly called **vital signs**. An electronic thermometer that reads the temperature in the ear will be used in this facility. The cover on the tip that goes in the patient’s ear is for one patient only. The cover is changed for each patient. If there are plenty of covers they can be thrown away after each use, but if there is a limited supply, keep the cover at the patient’s bed side so it can be re-used for the same patient. Someone will show you how to use the thermometer. To measure the pulse, locate the pulse on the patient’s inner wrist or use a stethoscope to listen to the heart beat through the chest. Count the number of heart beats in 15 seconds then multiply the number times 4 to get the number of beats in a minute. To measure the respiratory rate, watch the patient’s chest and count each breath in 15 seconds and multiply times 4 to get the number of breaths in a minute. Blood pressure is measured with a blood pressure cuff around the upper arm and a stethoscope listening for the heart beat at the inner elbow. If you need to measure vital signs someone will show you how and let you practice. Vital signs are then “documented” or written down on the patient’s papers or “chart”.

CONFIDENTIALITY

Medical providers and those that care for patients in any type of medical facility are bound by law to keep personal medical information **confidential**. You will probably be asked by friends, family members, and others in the community about the patients in the minimum care facility. You should never offer information about the patients (even information about whether they are in the facility or not) or activities in the facility. When you are asked questions you may tell the person how to get the information they need from the proper sources. A phone number will be provided at the time the facility is

opened. Family members may also need the “security code” given to them when the family member was admitted to get information over the phone or from a website. We also provide information to the newspapers, radio, and television about how the public can obtain information about their loved ones.

DEATH AND DYING

It is expected that some of the patients you are taking care of will die even though you and others have done everything you can to help them. This facility will not attempt artificial respirations or cardiac resuscitation. When the medical director determines that a patient has little chance of living he may designate the patient for “**palliative care**”. Palliative care means providing comfort and dignity for the patient in their last hours as much as possible with the care providers and supplies that are available. Although you may be instructed to care for those likely to live first, to the extent possible those who are dying will be given equal care.

Those designated as palliative care may remain among the other patients or may be moved to a designated area of the facility to make room in the treatment area for new patients that have a better chance of getting well. Moving patients to another area should only be done if ordered by the medical director. When you notice that a patient is not breathing, notify the medical director or medical provider. If you find that you are having trouble handling the impact of seeing very ill and dying patients in this situation, please let someone know so that you can be relieved of duty and receive support from our crisis counselors.

SECURITY

No person who is not working in the facility or a patient in the facility is allowed to enter. This is for their protection and the facilitation of the work you are here to do. Families bringing patients to be admitted will be met in a separate triage area. Families are not allowed to enter any other part of the building. Media representatives are not allowed in building. If you are asked to speak to a media representative based on your role in the MCF, please refer the media representative to the Site Commander.

You are expected to sign in and out of the facility whenever entering or leaving. You will be assigned an ID which will consist to two parts. In one part will be a number ID badge issued to you. In other you should place a government issued ID (such as driver’s license) with a picture. Please wear the ID at all times when on duty.

When checking out, do not take personal protective equipment (e.g., masks) with you. They must be left in your assigned locker space.

GOING OFF DUTY

When your work period (shift) is over tell the next care provider what you can about what needs to be done. Show the new care provider how to use any equipment and complete any cares or treatments that you have been trained to do such as vital signs, using the

patient lift, giving fluids through the naso-gastric tube, and other patient care activities. Take off your gown, mask, and gloves in the designated safe area, either store them for the next time you come to work at the facility or throw them away (you will receive instructions based on the amount of gowns, and masks available), wash your hands, and leave the facility. If showers are available, you may be able to shower before you go home and put on clean clothes that you have brought. If not, shower as soon as you get home.

Influenza viruses can live for a few hours on environmental surfaces outside the body, so as a precaution you should launder your work clothes separately from those of your family, and clean any personal items that you may have taken with you to the facility. If an object that you think could have influenza virus on it is left in the open air for a day, any influenza virus should be inactivated. However, note that in caring for patients, you could be exposed to infectious agents other than influenza, some of which may be more durable in the environment than influenza.

ADDITIONAL ORIENTATION

You should receive additional orientation to the specific facility you work in which may include:

- Building tour
- Location of key resources
- Introduction to key staff and roles
- Shift scheduling
- Assignment of locker
- Assignment and labeling of personal protective equipment
- Access to supply areas
- Assignment to mentor

ATTACHMENT J



NORTH DAKOTA
DEPARTMENT *of* HEALTH

PANDEMIC INFLUENZA

CARING FOR SICK PEOPLE AT HOME

What is pandemic flu?

Pandemic flu means that a new strain of influenza has spread all over the world and is affecting a large number of people. During a pandemic, healthcare facilities will be very busy. In many cases, people sick with pandemic influenza can be cared for at home. The information provided here will help you protect yourself when caring for someone who is sick, and give you the information you need to help the sick person recover.

The following guidelines will help you care for someone who is sick:

- **Rest in bed.** Rest helps restore energy and strengthens the immune system, helping fight illness and speed recover.
- **Drink plenty of fluids.** Preventing dehydration is one of the most important things you can do to treat influenza. To prevent dehydration you can buy electrolyte drinks (sports drinks) at the pharmacy or grocery store or make your own.
- **Control fever.** Stock a generous supply of medications such as acetaminophen or ibuprofen. Keeping a fever low helps a loved one feel better and reduces the risk of dehydration. Do not give aspirin to anyone younger than 20.
- **Keep a record of vital signs.** A record of temperature, blood pressure and pulse, along with general observations regarding breathing difficulties, bathroom trips and fluid intake, can be helpful as you care for a loved one.

► **Caregivers should wash hands thoroughly after providing care!**

Refer to the following pages for more detailed information regarding:

Keeping yourself and other family members from getting sickpage 2

Keeping a sick person clean and preventing bed sores.....page 3

Preventing dehydration.....page 4

Managing fever.....page 5

Providing essential medications.....page 6

When to ask for help.....page 7

KEEPING YOURSELF AND OTHER FAMILY MEMBERS FROM GETTING SICK

Although caring for a person with influenza may increase your risk of getting sick, there are things you and your family can do to reduce that risk.

- **Avoid direct contact.** Avoid being near the sick person's face as much as you can.
- **Wear a mask.** If you are within three feet of the person, and N95 mask is recommended. If this type of mask is not available, a surgical mask or even a homemade mask is recommended. Instructions for creation of a homemade mask from heavy duty T-shirt material can be found on the following webpage: <http://www.cdc.gov/ncidod/EID/vol12no06/05-1468-G.htm> . Any sort of cloth over the face may provide some protection.
- **Keep others away from the sick person.** Minimize the number of people who have contact with the sick person. Only those providing care should be in close contact.
- **Wash hands thoroughly and often!** Wash your hand thoroughly after providing care. If available, wear protective gloves when providing care. Even if you use gloves, wash your hands after providing care.
- **Avoid touching your eyes and mouth.** Don't touch your eyes or mouth without washing your hands first.
- **Wear protective clothing.** Wear a dressing gown (robe) or other removable clothing when caring to the sick person. Remove the outer clothing before leaving the room.
- **Keep sick family members separated.** If more than one person in the household is sick with pandemic influenza, it will be easiest to provide care for them in the same room.

KEEPING A SICK PERSON CLEAN AND PREVENTING BED SORES

If a person becomes wet or soiled because they cannot make it to the bathroom, their sheets and blankets will need to be changed and their skin cleaned and dried. For a sick adult, this is easier for two caregivers, but one person can do it.

1. Put on rubber, vinyl or latex gloves.
2. Roll the patient on their side and clean the patient's skin.
3. Loosen the sheets on the side of the bed, at the patient's back, and at the foot and head of the bed and roll the sheets towards them as close to them as possible.
4. Roll the patient to the other side and remove the sheets and blankets.
5. Use the same process to put new sheets under the patients.
6. Avoid trying to pull the sheet under a person because this could damage skin.

Patients who are very sick and weak are often not able to turn over in bed or re-position themselves. Patients need to be carefully turned every two hours to prevent bed sores caused from the pressure of lying in the same position for too long. Patients should be turned from side to back to side.

1. Reach across the person grasping the blankets or sheets that are under the person and pull them toward you, rolling the person on his or her side.
2. Use pillows or folded blankets to help "prop" the patient into the desired position.
3. Position the arms and legs in a way that looks comfortable to you, making sure they are not pinned under or causing bony areas to rest against other bony areas.

PREVENTING DEHYDRATION

Dehydration occurs when people lose more water than they take in. Dehydration can be a serious condition. It's very important to make sure a person sick with influenza is drinking enough liquids.

What should they drink?

Fluid loss includes both water and salts, so if a person is not eating, giving solutions with salts and sugars is best. Juice is a good example. Pedialyte or other commercial hydration solutions can be used. If these are not available, solutions can be made with ingredients in the home.

- 1 quart of water
- 1 teaspoon of salt
- 8 teaspoons of sugar
- ⅓ teaspoon of baking soda

If water is all that is available, or all that the person will accept, give them water.

What if they need help to drink?

1. Raise the head of the bed or assist the person to sit up in bed.
2. Assist the person to sip small amounts of liquid. Offer something to drink often.
3. Monitor how much they are drinking. If a child is drinking less than the amount recommended in the gray box above or an adult is drinking less than 1½ quarts per day (more if they have a fever), you'll need to watch closely for dehydration.

→ If the patient is unconscious and cannot swallow, do NOT try giving them fluids!
Call a health-care professional for help.

How do I know if they are dehydrated?

To test for dehydration, consider the following:

- Is the person drinking the recommended minimum amount of fluids?
- Look inside the person's mouth and see if it is dry.

How much should they drink?

Adults – Minimum of 1½ to 2 quarts per day

Kids:

10 lb. child – Minimum 1 pint per day

20 lb. child – Minimum 1 quart per day

30 lb. child – Minimum 1¼ quarts per day

40 lb. child – Minimum 1½ quarts per day

- Look at the eyes and inside the lower lids and see if they are moist or dry.
- Feel in the armpit or in the groin area for sweat moisture.
- Gently pinch and pull up an area of loose skin (e.g., back of the hand.) When released, the skin should return to position quickly, not slowly. You can compare to your own skin.
- Is the person going to the bathroom (making urine) several times per day?

If the person seems very dry, contact their doctor or health-care professional for advice and help.

MANAGING FEVER

Fever is an expected symptom of influenza. In fact, fever is part of the body's defense mechanism against the infection and helps to kill the virus. Fever associated with influenza should not reach high enough to be an emergency (106° or higher). But fever will increase the loss of liquids and if the person is not taking in enough fluids, he or she can become dehydrated faster. Lowering a fever also will make a person more comfortable. The fever should always be reduced in a pregnant woman.

Reducing Fever

- Give plenty of fluids
- Give acetaminophen (for example: Tylenol®) or ibuprofen (for example: Advil®). Do not give aspirin to anyone younger than 20. Pregnant women should take acetaminophen rather than ibuprofen or aspirin.
- A sponge bath with lukewarm water can provide comfort. Do not use cold water, which can cause shivering and make the fever worse.

Continue to monitor. Keeping a record of the person's temperature can be helpful.

PROVIDING ESSENTIAL MEDICATIONS

People who are sick with influenza should continue to take medications that have been prescribed to them as long as they are alert. Follow these guidelines:

- If the person has a hard time swallowing pills, most pills can be crushed or capsules opened and put in a small amount of food. Check the information on the bottle. If the bottle says not to crush it, don't crush it.
- Know which medications are essential and which aren't. If a patient is alert, they can tell you. Otherwise, general knowledge of the person's medical history is helpful.

Special information for those with diabetes:

Insulin and diabetes pills can pose a special problem if the person is not eating or not eating normally. Giving the usual dose of medicine to lower blood sugar may be too much if the person isn't eating much. However, not giving any diabetes medicine may result in very high blood sugar which impairs the body's ability to fight the infection and causes the body to lose more fluids. In addition, some people with diabetes cannot make any insulin and will die if they don't receive some insulin by injection.

Home glucose monitoring (testing the blood sugar) will be very helpful. Blood sugars should optimally be kept around 150 to 200 and should be checked three or four times a day if possible. Attempting tighter control (that is, lower blood sugars) may be a problem if the person is not very alert. They won't be able to let you know if they have a reaction and they may have difficulty eating food to get their blood sugar back up. Even in the hospital, blood sugar levels can be difficult to manage, so professional help may be needed if the blood sugar level is staying too low (e.g., less than 60) or way too high (more than 300). Blood sugars less than 40 are dangerous and must be raised immediately.

If you cannot do home glucose monitoring at home and no professional help is available, it may be possible to monitor urine for sugar with strips from the pharmacy for those people with diabetes who are not on insulin. By letting the person get rid of some sugar in their urine, but not a large amount, the person may be able to stay out of trouble until they resume a diet which allows them to take their full medication dose. Using this method requires being able to catch some urine to test it, and is of little use to people on insulin whose blood sugar level may rise or fall rapidly.

WHEN TO ASK FOR HELP

Because health-care resources will be limited during a pandemic, those people who can be cared for at home will need to stay at home. However, some people will simply be too sick to be cared for at home. While it is not possible to describe every circumstance, the following are some guidelines for when you might want to seek health care.

- Has not been able to drink any or very little fluids for two days.
- Seems very dehydrated. (see page 4 for more information)
- Does not respond when spoken to or touched and cannot be woken up.
- Has other serious health conditions (heart disease, transplant patients, severe high blood pressure, severe asthma) and cannot take their medication.
- Has diabetes and is not eating much, is on insulin and blood sugar cannot be monitored at home.
- Person is turning blue or having difficulties breathing.
- Very high blood pressure or very low blood pressure (if checked at home.) For example, an adult with a top number of more than 180 or a bottom number more than 110. Similarly, a top number less than 80 would be much too low for almost all people.
- Flu symptoms that seem to get better for a day or longer, then the person worsens with fever and cough.
- Pain or pressure in the chest or belly.
- A child who is so irritable they do not want to be held.
- Sudden dizziness.
- Severe or persistent vomiting.

During a pandemic, some people with influenza will develop life threatening problems completely unrelated to influenza such as heart attacks or asthma attacks. Even though health care will be limited, those people should still be evaluated immediately in an emergency room.

If you are concerned that the event is life threatening, call 9-1-1!

You will be instructed on whether to take the patient to the hospital yourself or whether an ambulance is available to assist.

Your loved one is being admitted into a
Minimum Care Facility – What do you need to know?

This facility is called a minimum care facility. Your loved one is being admitted because he or she cannot be cared for at home right now and hospitals statewide are full.

For most patients, the treatment of influenza is supportive. That simply means the person needs a basic level of care to give them time to fight off the infection on their own. Fluids, turning, cleaning and other personal care provided by the caregivers in this facility will increase chances of survival. Although a licensed health-care provider is in charge of supervising all patient care in this facility, caregivers who provide most of the care are non-medical volunteers from your community.

The level of care in this facility is not the same as in a hospital. If space becomes available in the hospital, we will send your loved one there to be admitted. However, until there is room for all patients in the hospital, we will send those to the hospital first who are most likely to benefit from hospital care. If your loved one improves enough to be cared for at home, we will ask you to take him or her home to make room for other patients.

The vast majority of patients are expected to survive, but unfortunately this illness can be severe, and some patients may not be able to fight off the infection. If staff members know in advance that your loved one is not likely to live, you will be contacted and given the option of taking him or her home so that you can be with together. Those who are dying and remain in the facility will be given such comfort care as is available. If your loved one dies in the facility, you will be notified before he or she is moved to the community morgue.

Patients who are alert may request that they be discharged home; however, our ability to comply will depend on the availability of a family or friend to come and get them. If your loved one is not alert and you are the guardian or next of kin, you have the right to request that your loved one be discharged to your care at any time.

Help Your Community – Volunteer!

This facility needs volunteers in order to function and provide valuable care. If you are able to help, please let us know by calling 888.8888. This facility needs people to do many types of jobs, but it especially needs people willing to care of the sick. If you volunteer, you will be trained how to keep yourself well, and you will be provided with a respirator that can be worn in the facility to protect you from breathing in the virus. However, even with the training and protective equipment, you may be at increased risk of becoming sick. If you volunteer and have a loved one in the facility, you will be expected to care for other patients in addition to your family member without preferential treatment to any.

Visitation

Influenza is a contagious disease, meaning it can be easily passed from person to person. Because of the risk of spreading the disease, this facility is closed to visitors. Only staff and volunteers are allowed inside the facility. This applies to parents of sick children as well. If you would like to help provide care for your child, you will need to volunteer and help care for others as well.

IMPORTANT – It is possible that when you leave your loved one at this facility, that you will not see him or her alive again. Family members need to be prepared for the possibility that their loved one may die while in the minimum care facility. Family members will not be allowed in the facility even under these tragic circumstances. We realize that this will be very difficult for family members, but we cannot risk more illness and death by allowing anyone but patients and volunteers into the facility.

Checking on a Patient

At the time you bring your loved one to the facility, you will be provided with a patient number representing your family member . Information about your loved one will be made available on this website: www.abcdefghijklmnpqrstuvwxy. By finding the patient number for your loved one on the website, you will be able to learn about their condition. This information will be updated about every 12 hours. The facility will not have sufficient staff to provide telephone reports, so this will be your primary source of information.

The information provided will include the patient’s status. They are explained below.

- Undetermined: Patient is waiting physician and/or assessment.
- Good: Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.
- Fair: Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are favorable.
- Serious: Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.
- Critical: Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.

The status of a patient also may be listed as “palliative.” This means that the person is not expected to survive, but is receiving comfort care. If at all possible, you will receive notice that your loved one is not expected to survive before you see this condition posted on the website.

Please do not ask volunteers about your loved one. Those providing care will be extremely tired during their hours off duty and must be allowed to rest. In addition, they are bound by the confidentiality laws of the state of North Dakota and have been instructed not to provide any information about patients in the facility. This is to protect them and protect the confidentiality of the patients.

Patient Care

It is important to remember that this facility is NOT a hospital or normal clinic. The facility is under the direction of a medical director, but most of the staff will be volunteers.

Patients will be given a lot of “mom” care, meaning:

- Hydration – This may include an IV or a tube in the stomach if the patient cannot swallow.
- Hygiene – This includes keeping the patient clean and changing bed linens.
- Medication – This will be limited to medication critical to life. (This facility does not have a pharmacy. Families should bring prescriptions to the facility when patient is admitted.)
- Nutrition – Patients who cannot swallow will not be provided nutrition other than a solution containing sugar. Once the person is alert enough to keep food from going into their lungs during swallowing, he or she will be fed or discharged to be cared for at home.

Personal Belongings

Families should bring the following when a patient is admitted:

- Medications and medical supplies patient will need (except controlled substances such as prescription pain killers)
- Mobility aids (wheelchairs, canes, etc.)
- Family contact information

Families should NOT bring:

- Personal items (Religious items such as a bible will be allowed, but we cannot guarantee their return.)
- Cell phones

Please Note: Insurance information is not needed. All services provided by this facility are FREE.

We Need Your Help!

We need your help to stop the spread of pandemic influenza. Follow these simple steps to keep from spreading germs:

- Cover your coughs and sneezes and wash your hands frequently.
- Stay away from sick people as much as possible.
- If you are sick, stay away from others as much as possible.

For more information please contact: ???????

Attachment K

Preparation of Oral Rehydration Solution

Rehydration solution for dehydrated patients

To be added to one quart of water:

1 level teaspoon salt*

8 teaspoons sugar

Maintenance fluids (daily use)

To be added to one quart of water:

1/2 teaspoon lite* salt

1/2 teaspoon salt

8 teaspoons sugar

The mixture of salt and sugar will be put in small baggies, sealed and carefully labeled and stored for use.

If pre-mixing the solution, make sure hands are carefully cleaned and gloved and mixing containers are clean.

* 1 teaspoon table salt = 2,300 mg (100 mEq) sodium

** 1/2 teaspoon Morton's Lite Salt = 600 mg (26 mEq) sodium and 720 mg (18 mEq) potassium

Note: Normal Saline IVF=154 mEq Sodium per liter

Attachment L

Infection Control Precautions

Rating Categories: Recommendations are rated according to the following categories:

Category IA. Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies.

Category IB. Strongly recommended for implementation and supported by certain experimental, clinical, or epidemiologic studies and a strong theoretic rationale.

Category IC. Required by state or federal regulation, or representing an established association standard. (Note: Abbreviations for governing agencies and regulatory citations are listed where appropriate. Recommendations from regulations adopted at state levels are also noted. Recommendations from AIA guidelines cite the appropriate sections of the standards.)

Category II. Suggested for implementation and supported by suggestive clinical or epidemiologic studies, or a theoretic rationale.

Unresolved issue. No recommendation is offered. No consensus or insufficient evidence exists regarding efficacy.

Standard Precautions

Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care.

IV.A. Hand Hygiene

IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces.

IV.A.2. When hands are visibly dirty, contaminated with proteinaceous material, or visibly soiled with blood or body fluids, wash hands with either a nonantimicrobial soap and water or an antimicrobial soap and water.

IV.A.3. If hands are not visibly soiled, or after removing visible material with nonantimicrobial soap and water, decontaminate hands in the clinical situations described in IV.A.2.a-f. The preferred method of hand decontamination is with an alcohol-based hand rub. Alternatively, hands may be washed with an antimicrobial soap and water. Frequent use of alcohol-based hand rub immediately following handwashing with nonantimicrobial soap may increase the frequency of dermatitis.

Perform hand hygiene:

IV.A.3.a. Before having direct contact with patients.

IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.

IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).

IV.A.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care.

IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient .

IV.A.3.f. After removing gloves.

IV.A.4. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores (e.g., *C. difficile* or *Bacillus anthracis*) is likely to have occurred. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores.

IV.A.5. Do not wear artificial fingernails or extenders if duties include direct contact with patients at high risk for infection and associated adverse outcomes (e.g., those in ICUs or operating rooms).

IV.A.5.a. Develop an organizational policy on the wearing of non-natural nails by healthcare personnel who have direct contact with patients outside of the groups specified above.

IV.B. Personal protective equipment (PPE) ([see Figure](#))

IV.B.1. Observe the following principles of use:

IV.B.1.a. Wear PPE, as described in IV.B.2-4, when the nature of the anticipated patient interaction indicates that contact with blood or body fluids may occur.

IV.B.1.b. Prevent contamination of clothing and skin during the process of removing PPE.

IV.B.1.c. Before leaving the patient's room or cubicle, remove and discard PPE.

IV.B.2. Gloves

IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur.

IV.B.2.b. Wear gloves with fit and durability appropriate to the task.

IV.B.2.b.i. Wear disposable medical examination gloves for providing direct patient care.

IV.B.2.b.ii. Wear disposable medical examination gloves or reusable utility gloves for cleaning the environment or medical equipment.

IV.B.2.c. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens.

IV.B.2.d. Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face).

IV.B.3. Gowns

IV.B.3.a. Wear a gown, that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

IV.B.3.a.i. Wear a gown for direct patient contact if the patient has uncontained secretions or excretions.

IV.B.3.a.ii. Remove gown and perform hand hygiene before leaving the patient's environment.

IV.B.3.b. Do not reuse gowns, even for repeated contacts with the same patient.

IV.B.3.c. Routine donning of gowns upon entrance into a high risk unit (e.g., ICU, NICU, HSCT unit) is not indicated.

IV.B.4. Mouth, nose, eye protection

IV.B.4.a. Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed.

IV.B.5. During aerosol-generating procedures (e.g., bronchoscopy, suctioning of the respiratory tract [if not using in-line suction catheters], endotracheal intubation) in patients who are not suspected of being infected with an agent for which respiratory protection is otherwise recommended (e.g., *M. tuberculosis*, SARS or hemorrhagic fever viruses), wear one of the following: a face shield that fully covers the front and sides of the face, a mask with attached shield, or a mask and goggles (in addition to gloves and gown).

IV.C. Respiratory Hygiene/Cough Etiquette

IV.C.1. Educate healthcare personnel on the importance of source control measures to contain respiratory secretions to prevent droplet and fomite transmission of respiratory pathogens, especially during seasonal outbreaks of viral respiratory tract infections (e.g., influenza, RSV, adenovirus, parainfluenza virus) in communities.

IV.C.2. Implement the following measures to contain respiratory secretions in patients and accompanying individuals who have signs and symptoms of a respiratory infection, beginning at the point of initial encounter in a healthcare setting (e.g., triage, reception and waiting areas in emergency departments, outpatient clinics and physician offices).

IV.C.2.a. Post signs at entrances and in strategic places (e.g., elevators, cafeterias) within ambulatory and inpatient settings with instructions to patients and other persons with symptoms of a respiratory infection to cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions.

IV.C.2.b. Provide tissues and no-touch receptacles (e.g., foot-pedal operated lid or open, plastic-lined waste basket) for disposal of tissues.

IV.C.2.c. Provide resources and instructions for performing hand hygiene in or near waiting areas in ambulatory and inpatient settings; provide conveniently-located dispensers of alcohol-based hand rubs and, where sinks are available, supplies for handwashing.

IV.C.2.d. During periods of increased prevalence of respiratory infections in the community (e.g., as indicated by increased school absenteeism, increased number of patients seeking care for a respiratory infection), offer masks to coughing patients and other symptomatic persons (e.g., persons who accompany ill patients) upon entry into the facility or medical office and encourage them to maintain special separation, ideally a distance of at least 3 feet, from others in common waiting areas.

IV.C.2.d.i. Some facilities may find it logistically easier to institute this recommendation year-round as a standard of practice.

IV.D. Patient placement

IV.D.1. Include the potential for transmission of infectious agents in patient placement decisions. Place patients who pose a risk for transmission to others (e.g.,

uncontained secretions, excretions or wound drainage; infants with suspected viral respiratory or gastrointestinal infections) in a single-patient room when available.

IV.D.2. Determine patient placement based on the following principles:

- Route(s) of transmission of the known or suspected infectious agent
- Risk factors for transmission in the infected patient
- Risk factors for adverse outcomes resulting from an HAI in other patients in the area or room being considered for patient placement
- Availability of single-patient rooms
- Patient options for room-sharing (e.g., cohorting patients with the same infection)

IV.E. Patient-care equipment and instruments/devices

IV.E.1. Establish policies and procedures for containing, transporting, and handling patient-care equipment and instruments/devices that may be contaminated with blood or body fluids.

IV.E.2. Remove organic material from critical and semi-critical instrument/devices, using recommended cleaning agents before high level disinfection and sterilization to enable effective disinfection and sterilization processes.

IV.E.3. Wear PPE (e.g., gloves, gown), according to the level of anticipated contamination, when handling patient-care equipment and instruments/devices that is visibly soiled or may have been in contact with blood or body fluids.

IV.F. Care of the environment

IV.F.1. Establish policies and procedures for routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling.

IV.F.2. Clean and disinfect surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to the patient (e.g., bed rails, over bed tables) and frequently-touched surfaces in the patient care environment (e.g., door knobs, surfaces in and surrounding toilets in patients' rooms) on a more frequent schedule compared to that for other surfaces (e.g., horizontal surfaces in waiting rooms).

IV.F.3. Use EPA-registered disinfectants that have microbiocidal (i.e., killing) activity against the pathogens most likely to contaminate the patient-care environment. Use in accordance with manufacturer's instructions.

IV.F.3.a. Review the efficacy of in-use disinfectants when evidence of continuing transmission of an infectious agent (e.g., rotavirus, *C. difficile*, norovirus) may indicate resistance to the in-use product and change to a more effective disinfectant as indicated.

IV.F.4. In facilities that provide health care to pediatric patients or have waiting areas with child play toys (e.g., obstetric/gynecology offices and clinics), establish policies and procedures for cleaning and disinfecting toys at regular intervals. *Category IA*

- Use the following principles in developing this policy and procedures:
- Select play toys that can be easily cleaned and disinfected
- Do not permit use of stuffed furry toys if they will be shared

- Clean and disinfect large stationary toys (e.g., climbing equipment) at least weekly and whenever visibly soiled
- If toys are likely to be mouthed, rinse with water after disinfection; alternatively wash in a dishwasher
- When a toy requires cleaning and disinfection, do so immediately or store in a designated labeled container separate from toys that are clean and ready for use.

IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently (e.g., daily).

IV.F.5.a. No recommendation for use of removable protective covers or washable keyboards. *Unresolved issue*

IV.G. Textiles and laundry

IV.G.1. Handle used textiles and fabrics with minimum agitation to avoid contamination of air, surfaces and persons.

IV.G.2. If laundry chutes are used, ensure that they are properly designed, maintained, and used in a manner to minimize dispersion of aerosols from contaminated laundry.

IV.H. Safe injection practices The following recommendations apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems

IV.H.1. Use aseptic technique to avoid contamination of sterile injection equipment.

IV.H.2. Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.

IV.H.3. Use fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.

IV.H.4. Use single-dose vials for parenteral medications whenever possible.

IV.H.5. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.

IV.H.6. If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile.


IV.H.7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

IV.H.8. Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.

IV.I. Infection control practices for special lumbar puncture procedures Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space (i.e., during myelograms, lumbar puncture and spinal or epidural anesthesia.

IV.J. Worker safety Adhere to federal and state requirements for protection of healthcare personnel from exposure to bloodborne pathogens.

Contact Precautions

V.B.1. Use Contact Precautions as recommended in Appendix A of the [HICPAC/CDC Isolation Guideline](#) for patients with known or suspected infections or evidence of syndromes that represent an increased risk for contact transmission. For specific recommendations for use of Contact Precautions for colonization or infection with MDROs, go to the  [MDRO guideline](#) (PDF 234KB/74 pages)

V.B.2. Patient placement

V.B.2.a. In *acute care hospitals*, place patients who require Contact Precautions in a single-patient room when available. When single-patient rooms are in short supply, apply the following principles for making decisions on patient placement:

- Prioritize patients with conditions that may facilitate transmission (e.g., uncontained drainage, stool incontinence) for single-patient room placement.
- Place together in the same room (cohort) patients who are infected or colonized with the same pathogen and are suitable roommates.
- If it becomes necessary to place a patient who requires Contact Precautions in a room with a patient who is not infected or colonized with the same infectious agent:
 - Avoid placing patients on Contact Precautions in the same room with patients who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission (e.g., those who are immunocompromised, have open wounds, or have anticipated prolonged lengths of stay).
 - Ensure that patients are physically separated (i.e., >3 feet apart) from each other. Draw the privacy curtain between beds to minimize opportunities for direct contact.)
 - Change protective attire and perform hand hygiene between contact with patients in the same room, regardless of whether one or both patients are on Contact Precautions.

V.B.2.b. In *long-term care and other residential settings*, make decisions regarding patient placement on a case-by-case basis, balancing infection risks to other patients in the room, the presence of risk factors that increase the likelihood of transmission, and the potential adverse psychological impact on the infected or colonized patient.

V.B.2.c. In *ambulatory settings*, place patients who require Contact Precautions in an examination room or cubicle as soon as possible.

V.B.3. Use of personal protective equipment

V.B.3.a. **Gloves** Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails). Don gloves upon entry into the room or cubicle.

V.B.3.b. Gowns

V.B.3.b.i. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient-care environment.

V.B.3.b.ii. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other patients or environmental surfaces.

V.B.4. Patient transport

V.B.4.a. In *acute care hospitals and long-term care and other residential settings*, limit transport and movement of patients outside of the room to medically-necessary purposes.

V.B.4.b. When transport or movement in any healthcare setting is necessary, ensure that infected or colonized areas of the patient's body are contained and covered.

V.B.4.c. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions.

V.B.4.d. Don clean PPE to handle the patient at the transport destination. *Category II*

V.B.5. Patient-care equipment and instruments/devices

V.B.5.a. Handle patient-care equipment and instruments/devices according to Standard Precautions.

V.B.5.b. In *acute care hospitals and long-term care and other residential settings*, use disposable noncritical patient-care equipment (e.g., blood pressure cuffs) or implement patient-dedicated use of such equipment. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient.

V.B.5.c. In *home care settings*

V.B.5.c.i. Limit the amount of non-disposable patient-care equipment brought into the home of patients on Contact Precautions. Whenever possible, leave patient-care equipment in the home until discharge from home care services.

V.B.5.c.ii. If noncritical patient-care equipment (e.g., stethoscope) cannot remain in the home, clean and disinfect items before taking them from the home using a low- to intermediate-level disinfectant. Alternatively, place contaminated reusable items in a plastic bag for transport and subsequent cleaning and disinfection.

V.B.5.d. In *ambulatory settings*, place contaminated reusable noncritical patient-care equipment in a plastic bag for transport to a soiled utility area for reprocessing.

V.B.6. Environmental measures

Ensure that rooms of patients on Contact Precautions are prioritized for frequent cleaning and disinfection (e.g., at least daily) with a focus on frequently-touched surfaces (e.g., bed rails, overbed table, bedside commode, lavatory surfaces in patient bathrooms, doorknobs) and equipment in the immediate vicinity of the patient.

V.B.7. Discontinue Contact Precautions after signs and symptoms of the infection have resolved or according to pathogen-specific recommendations in Appendix A of the [HICPAC/CDC Isolation Guideline](#)

Droplet Precautions

V.C.1. Use Droplet Precautions as recommended in Appendix A of the [HICPAC/CDC Isolation Guideline](#) for patients known or suspected to be infected with pathogens transmitted by respiratory droplets (i.e., large-particle droplets >5 μ in size) that are generated by a patient who is coughing, sneezing or talking.

V.C.2. Patient placement

V.C.2.a. In acute care hospitals, place patients who require Droplet Precautions in a single-patient room when available. When single-patient rooms are in short supply, apply the following principles for making decisions on patient placement:

- Prioritize patients who have excessive cough and sputum production for single-patient room placement.
- Place together in the same room (cohort) patients who are infected the same pathogen and are suitable roommates.
- If it becomes necessary to place patients who require Droplet Precautions in a room with a patient who does not have the same infection:
- Avoid placing patients on Droplet Precautions in the same room with patients who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission (e.g., those who are immunocompromised, have or have anticipated prolonged lengths of stay). *Category II*
- Ensure that patients are physically separated (i.e., >3 feet apart) from each other. Draw the privacy curtain between beds to minimize opportunities for close contact.
- Change protective attire and perform hand hygiene between contact with patients in the same room, regardless of whether one patient or both patients are on Droplet Precautions.

V.C.2.b. In *long-term care and other residential settings*, make decisions regarding patient placement on a case-by-case basis after considering infection risks to other patients in the room and available alternatives

V.C.2.c. In *ambulatory settings*, place patients who require Droplet Precautions in an examination room or cubicle as soon as possible. Instruct patients to follow recommendations for Respiratory Hygiene/Cough Etiquette.

V.C.3. Use of personal protective equipment

V.C.3.a. Don a mask upon entry into the patient room or cubicle.

V.C.3.b. No recommendation for routinely wearing eye protection (e.g., goggle or face shield), in addition to a mask, for close contact with patients who require Droplet Precautions.

V.C.3.c. For patients with suspected or proven SARS, avian influenza or pandemic influenza, refer to the following websites for the most current recommendations (<http://www.cdc.gov/ncidod/sars/>; <http://www.cdc.gov/flu/avian>; <http://www.pandemicflu.gov>).

V.C.4. Patient transport

V.C.4.a. In *acute care hospitals and long-term care and other residential settings*, limit transport and movement of patients outside of the room to medically-necessary purposes.

V.C.4.b. If transport or movement in any healthcare setting is necessary, instruct patient to wear a mask and follow [Respiratory Hygiene/Cough Etiquette](#))

V.C.4.c. No mask is required for persons transporting patients on Droplet Precautions.

V.C.4.d. Discontinue Droplet Precautions after signs and symptoms have resolved or according to pathogen-specific recommendations in Appendix A of the [HICPAC/CDC Isolation Guideline](#).

Rating Categories

Recommendations are rated according to the following categories:

Category IA. Strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies.

Category IB. Strongly recommended for implementation and supported by certain experimental, clinical, or epidemiologic studies and a strong theoretic rationale.

Category IC. Required by state or federal regulation, or representing an established association standard. (Note: Abbreviations for governing agencies and regulatory citations are listed where appropriate. Recommendations from regulations adopted at state levels are also noted. Recommendations from AIA guidelines cite the appropriate sections of the standards.)

Category II. Suggested for implementation and supported by suggestive clinical or epidemiologic studies, or a theoretic rationale.

Unresolved issue. No recommendation is offered. No consensus or insufficient evidence exists regarding efficacy.

Airborne Precautions

V.D.1. Use Airborne Precautions as recommended in Appendix A of the [HICPAC/CDC Isolation Guideline](#) for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route (e.g., *M tuberculosis*, measles, chickenpox, disseminated herpes zoster).

V.D.2. Patient placement

V.D.2.a. In *acute care hospitals and long-term care settings*, place patients who require Airborne Precautions in an AIIR that has been constructed in accordance with current guidelines.

V.D.2.a.i. Provide at least six (existing facility) or (new construction/renovation) air changes per hour.

V.D.2.a.ii. Direct exhaust of air to the outside. If it is not possible to exhaust air from an AIIR directly to the outside, the air may be returned to the air-handling system or adjacent spaces if all air is directed through HEPA filters.

V.D.2.a.iii. Whenever an AIIR is in use for a patient on Airborne Precautions, monitor air pressure daily with visual indicators (e.g., smoke tubes, flutter strips), regardless of the presence of differential pressure sensing devices (e.g., manometers).

V.D.2.a.iv. Keep the AIIR door closed when not required for entry and exit.

V.D.2.b. When an AIIR is not available, transfer the patient to a facility that has an available AIIR.

V.D.2.c. In the event of an outbreak or exposure involving large numbers of patients who require Airborne Precautions:

- Consult infection control professionals before patient placement to determine the safety of alternative room that do not meet engineering requirements for an AIIR.
- Place together (cohort) patients who are presumed to have the same infection(based on clinical presentation and diagnosis when known) in areas of the facility that are away from other patients, especially patients who are at increased risk for infection (e.g., immunocompromised patients).
- Use temporary portable solutions (e.g., exhaust fan) to create a negative pressure environment in the converted area of the facility. Discharge air directly to the outside, away from people and air intakes, or direct all the air through HEPA filters before it is introduced to other air spaces

V.D.2.d. In *ambulatory settings*:

V.D.2.d.i. Develop systems (e.g., triage, signage) to identify patients with known or suspected infections that require Airborne Precautions upon entry into ambulatory settings.

V.D.2.d.ii. Place the patient in an AIIR as soon as possible. If an AIIR is not available, place a surgical mask on the patient and place him/her in an examination room. Once the patient leaves, the room should remain vacant for the appropriate time, generally one hour, to allow for a full exchange of air.

V.D.2.d.iii. Instruct patients with a known or suspected airborne infection to wear a surgical mask and observe Respiratory Hygiene/Cough Etiquette. Once in an AIIR, the mask may be removed; the mask should remain on if the patient is not in an AIIR.

V.D.3. Personnel restrictions Restrict susceptible healthcare personnel from entering the rooms of patients known or suspected to have measles (rubeola), varicella (chickenpox), disseminated zoster, or smallpox if other immune healthcare personnel are available.

V.D.4. Use of PPE

V.D.4.a. Wear a fit-tested NIOSH-approved N95 or higher level respirator for respiratory protection when entering the room or home of a patient when the following diseases are suspected or confirmed:

- Infectious pulmonary or laryngeal tuberculosis or when infectious tuberculosis skin lesions are present and procedures that would aerosolize viable organisms (e.g., irrigation, incision and drainage, whirlpool treatments) are performed.
- Smallpox (vaccinated and unvaccinated). Respiratory protection is recommended for all healthcare personnel, including those with a documented “take” after smallpox vaccination due to the risk of a genetically engineered virus against which the vaccine may not provide protection, or of exposure to a very large viral load (e.g., from high-risk aerosol-generating procedures, immunocompromised patients, hemorrhagic or flat smallpox).

V.D.4.b. No recommendation is made regarding the use of PPE by healthcare personnel who are presumed to be immune to measles (rubeola) or varicella-zoster based on history of disease, vaccine, or serologic testing when caring for an individual with known or suspected measles, chickenpox or disseminated zoster, due to difficulties in establishing definite immunity.

V.D.4.c. No recommendation is made regarding the type of personal protective equipment (i.e., surgical mask or respiratory protection with a N95 or higher respirator) to be worn by susceptible healthcare personnel who must have contact with patients with known or suspected measles, chickenpox or disseminated herpes zoster.

Attachment M

TEMPLATE FOR MINIMUM CARE FACILITY PLANS

◆ Background

- Geographic coverage, population size coverage, and total number of acute care beds required to cover 0.8% of population in geographic target area
This should define all the counties (or other geographic subdivisions) which are covered by this planning processes

- Number of facilities and number of beds in each facility
- Coalition members, who they represent, and any assigned roles

It is assumed that the coalition will develop plans for all the sites in the jurisdiction covered

- County contributions

What are the agreed upon contributions from each county which is participating in the planning. Contributions might include identification of persons to fill some lead positions (e.g., site commander, medical director), host site, money, percentage of volunteers recruited pre-event and during an event, contribution to planning effort (e.g., obtaining MOUs, sources of beds,, plan writing, facilitation, etc.)

- Lead planning agency

There is expected to be a single lead planning agency for the jurisdiction covered. The lead planning agency is that entity responsible for facilitating the coalitions work, ensuring the plan is developed, ensuring planning steps are executed (e.g., site section, MOUs, supplies, etc), and providing consultation and training to the initial team at the time of implementation. It is not assumed that the planning agency does all the work or bears all planning costs.

◆ Facility #1

ADMINISTRATION

- Lead implementation agency

The implementation agency is the entity that administratively staffs the MCF once it is activated. It may not be the same agency as the planning agency. A different lead implementation agency may be responsible for each MCF within the jurisdiction covered.

- Name and location of this facility

- Facility assets and deficiencies

- Source and acquisition of non-medical supplies
- Source and acquisition of beds
- Source of security services
- Source of food services
- Source of laundry services
- Source of janitorial services
- Physical characteristics and deficiencies (acute care floor space, ancillary rooms, flooring, lighting, locker rooms, office space, communication equipment on-site, communication connectivity, floor plan)

- Recruitment methods and responsibility
 - Volunteer registration
 - Volunteer roster creation
 - Registration with workers' compensation insurance
- Creation of schedules for staffing
 - Responsibility for
 - Number of days in advance scheduling is maintained
 - Communication of schedule to workers
- Communications flow

Define who will be responsible for making contact, how often routine communications will occur, how contact will be made (e.g., technology method) and to whom.

- Communications to local public health DOC
 - Communications to local EOC
 - Communications to NDDoH DOC
 - Communications with affiliated hospital
 - Report generation and submission
 - Entering data into HC Standard including requests for supplies
- Documentation procedures for document retention and cost tracking
- Ethics oversight committee for this facility

The persons assigned to ethics oversight may be the same for all facilities or may be facility specific.

- Deaths

Estimate the number of deaths per day for this facility during peak pandemic. It is not possible to know what this number will be, but assume at peak, that this would be two deaths per day per 120 acute bed unit.

◆ Facility #2, #3, etc

Complete the above sections for each additional facility within the planning jurisdiction.

◆ Patient Care Procedures

This section may reference specific sections of the Concept of Operations paper and will be the same for all facilities within the jurisdiction of this plan.

- Scope of care
- Initial admission criteria
- Receipt of patients for admission
- Admission processing
- Discharge processing
- Documentation
- Requirements for PPE use
- Role of ethics oversight committee
- Access to facility
- Pediatric care procedures
- Security

- ◆ Facility closure
 - Down staffing and partial demobilization
 - Disinfection
 - Return of durable medical equipment to sources
 - Waste disposal
 - Forwarding of medical records and procedural records to the state
 - Retention of cost documents at the local level