FIRE AND DISASTER PLAN

NORTHWOOD DEACONESS HEALTH CENTER

FIRE AND DISASTER PLAN

Reviewed & Revised

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EXTERNAL DISASTER

EXTERNAL DISASTER: Community disasters involving large numbers of casualties: storm, tornado, fire, flood, explosion, epidemic, civil defense, etc.

A. Verification

The following signals have been established by the city of Northwood to alert everyone:

FIRE - a 3-minute rapidly alternating high and low pitch

ALERT - a 3-minute steady siren blast for tornado sightings in the immediate area, etc.

ATTACK - a 3-minute up and down scale siren wail

ALL CLEAR - a 1-minute steady siren blast

All personnel on duty shall proceed to their assigned duty stations immediately upon hearing the warning signal of an impending disaster. All personnel off duty shall report to work **IF** they are notified to do so.

B. Notification of Disaster

First information about a disaster will come by telephone or by police radio. Personnel on duty will be put on alert status. All reports of disasters will be immediately reported to the Administrator and Medical Staff. The "Fire and Disaster Plan Recall Tree" shall be initiated if needed.

C. Admission

Patients being brought to the hospital for treatment will be brought to the vacated ambulance garages where they will be screened by the admissions doctor and classified as follows:

1. Those dead on arrival shall be transferred to local morgue.

2. All persons requiring specialized medical care not available at this hospital shall be transferred to a specialty center in Grand Forks or

Fargo. Only those ambulances or vehicles that are not busy with transporting victims to the hospital from the disaster area shall be used.

3. Immediate Treatment: Patients for whom expedient procedures will save life or limb, i.e.: those with extensive lacerations, hemorrhages, respiratory defects, severe crushing injuries, open fractures, incomplete amputations, severe burns, etc....

   These patients will receive immediate medical attention and shall be admitted to the hospital on cots, mattresses or stretchers. When all Acute hospital rooms are filled with at least two or more patients, then corridors will be utilized for further cases, as well as Doctors lounge, Nurses lounge, PT, Receiving room, Procedure Room and hospital link to north wing of LTC.

4. Delayed Treatment: Patients who after emergency care incur little increased risk by delay in further treatment, i.e.: those with moderate lacerations without extensive hemorrhage, closed fractures, etc...

   These patients after receiving initial emergency care will then be assisted to the corridors within LTC and remain there until all "Immediate Treatment" patients have been attended to.

5. Minimal Treatment: Those patients who can be attended to by nursing service, treated and released, i.e.: those with minor injuries, small cuts, sprains, etc...

When it is decided which classification each of the casualties are to be in, they will then be tagged and directed to the proper area. Tagging system can be obtained from EMT's.

Records must be kept at a minimum during a disaster.

Those casualties contaminated with filth (dirt and other debris) shall be hosed or brushed off as much as possible before being processed through the triage area.

Those casualties contaminated with suspected radioactive material shall shed their clothing and be hosed off prior to entering the triage area.

D. Sealing Off the Hospital

"Sealing off the hospital" means to have absolute control over all spectators and unauthorized persons into the treatment areas of the hospital. This includes the ambulance entrance and unloading area, the triage area, and all rooms within the hospital where patients are receiving emergency medical care. See policies on Controlled Access and Lock Down.

One or more persons should be assigned to control all entrances and exits to the hospital. This means to stand at the doors and allow only authorized persons or those persons that are actually needed in the hospital. Prevent all others from gaining access to the hospital or triage area. Only the following shall be permitted to enter: ambulance crews, triage personnel, police and highway patrol.

A cable or rope shall be hung between the northeast corner of the chapel and the southeast corner of the clinic with a sign attached in the middle reading "NO ENTRY". Three or four assigned persons shall control this particular entrance and allow only authorized persons or vehicles to pass through.

E. Public Information Center

All the information regarding victims of a disaster will be relayed to the public information center which will be located at the Northwood City Hall. Patient condition, disposition, or information to the news media will be available at this public information center and **not at the hospital**. Hospital personnel will be able to maintain communication with the public information center through telephone or 2-way radio communications.

F. Temporary Living Quarters

For those victims who have been examined and discharged -- if they do not live nearby or if they have lost their homes -- they shall be assisted to the community based center which may be the school, community center, or a church where arrangements will then be made by city officials to return each victim to their friends or relatives as soon as possible.

The Swarstad Chapel basement may be utilized by the immediate family of a disaster victim while they are awaiting word of the condition to their relative as to their disposition. Once this information is available, they should then leave the Chapel Basement.

Area pastors might be available to assist whenever possible.

FOR AN IN-HOUSE FIRE, SEE THE **"FIRE PROCEDURE"** MANUAL.

G. The card below shall be posted throughout the entire complex:

IN CASE OF FIRE

IN YOUR AREA:

R escue anyone in immediate danger

A lert, pull nearest fire alarm and report to hospital nurses station the type and exact location of fire (ext. 6444)

C ontain - close all doors and windows

E xtinguish if possible

IN OTHER AREAS:

1) Close all doors and windows.
2) Turn off all electrical equipment

FIRE EXTINGUISHERS:

KNOW HOW ---------- to use your fire extinguisher.
KNOW WHICH ------- fire extinguisher to use for various types of fires.
KNOW WHERE ------- your fire extinguishers are located (see floor plans).

TYPES OF FIRE AND EQUIPMENT TO USE:

For CLASS A fires: Wood, textiles, rubbish, paper, etc.	**USE:** Water extinguisher, fire hose blanket, etc.
For CLASS B fires: Oil, grease, paint, ether	**USE:** CO_2 extinguisher, blanket
For CLASS C fires: Motors, electrical	**USE:** CO_2 extinguisher, dry chemical extinguisher (disconnect if possible)

POINTS TO REMEMBER IN FIGHTING A FIRE:

1. Always stay between the fire and the way out to safety.
2. Crouch low to avoid smoke and heat.
3. Aim the extinguisher at the base of the flames.
4. Always feel the temperature of a door prior to opening.
5. If necessary, place a moist towel over mouth and nose.

3-28-90
7-17-17
10-05-20

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL DEPARTMENTS	RISK MANAGEMENT	8/12/10	8/25/16 10/05/20	SEVERE WEATHER	1 OF 3

POLICY:

To provide for the safety of our patients/residents, staff and visitors, the following procedures will be followed in the event of a tornado/severe wind.

NOTE: Tornado alerts are of two types of classification:

a. Tornado Watch – Tornado & severe thunderstorm are possible
b. Tornado Warning – Tornado detected; take shelter

PROCEDURE:

The following actions will be taken:

1. Will be announced over the intercom system three (3) times in a row; then after a 10 to 15 second delay, it will be announced again three (3) times. Code is "Severe Weather".
2. Acute Nursing personnel will maintain contact with the police department via radio or phone.
3. All residents/patients outside of the building are to be brought back inside the facility.
4. Turn TV on to local channel.
5. Place Med Cart in a room out of the hallway.
6. If possible, secure any outside objects such as garbage cans, furniture, etc. from becoming projectiles in a high wind type situation.
7. Locate flashlights, batteries, First Aid kits, etc. to be available for emergency use if needed.

NOTE: If a tornado warning has been called for the area of Northwood a Severe Weather code will be called. Initiate the following procedures:

1. All Acute Care patients, Long Term Care residents, and Clinic patients shall be assisted to the hallways or center-most portion of the building, keeping them away from windows and glass areas. All patients and residents will be given something (blanket, wash basin, towel, etc.) to cover their face and head with, if necessary.

   a. If time does not permit these arrangements, then all patients and residents should be assisted in seeking cover in their room – under blankets, covering face and head, etc.

b. After a patient/resident room has been checked and the individuals are moved to a safe area, the door of the room will be marked with a hot pink magnet in the hospital. In LTC the yellow/green tabs can be pulled away from the wall above the door to the room.

2. Keep residents away from windows and doors, etc.

3. Close all smoke barrier doors.

4. All doors and curtains shall be closed.

5. Contact Administrator and Safety Director, as well as other department managers as the situation exists.

6. After <u>all</u> patients and residents are accounted for, then all employees shall also seek cover in the same manner.

7. East Unit charge nurse to call Dietary and Activities to make sure they heard the page. All employees take notice of other departments and make sure they are aware of the severe weather announcement.

8. Any ancillary staff, when available, are to report to the nearest nurses station and take directions from the charge nurse as to where they can assist.

9. After the 'all clear' has been announced, it will be safe to come out of shelter, but not before.

10. In the event of actual damages, refer to partial and total evacuation procedures.

After tornado passes:

1. Reassure and calm patients/residents.

2. Check all patients/residents for injuries and other ill effects.

3. Check for fires throughout the facility while accomplishing #1 or #2 above.

4. If necessary, the Administrator/or designated charge person, in coordination with local building inspector, will inspect the facility for damage.

5. If no structural or minimal structure damage has occurred, utilities will be turned on one at a time by the following respective utility, the maintenance worker or person in charge.

6. If major structural damage has occurred, evacuate patients/residents from damaged area as soon as possible.

   a. Establish additional security for the facility by the local police, and when appropriate, by requesting help from the regional emergency center.

   b. Notify State Health Department as soon as possible.

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL DEPARTMENTS	RISK MANAGEMENT	11/11/09	9/28/11 10/10/17 12/06/17 6/20	EVACUATION OF FACILITY	1 OF 5

POLICY:

If possible, patients/residents will be evacuated internally to another area; but due to certain situations, to provide for the safety of our patients/residents, staff and visitors, evacuation of the entire facility may be required.

PROCEDURE:

The most common reasons for general evacuation are:

1. Widespread fire
2. Large amounts of smoke
3. Hazardous materials explosion – this would result from a truck or train accident, vehicle rollover or accident, train derailment or explosion.
4. Biohazard terrorist threat – this would be caused from a release of a hazardous bacteria, anthrax, smallpox, etc. If inside the facility, immediate evacuation would be necessary; if bacteria outside the facility, close all air intakes and notify 911.

Upon the order of the Administrator, Director of Nursing, Safety Director, or any other authority in charge to evacuate the entire facility, the following procedures are to be initiated:

1. Page all pertinent staff to report to the Incident Command Center, Inservice Conference Room. Evacuating patients/residents and staff in danger must be your first priority.

2. Inform staff as to the situation and that total evacuation has been ordered. Provide staff with the evacuation tags and back packs. Patients/residents should be evacuated according to their physical condition. Evacuation should be in this order:
   a. Ambulatory first
   b. Wheelchair second
   c. Bedridden third

3. Assign staff members to begin transfer to a designated safe location, beyond the fire barrier doors if the evacuation is due to fire.

4. As rooms are evacuated, doors are to be closed and marked (magnets or flags)

5. Elevators are not to be used. Assign staff member to man the telephone and begin recalling extra staff and/or police and fire departments.

6. Contact NDDoH 701-328-2270 and NDDoH will contact other hospitals and LTC facilities for possible transfers.

7. When moving patients/residents, KEEP TO THE RIGHT AT ALL TIMES.

8. Refer to the floor plans posted and in manuals to know what evacuation routes should be followed, if necessary.

9. After all residents have been transferred to a safe location to await transfer to the receiving centers, a head count will be done to account for all patients, residents, and staff. Report information about missing persons to the Incident Commander immediately.

10. Assign staff member to remain with the patients/residents. Do not let anyone return to the building or to the danger area.

11. Assign a staff member, if time and situation allows, to begin gathering the following items to be transferred with the patients/residents. No one's life is to be put in danger to evacuate these items:
    a. Med Cart and emergency drug kit
    b. Medical charts, laptop computers, paper copies of latest MAR
    c. Business records (if possible)
    d. Extra blankets and/or clothing (if possible)
    e. Totes on wheels will be stored in the back of Purchasing room. Rain ponchos and flashlights will be stored in them and they can be used to pack necessary items in.
    f. Grab batteries for the flashlights.

12. Upon arrival of transportation sources, begin transportation of patients/residents to the designated receiving centers. With nice weather, ambulation and wheelchairs are an option.

13. Listing of vehicle supplies:
    a. Ambulance service
    b. Police departments
    c. School district
    d. Employee vehicles
    e. Areas EMS
    f. Van

14. Areas that we could evacuate to: Northwood Public School would be first choice.
    a. Community Center
    b. Churches
    c. Area nursing homes
    d. Area hospitals

15. Contacts for Northwood Public School:
    a. Shane Azure 701-238-4254
    b. Cydnee Strand 701-430-6919
    c. Sarah Burger 218-791-4595
    d. Sandy Enger 701-329-2428
    e. Shawn Richards 218-371-1118
    f. office 701-587-5221

16. Areas that need to be assigned to staff to either notify or assist with:
    a. Clinic
    b. Chiropractor
    c. Dakota Apartments
    d. Assisted Living

    * The person assigned to Dakota Apartments will need a master key to get in. Keys are available from acute nursing, DON, facility services, and administration.

17. Managers will be requested to carry personal cell phones at all times.

18. Ambulances are to be removed from garage ASAP so that emergency care can always be covered.

19. Dietary is to obtain food items from kitchen and bring to receiving facility if time and safety permits.

20. In emergencies, always remember to account for each staff member.

21. Safety precautions during evacuation:
    a. When traveling through smoke, keep low. Smoke and heat rise. Crawl along the floor if necessary but remain low.
    b. Do not run, or allow anyone to run, in smoke-filled areas.
    c. When going through smoke, cover your face from the nose down.
    d. Do not touch anything. Watch for falling debris, wires, etc.
    e. Do not open a door into an area where a fire might be, even if the door is not warm. Before opening the door, follow the procedures outlined below. (Should a fire be on the other side, this test will aid you in closing the door instead of letting the fire blast through.)
        - Brace your shoulder against the door.
        - Brace your foot against the base of the door.
        - Place one hand on the doorknob.
        - Place one hand along the door opening at about head level.
        - Open the door slowly.
        - Be sure that the face is turned away from the door opening.
        - If smoke seeps through, close the door immediately.
        - Place a blanket, coat, etc., under the door to prevent smoke from entering the room.

    f. If safe, proceed to evacuate. Be sure to test all doors in this manner. Should a door be opened, and fire is present, the air from the room which you are entering could create the phenomenon called "flashover," causing the heated gases in the room to explode.
    g. Choose the safest way out.
    h. Be sure to close all doors and windows as you pass through.
    i. Once you are out, do not let anyone return.
    j. Remain calm. Do not panic. Follow all instructions issued.

22. PENDING EVACUATION
    a. Activate Incident Command
    b. Contact NDDoH
    c. Determine which resident/patients might be able to go to families and contact in advance.

c. Assess
- Available staff to support transferred resident/patient
- Total beds and types of beds needed
- Potential transportation needs based on resident/patient mobility and number

d. Complete HC Standard Information and prepare Triage tags and back packs

e. Organize resident/patient resources
- Resident/patient's important belongings/equipment
- Medications, snacks and water for transport period
- Medical charts
- Consider personal needs such as glasses, dentures, hearing aids, and valuables.

23. **Remember:**

a. Notify
- Families of evacuation and the current location of their loved ones
- NDDoH
- Fire
- Law enforcement
- Maintenance

b. Leave message on your facility phone with contact number and information regarding your status

c. Consider security needs of evacuated building

24. **Carries**:

a. Side-By-Side Come-A-Long: This is used for a victim who is able to walk but just needs manual assist. Put victim's weaker side next to your body; put the victim's arms over your shoulder, hold his/her wrist, and wrap your other arm around his/her waist and walk.

b. Blanket Drag: This is used for the resident who cannot walk. One person can perform this. Look at the victim's size, your size and strength.

1) Push the bed up against the wall or lock the brake.
2) Have the bed in the lowest position possible.
3) Lay the blanket on the floor.
4) Kneel on one knee using your other knee as a midpoint between the floor and the bed.
5) Gently lower the victim onto your raised knee and ease him/her into the lying position letting his/her lower body slide off your knee first, protecting his/her neck and head.
6) Grasp blanket up around head/shoulder area and drag him/her to safety, head first.

c. Hip Carry: Works well for smaller victims or someone who has had abdominal surgery.

1) Lock the bed or push against the wall in the highest position.
2) Back up towards the bed and grasp the resident's wrist with your hand that is the closest to the head and bring it around to your shoulder.
3) Put your other hand and arm around the resident's back and hold on tight in the auxiliary region.
4) Wrap other arm around the victim's knees and lift the resident.
5) Go sideways through the doors.
6) To ease this person down, back their buttocks against a wall and slide down the wall.

Two-Man Carries:

a. Swing Carry: Assist resident to a sitting position on the edge of a locked bed (waist high)
1) Have a rescuer get on each side of the victim and put the victim's arms around his/her own shoulders.
2) One of the rescuers nearest the victim then goes around the victim's back (either grabs the other rescuer's wrist or grabs onto the victim at the waist).
3) With your other hand, each rescuer reaches under the victim's knees and clasps the other rescuer's wrist.
4) Lift together and carry the resident to safety.
5) Lower to the floor by kneeling with the leg closest to the victim and lowering resident's feet first.

b. Extremity Carry: One rescuer at the top of the victim; the other is between legs at knee level.
1) Lock the bed up against the wall. Bed at waist height.
2) Bring victim to the sitting position.
3) Top rescuer gets into position first, putting their arms under the victim's arms and clasping their own hands.
4) The bottom rescuer then backs between the victim's legs so he can grasp the victim's legs behind the knees.
5) Together they now can walk.
6) This works well for long distance carries.
7) To lower foot end first, rescuer between legs lowers down to the knees and places the victim's feet and legs down.

REMEMBER NOTHING IS ENGRAVED IN STONE WHEN IT INVOLVES GETTING A RESIDENT TO SAFETY. EVERY SITUATION IS DIFFERENT AND MUST BE HANDLED THAT WAY.....SITUATION TO SITUATION.

T H I N K : USE COMMON SENSE!

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL DEPARTMENTS	RISK MANAGEMENT	3/14/12		SHELTER IN PLACE	1 OF 5

1. **Purpose**

The purpose of this plan is to provide guidance for NDHC during a crisis or emergency that forces the patients/residents, staff and others to stay in this facility for a 96-hour period in a self-sufficient way. The health and safety of the people here is the first priority of NDHC. NDHC is responsible for keeping patients/residents healthy, property safe and medical equipment in good working order to sustain life during this emergency incident. NDHC is also responsible for communicating the status of the facility to local authorities, responsible parties for patients/residents, the department of health, and the local community. The CEO, or acting CEO, will trigger this plan in the event of the following hazards previously defined in the Hazard Analysis: winter storm, biohazardous event.

2. **Scope**

This plan includes sheltering-in-lace place procedures for staying in this facility for a four-day period, an ordering plan for supplies and medicines, sheltering guidelines, and a demobilizing plan for returning to normal functions. The emergency manual includes facility floor plans. The plan is intended to function from the time NDHC decides to initiate the sheltering-in-place procedures until the emergency is contained.

A. Hazard Analysis Summary:
According to our Hazard Analysis, NDHC may shelter in place because of storms, biohazard event, and natural disasters; or, there is a community disaster or emergency event and the residents and staff have been ordered to remain in the building by local authorities. Therefore, in order to save lives and protective property it is safest to shelter in place.

B. Capability Assessment:
NDHC will shelter in place for a period of 96 hours (four days) until the disaster concludes or local services are restored. With the food supplies this facility has on hand, a generator in place that will supply power for telephones, cooking, lights, heat and other critical medical equipment, adequate planning for staff shortages, and adequate housekeeping and infection control supplies, this facility should be self-sufficient baring unforeseen difficulties.

3. **Policy**
NDHC will have defined procedures to protect the life safety of patients/residents and staff should there be a hazard that causes the facility to decide either to shelter in place or to evacuate.

A. Decision to Shelter-in-Place verses Evacuation:

1. The staff person, who identifies an internal hazard or who is notified of an external hazard, is responsible to notify the CEO or Acting CEO.

2. Shelter-in-place is the preferred option, unless the decision is made by the CEO or Acting CEO to evacuate, considering the circumstances of the incident.

   a. Initiate the Emergency Management Plan and operate under the Incident Command System.

   b. The Incident Command will assess the need for the diversion of incoming patients. "911" (dispatch) is to be notified by the Liaison Officer if patients are to be diverted. The appropriate referral facilities/agencies are to be notified that admissions are to be cancelled. The Liaison Officer is also to notify the EOC if activated, or Office of Emergency Management.

3. The decision to shelter-in-place or evacuate is to made in consultation with the response agency Incident Commander and also Unified Command, if established, e.g. the Health, EMS, Human Services and others, as appropriate.

   a. If there is no response agency Incident Commander, healthcare facility Incident Command is to do all that is necessary to protect the life and safety of its patients, staff and visitors. Incident Command is to notify Office of Emergency Management/911 (dispatch) of its decision.

   b. Prior to the actual need to shelter-in-place or evacuate, the healthcare facility is to consult with the local Emergency Management Director, Fire Department, Law Enforcement, Public Health, EMS, Human Services and others, as appropriate so that these agencies are aware of and are in agreement with this plan and its procedures.

B. Decision to Shelter-in-Place:

1. Incident Command is to make an assessment whether NDHC faces an internal or external hazard or both.

2. If the decision is made to shelter-in-place due to an internal and/or external environmental hazard, Incident Command will notify local authorities by calling 911 (dispatch), if appropriate, and will make an assessment for the need to initiate environmental engineering interventions. The primary decisions are:

   a. The decisions on how to protect patients/residents, staff and visitors by movement to a more secure area will be made by Incident Command in collaboration with the response agency Incident Commander or Unified Command, as appropriate.

   b. The decisions on how to protect the building will be made by Incident Command, based on the known hazards and their effects on the building and its inhabitants in collaboration with the response agency Incident Commander or Unified Command, as appropriate.

3. Initiate a process to secure the building (lockdown), if necessary.

4. Staff is to be advised to stay within the building and to advise all patients/residents and visitors to stay within the building until further notice.

5. If shelter-in-place is expected to last for more than 24 hours, Incident Command is to inform all departments that all resources are to be conserved. For example (the following list is not meant to be inclusive):

   a. This is the Incident Command System Branch that carries out all activities related to the management of the incident. (Operations)

   b. Establish a patient management plan, including identifying the current census, the cancellation of elective admission and procedures, etc., establish a workforce plan, including a plan to address staff needs for the expected duration of the shelter-in-place. (Planning)

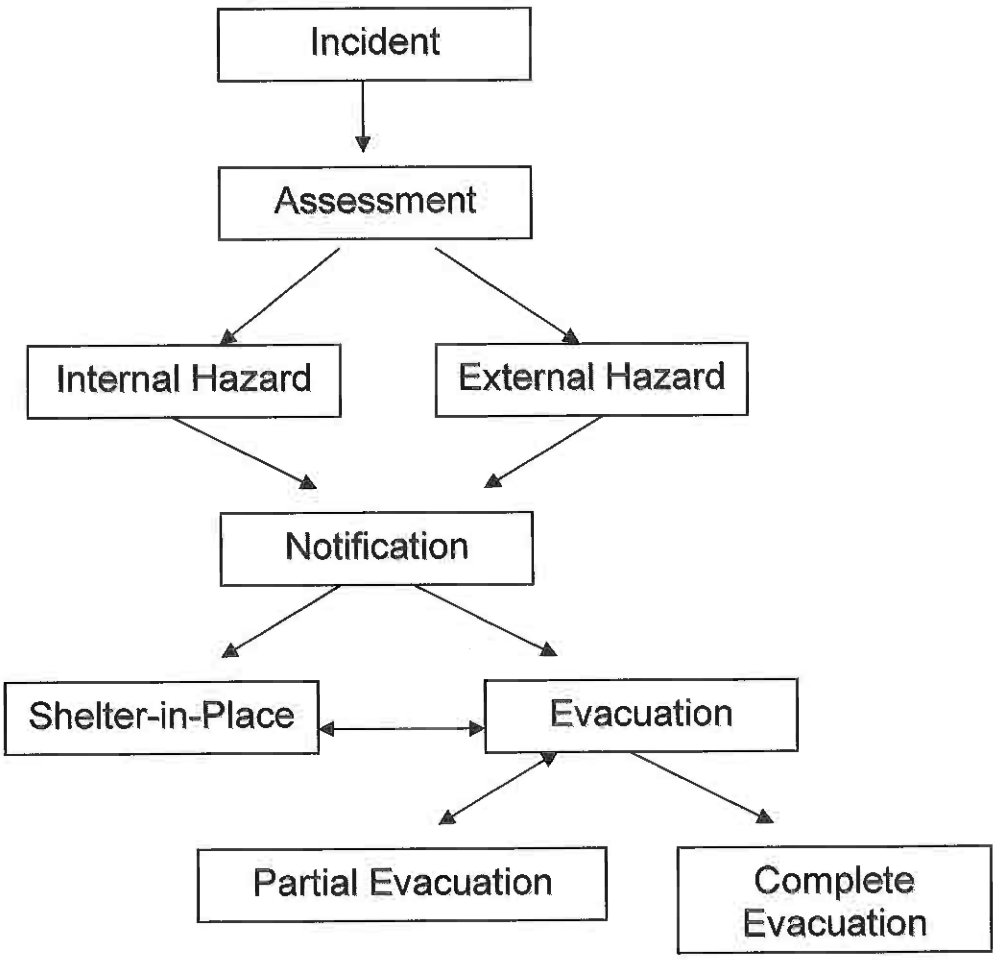
c. Establish communications and a backup communications plan with the local Emergency Management, Fire Department, Law Enforcement, Public Health, EMS, Human Services and others, as appropriate and the Emergency Operations Center (when activated). The Public Information Officer is to refer all communications through the EOC. (Liaison)

d. Provide local Emergency Management with a "situation report", including resources needed, e.g. the amount of generator fuel available and the duration that this fuel is expected to last. (Logistics)

6. Each department manager/critical functions is expected to provide in writing to the Logistics Chief, within one hour of the activation of Incident Command, the resources that it has available, the expected duration of these resources, and the contingency plan to conserve these resources should replenishment of supplies be in jeopardy.

7. Incident Command is to determine in collaboration with the response agency Incident Commander or Unified Command, as appropriate, when shelter-in-place can be terminated and to identify the issues that need to be addressed to return to normal business operations, including notification of local authorities about the termination of shelter-in-place.

C. Decision to Evacuate: See Evacuation Policy in Emergency Manual.



NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	SAFETY	11/03/93	6/18/95	BOMB THREAT TELEPHONE CHECKLIST	1 OF 1

POLICY: The Bomb Threat Telephone Checklist will be completed by the person receiving the bomb threat.

PURPOSE: To assist in identifying person(s) or evaluating threat.

PROCEDURE:

1. Keep person talking as long as possible.

    a. If possible have a coworker listen in on call and both take notes.

2. Complete form with as much information as possible.

    a. Write word for word conversation as remembered.

BOMB THREAT CHECKLIST
Telephone Procedures

Date: _____ Time Received: _____ AM/PM Concluded: _____ AM/PM

- REMAIN CALM, BE COURTEOUS, LISTEN TO, AND DO NOT INTERRUPT THE CALLER
- GET ATTENTION OF ANOTHER PERSON - GIVE NOTE SAYING "CALL POLICE - BOMB THREAT" **9-911**
- IF YOUR PHONE HAS CALLER ID DISPLAY, RECORD NUMBER OF INCOMING CALL _____
- WRITE DOWN EXACT WORDS OF THE CALLER AND THREAT
- DON'T HANG UP THE PHONE. LEAVE LINE OPEN
- NOTIFY A SUPERVISOR

_____

TRY TO KEEP THE CALLER ON THE PHONE AND TALKING BY ASKING THE FOLLOWING QUESTIONS:

1. WHEN WILL IT EXPLODE? AT WHAT TIME? _____
2. WHERE IS IT LOCATED? WHAT ROOM? _____
3. WHAT DOES IT LOOK LIKE? _____
4. WHAT KIND OF BOMB IS IT? _____
5. WHAT WILL SET IT OFF? _____
6. WHY ARE YOU DOING THIS? _____
7. WHO ARE YOU? _____ WHAT IS YOUR NAME? _____
8. ARE YOU AWARE THAT IT COULD KILL OR INJURE INNOCENT PEOPLE IN ADDITION TO THOSE YOU INTEND TO HURT? _____
9. WHEN WAS THE BOMB PLACED? _____ DID YOU PLACE THE BOMB? _____
10. WHO WOULD DO SOMETHING LIKE THIS? _____
11. WHY WOULD SOMEONE DO SOMETHING LIKE THIS? _____
12. ARE YOU PART OF AN ORGANIZATION? ____ IF SO, WHICH ONE? _____
13. WHERE ARE YOU CALLING FROM? _____
14. WHAT IS YOUR ADDRESS? _____

DESCRIPTION OF CALLER (check all that apply)

Sex: Male_____ Female_____ Unknown_____ Approximate Age_____

Voice	Speech	Language	Behavior	Background Noises
☐ Clean	☐ Accented	☐ Educated	☐ Agitated	☐ Airport
☐ Distorted	☐ Deliberate	☐ Foreign	☐ Angry	☐ Animals
☐ Loud	☐ Distinct	☐ Foul	☐ Blaming	☐ Baby
☐ Muffled	☐ Fast	☐ Intelligent	☐ Calm	☐ Birds
☐ Nasal	☐ Hesitant	☐ Irrational	☐ Fearful	☐ General Noise
☐ Pitch-High	☐ Lisp	☐ Rational	☐ Laughing	☐ Guns Firing
☐ Pitch-Med	☐ Slow	☐ Slang	☐ Nervous	☐ Gymnasium
☐ Pitch-Low	☐ Slurred	☐ Uneducated	☐ Righteous	☐ Machinery
☐ Pleasant	☐ Stuttered	☐ Unintelligible	☐ Crying	☐ Music
☐ Raspy	☐ If Accented,	☐ If Foreign,	☐ Other:	☐ Party
☐ Smooth	Describe:	Describe:		☐ Quiet
☐ Soft				☐ Restaurant
☐ Squeaky				☐ Talking
☐ Unclear				☐ Tavern/Bar
☐ Familiar				☐ Television
☐ Other				☐ Traffic
				☐ Train
				☐ Typing
				☐ Water/Wind
				☐ Other:

Name Of Person Receiving Call: _____

Phone Number Threat Was Received On: _____

Name Of Possible Suspect: _____

POLICE 9+911 (Emergency) 701-587-5651 (Non Emergency)

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	RISK MANAGEMENT	11/10/92	3/18/03 6/14/07 10/10/12 01/09/19	BOMB THREAT PLAN	1 OF 5

POLICY: The CEO or designee is responsible for coordinating and determining action in time of bomb threat. On evenings, nights, and weekends, or whenever Administration or person in charge in absence of CEO (see Personnel Policies) is not available, Acute Charge Nurse of duty will initiate bomb threat plan and continue until CEO or person in charge arrives. Always take a bomb threat seriously.

PURPOSE:

1. To assure correct action taken after bomb threat.
2. To provide as safe an environment as possible.
3. To provide a guide for determining action.

PROCEDURE:

A. Written Threats

1. Immediately notify CEO or person in charge in absence of CEO (see Personnel Policies).
2. Save <u>all</u> material such as paper, envelope, etc. that are with the threat for use in the investigation later.
3. **DO NOT** discuss threat with anyone other than the CEO or person in charge.
4. CEO, or person in charge in absence of CEO (see Personnel Policies), will coordinate Bomb Threat Plan; incident command will be set up.
5. **DO NOT** touch the document any more than necessary. Allow no one else to handle the document.
6. Activate emergency response at 9-911.

B. Phone Bomb Threat

1. Try to hold caller on line and signal other staff members that a bomb threat is being received and to call 9-911 to activate emergency response. If possible, have co-worker listen in on call and both take notes.
2. Complete *Bomb Threat Telephone Checklist* (orange paper). Write word for word conversation as remembered.
3. Immediately notify CEO or person in charge.
4. CEO or designee will coordinate Bomb Threat Plan; incident command will be set up.

C. Finding a Suspicious Object or Receiving a Suspicious Letter or Package

1. **DO NOT** touch the object. Allow no one else to touch the object.
2. Activate emergency response at 9-911.

D. Coordination and Activation of Bomb Threat Plan

1. Upon notification, CEO or person in charge in absence of CEO (see Personnel Policies) will review threat and determine action to be taken.

   a. Page "Code Orange" x 2, 15 seconds apart.
   b. Notify police department (use 9-911). If not notified already, they in turn will notify the Grand Forks Sheriff's Department and Fire Department, if necessary.
   c. Notify Maintenance of threat, to remove ambulance away from facility immediately.

2. Coordinate with Law Enforcement.

   a. Determine scope of threat.
   b. Determine threat feasibility.
   c. Determine extent of evacuation, if any.
   d. Call back medical/support personnel.

3. Staff Duties

   a. Provide direct care to patients/residents.
   b. Prepare for and execute evacuation if required. (See Evacuation Policy)
   c. Assist law enforcement as required.
   d. Use caution as duties are performed.

4. Individual department search plans, which include thorough, but rapid, searchers of each area.

   a. Department Managers (or charge nurses when Department Managers are not here) will authorize and coordinate the search and/or evacuation.
   b. Assign searchers and entrance monitors. People who work in the area will conduct the initial search.

c. Monitor all entrances and exits to the facility during a search to prevent entry or leaving of unauthorized personnel. Establish controlled access as per policy.

d. Instruct searchers:
   1) Not to turn lights off and on.
   2) Communicate by telephone.
   3) To search for and report suspicious objects but not to touch, move or jar the object or anything that is attached.
   4) To continue searching even after one or more suspicious objects found until CEO determines search concluded.
   5) Mark searched areas with masking tape or post-it notes on doors and other openings to help ensure that no space will be missed.
      a. During hours when other departments aren't here, the following units will search the assigned areas:
         1) Acute Nursing: All of the hospital plus ambulance garages and link.
         2) West Unit: West Unit, including lounges, nurses lounge, Activities, Dietary, Dakota lounge, and staff cafeteria.
         3) North & South Units: North and South Units, including lounges, beauty shop, Activities, and Dakota Unit.
         4) Lab will be called to search Lab, and Maintenance will be called to check offices, boiler, rehab and chiropractor office. Clinic staff will be called to search clinic.

   6) Things to consider with suspicious package:
      a. address: ie, "for Susan's eyes only" – usage of unpleasant abjection; ie, "the jerk Joe Brown"
      b. oily
      c. excessive amount of postage for weight of package
      d. no return address
      e. keep people away from suspicious package

   7) Report back to incident command immediately if suspicious item is found and/or at completion of search.

E. Evacuation

1. Evacuation to be determined by the Incident Commander.
2. Determine area to be evacuated based on 300 feet blocked area around object for relocation to another site in-house or complete evacuation plan. Refer to evacuation policy
3. Evacuate first to outside area and then plan for evacuation to another building. (See Evacuation Policy)
4. Acute nursing takes supplies to allow for setup of emergency station away from facility.
5. Use triage tags for residents and patients at a minimum to include name and major diagnosis; if triage tags not available, use masking tape.

F. All Clear

1. Immediately after an "all clear" has been verified per Bomb Squad, the information will be paged "Code Orange clear." Repeat several times.

G. News Media

1. Any news media or any outsiders are referred to the Incident Commander.

H. Safety Committee: A written critique of the operation is required to be submitted to the Safety Committee within 48 hours after the event by all department managers and/or supervisors.

I. Room Search Procedure: When a request for a room search is initiated, all service areas should initiate a search of their entire area including every room, bathroom, closet, storage area, stairwell and hallway. The following room search technique is based on the use of a two-person searching team to locate a suspicious package, hidden infant/child or potential suspect or evidence. There are many minor variations possible in searching a room. The following contains only the basic techniques.

1. When the two-person search team enters the room to be searched, they should first move to various parts of the room and stand quietly with their eyes closed and listen for any unusual sounds. Assess the room and start search procedures in a clockwise fashion to maintain consistency.

2. The individual in charge of the room searching team should look around the room and determine how the room is to be divided for searching. You should divide the room into two virtually equal parts. This equal division should be based on the number and type of objects in the room to be searched and not on the size of the room. After the room has been divided, both individuals go to one end of the room division line and start from a back-to-back position beginning with the walls and working toward each other.

3. Once a room search has been completed, it is imperative that personnel involved in a search be instructed to indicate "**Search Clear**" conspicuously posted in the area. Place a pink magnet on hospital door frame and in LTC, flag out the green and yellow flags above the doors. This will identify that this room has been searched and cleared.

EMERGENCY SERVICES: Phone Numbers and Civil Defense Numbers

1. **Ambulance Services:**

*	Grand Forks	780-1551	
	Grand Forks Airbase Hospital	747-5601	
	Hillsboro	636-3219	
	Larimore	343-6293	Station 13 Radio Unit 6640 &
*	McVille	322-4328	Unit 6441
*	Mayville	788-8865	
**	Northwood	587-6060	Station 8 (Hosp) Unit 6188 &
	If ambulance needed, instructed to call 911 to dispatch		Unit 6189
**	Thompson	599-2121	
	AirMed Care - Grand Forks	1-877-870-3315	
	Valley Med Flight	1-800-828-0168	

2. **Police Departments:**

Grand Forks	787-8000	Station 2
Grand Forks Airbase	747-6117	
Hatton	543-3243	
Larimore	343-2012	
Mayville	786-2555	
Northwood	587-5651	Chief of Police 1404, 1405 & 1406
Emerado Rescue Squad	594-5100	Assistant Chief

4. **Sheriff's Office:**

Grand Forks County	780-8280
Nelson County	247-2474
Traill County	636-4510
Steele County	524-2742

5. **Highway Patrol (Emergency)** N.D. call 1-800-472-2121
   ND HP Statewide 1-844-474-6347

6. **Medical Doctors:**

Dr. Berg	218-779-0053	
Dr. Ericka Stein	701-370-9763	
Condetta Ness, FNP	218-230-4106	Brian Twete 701-430-1886
McVille Hospital	322-4328	Lizz Sandberg 701-213-3054
Sanford Mayville Clinic	788-4545	Erik Burke 701-740-6852
Grand Forks Clinic	780-5000	Jean Marie Dahl 218-791-9854
Michigan Clinic	259-2118	
McVille Clinic	322-4347	
Larimore Clinic	431-2999	
Sanford Mayville Medical Center	788-3800	
Valley Community Health Center	343-6418	
Binford Clinic	676-2528	

* These hospitals have all officially agreed to provide backup service.

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
NURSING SERVICE AND CLINIC	MEDICAL STAFF	6/21/86	10/16/86 8/18/87 4/97 12/27/15 12/6/17 10/26/20	CODE BLUE	1 OF 1

POLICY: When an emergency arises where medical provider and emergency personnel is needed stat, CODE BLUE will be used. Procedures in CODE BLUE are to be used as a guideline. Each code situation is different. You may be asked to perform cares/tasks/assist with procedures not outlined under code roles. The charge nurse will determine in each situation what needs to be accomplished and direct staff in duties to ensure the most positive outcome for the patient.

PROCEDURE: When an emergency arises, and a health care provider is needed stat:

Page overhead **"Code Blue and location"**. Push **PAGE** button on phone and **00** for all facility and proceed with message. The provider will have to be called per acute nursing if clinic is closed. When using the paging system on the telephone, press **PAGE**, then after the beep, press **00**: for all facility, state CODE BLUE and location. [Repeat at least twice.]

Procedures for Code Blue:

a. Bring Crash Cart to location of Code.
b. Bring monitor/defibrillator to location of Code.
c. Bring suction set-up to location of Code.
d. Bring IV pump, Vitals machine, and Lucas Device to location of Code.
e. Call provider and lab as directed by charge nurse.
f. Assist with VS/CPR as directed by charge nurse. If doing compressions, may need to switch off doing compressions with person doing airway management for effectiveness or to relieve fatigue.
g. Maintain airway/ventilations, suctioning, O_2, oximeter.
h. Assist with IV start as needed.
i. Assist with monitor lead placement as needed.
j. Assist with CPR. Switch off with person doing compressions for effectiveness or to relieve fatigue.
k. Assess patient – Vital Signs
l. Place monitor leads. Interpret rhythm.
m. Start IV.
n. Give meds as directed.
o. Defibrillate as directed.
p. Recorder
q. Relieve person doing compressions/airway/meds as needed.
r. Direct visitors.
s. Answer lights

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	RISK MANAGEMENT	11/18/15		MISSING CHILD/SECURITY ALERT	1 OF 1

POLICY: MISSING CHILD/CHILD ABDUCTION- SECURITY ALERT- MISSING PERSON (INFANT/GENDER)

PROCEDURE: To protect infants/children from unauthorized transport and/or removal by unidentified persons. The intent of this procedure is not to physically restrain, or block exits so as to create a hostage and/or risk injury to the infant/child or employee. When any staff in the facility is notified that a child/infant is missing, proceed as follows:

1) Page overhead, "Security alert -Missing person (infant/gender)". Notify Administration.

2) The Department Managers or designated individuals will go to their departments and monitor corridors, elevators, exit doors and stairwells. **The role of the staff is not to stop the abductor, but to monitor and observe.**

Main Entrance	LTC Business Office, South
SCU Back Exit	South Wing
Emergency Entrance	Nurses Lounge
Ambulance Entrance	Far West, both ends
Link	Rehab door
By Maintenance	Receiving Room
Kitchen	Chapel
Dakota Parlor	Dakota Unit
Sunshine Parlor	Activities

3) The department originally contacted will initiate a search. If it is determined that a child is missing, the Police should be called via "911". Advise Administration that the Police have been called.

4) Administration will meet the Police at the Main North Entrance.

5) A staff member from the department originally contacted will stay with the parents/guardian until the child is found or until advised by the Police.

6) Page, "Security Alert all clear." When the situation is resolved.

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	SIR	02/16		SECURITY ALERT ARMED INTRUDER	1 OF 2

PURPOSE: To ensure that employees know how to respond to an Armed Intruder Event.
An Armed Intruder is....Anyone displaying or actively using a firearm or dangerous weapon. By way of example and not limited to, dangerous weapons include: guns, pistols, revolvers, stun guns, tasers, and BB guns, whether loaded or unloaded; switchblades, cudgels, metal knuckles, bombs or explosives.

POLICY: NDHC employees will take immediate action to minimize potential injury to self and others.
NDHC permits no weapons except for those carried by authorized law enforcement personnel.

PROCEDURE:

To provide an appropriate response for employees in an Armed Intruder situation.

- Employees directly confronted by an Armed Intruder: Follow the **RUN-HIDE-FIGHT** steps below.
- Employees in areas not directly confronted by an Armed Intruder:
  - Close all doors in your department/unit.
  - Keep hallway traffic to a minimum.
  - Remain vigilant of your surroundings.
  - Be prepared to act when directed by law enforcement or if the armed intruder enters your department/unit.

RUN - If there is an acceptable escape path, attempt to evacuate the premises.
- Have an escape route and plan in mind.
- Evacuate whether others agree to or not. Do not let others slow you down.
- Leave your belongings behind.
- Prevent others from entering the area where the armed intruder is.
- Keep your hands visible.
- Follow the instructions of any police officers.
- Do not attempt to move wounded people or non-ambulatory patients.
- Call 911 when you are safe.

HIDE – If evacuation is not possible, find a place to hide where the armed intruder is less likely to find you.

- Be out of the armed intruder's view (attempt to cover any windows in the door).
- Lock and/or block the door with heavy objects to protect you from shots fired in your direction.
- Silence any sources of noise (cell phones, pager, radios, televisions, etc).
- Do not trap or restrict your options for movement.
- Remain very quiet.

FIGHT – As a last resort, only if your life is in imminent danger, attempt to disrupt and/or incapacitate the armed intruder.

- Act aggressively as possible against the armed intruder.
- Improvise weapons, throw items at the intruder.
- Yell for distraction.
- Commit to your actions.

Staff will be alerted by an internal notification process based on your location.

911 – When law enforcement arrives.

- Remain calm, follow officer's instructions.
- Put down any items in your hands.
- Immediately raise hands and spread fingers.
- Keep hands visible at all times.
- Avoid quick movements towards officers.
- Avoid pointing, screaming, and/or yelling.
- Proceed to exit in the direction that officers entered the building. Do not stop to ask officers for help or direction.
- Know that help for the injured is on the way.

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL DEPARTMENTS	RISK MANAGEMENT	5/20/09		CONTROLLED ACCESS	1 OF 2

POLICY:

To provide for the safety of our patients/residents, staff and visitors, controlled access of the facility may be required in order to respond to events that may disrupt normal operations of the hospital.

The Incident Commander, Administrator, Director of Nursing, or Safety Director can activate controlled access status. In their absence, the charge nurse may activate controlled access status. That person will then page "your attention please, we are in controlled access" (repeat 3 times).

Once controlled access has been activated, all doors will be locked except for the Emergency Main entrance. All staff, patients and visitors are to access and exit the building through that area.

Controlled Access will remain in effect until the situation has resolved and it is determined that normal operations of the hospital can be resumed. At that time the Incident Commander or their designee will page "your attention please, controlled access all clear" (repeat 3 times).

PROCEDURE:

Response Checklist:

1. Secure and lock doors. Emergency entrance should be left unlocked.

   a. Back clinic door
   b. Rehab entrance
   c. Maintenance door
   d. Boiler Room (locked at all times)
   e. Kitchen door
   f. Front Chapel
   g. Back Chapel
   h. Dakota Parlor
   i. Dakota Apartments
   j. Sunshine Parlor
   k. Activities
   l. Rainbow Parlor
   m. Assisted Living
   n. South Wing (locked at all times)
   o. Far West (locked at all times)
   p. Link

2. Post signs on doors, directing them to the Emergency entrance. If possible, post an employee at the entrance to direct patients and visitors.

3. Make arrangements for supply delivery at designated times.

4. When normal operations can be resumed, announce the controlled access all clear, unlock doors that would normally be open, and remove signs for controlled access.

This Facility is in Controlled Access for security reasons.

All patients, visitors and staff are to enter and exit the building through the North Emergency Entrance.

H:\DISASTER\controlled access

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL DEPARTMENTS	RISK MANAGEMENT	5/20/09		LOCKDOWN	1 OF 2

POLICY:

Providing a secure environment for patients/residents, staff and visitors is a priority of our organization. In the event of a disaster where large numbers are trying to gain access to our facility, or incidents where dangerous individuals may be trying to access the building, a CODE LOCKDOWN may be initiated.

The decision to activate a lockdown can be made by Incident Command, Safety Director, Administrator, or Director of Nursing. In their absence, the charge nurse may make that decision. That person will then page "your attention please, code lockdown" (repeat 3 times). That individual will then assign duties as per response checklist.

During a Code Lockdown, the hospital will be locked and no one is permitted to enter or exit the building until the situation can be controlled or the threat of danger has passed. When the situation has been resolved, the authority who called the lockdown will page "your attention please, code lockdown all clear" (times 3).

PROCEDURE:

Response Checklist:

1. Secure and lock all doors (when possible, assign staff to monitor a specific door). Door locations:
   a. Back clinic door
   b. Rehab entrance
   c. Maintenance door
   d. Boiler Room (locked at all times)
   e. Kitchen door
   f. Front Chapel
   g. Back Chapel
   h. Dakota Parlor
   i. Dakota Apartments
   j. Sunshine Parlor
   k. Activities
   l. Rainbow Parlor
   m. Assisted Living
   n. South Wing (locked at all times)
   o. Far West (locked at all times)
   p. Link
2. Notify Sheriff's office of the lockdown situation, request law enforcement assistance, and put EMS on diversion until lockdown is cleared.
3. Inform patients and visitors of the situation and ask them to remain in the building until the all clear has sounded.
4. Post signs on doors stating we are in lockdown.

5. Use disaster call back tree to notify staff of situation. Shift changes will be held until lockdown is cleared.

6. Monitor lockdown event. In some situations it may be necessary to call in some staff in order to control and/or clear the situation. Those staff should be instructed to meet at a designated door and time to be allowed access into the building without allowing others entrance.

7. Announce all clear as soon as the situation allows. Return to regular operation of the hospital. Unlock doors that would normally be open. Remove lockdown signs.

This Facility is in

Lockdown

for security reasons.

No one is allowed in or out at this time.

H:\DISASTER\lockdown

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	SIR	3/21/18		Emergency Mode Operation Plan	1 OF 2

POLICY: It is the policy of this facility to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the patient/resident's electronic records in the event of an emergency or security incident (attack).

PROCEDURE:

1. The workstations and systems that house electronic medical records are considered critical systems and, therefore, will be plugged into outlets that are powered by the emergency generator.
2. Data will be backed up in accordance with backup procedures.
3. In the event of a power outage, the IT department and/or facility leadership will prioritize efforts in restoring systems. Considerations include:
    a. Restoration of power.
    b. Restoration of network connections.
    c. Restoration of medical record documentation systems.
    d. Restoration of personal/financial records.
    e. Restoration of third-party applications within various operating systems. (List of these applications are maintained by the security official.)
4. To prepare for the event of computer or network failure:
    a. Provider orders will be printed each month, verified for accuracy by a licensed nurse, and filed in the resident's medical record.
    b. When new orders are received during the month, the orders will be placed into the electronic record as well as handwritten orders will be maintained in the medical record.
    c. The most current comprehensive care plan will be printed and maintained in the resident's medical record.
    d. Paper copies of all nursing documentation screens, assessments, and transfer forms will be available for use, when necessary.
    e. Pre-printed discharge instructions based on common or reoccurring patient characteristics will be available for use, when necessary.
    f. Face Sheets and Cumulative Diagnosis Sheets will be maintained in the resident's medical record.
    g. Staff will be trained on the use of paper versions of electronic medical records and paper communication forms, such as pharmacy and laboratory requisitions and inter-departmental communications.

5. To prepare for known potential events that may result in power failure, such as weather events:
    a. Current provider orders and medication administration records (MARs) will be printed, verified for accuracy by a licensed nurse, and filed in the patient/resident's medical record.
    b. If new orders are received, the orders will be placed into the electronic record as well as handwritten orders will be maintained in the medical record.
    c. Electronic care plans will be printed and filed in the patient/resident's medical record.

6. In the event of computer or network failure, other forms of communication, such as fax and phone, will be used to obtain necessary information pertaining to a patient/resident's health.
    a. At a minimum, fax numbers for medical director, pharmacy, and laboratory will be pre-programmed into the fax machine.
    b. Current phone and fax numbers for emergency personnel, providers, facility leadership, pharmacy, and laboratory providers will be maintained and accessible to staff.
7. In the event of a cyber-attack:
    a. Affected systems will be shut down immediately and the use of paper records will be initiated.
    b. Backup data will be retrieved from off-site storage.
    c. Provider orders/medication administration records will be printed from pharmacy provider (if this service is available).
    d. Facility leadership, the security official, and IT department will work diligently to resolve the issue, including immediate notification of state and federal agencies (the security official maintains contact information).

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	SAFETY	01/10/18		Emergency Communication Procedures	1 OF 3

POLICY: To protect resident/patient health and safety in the event of an emergency or disaster, resident/patient care will be coordinated within the facility, across healthcare providers, and with health departments and emergency management agencies.

PROCEDURE:

1. The facility shall maintain accurate contact information for regular and contract staff, providers, volunteers, and other long-term care facilities and CAHs.

2. The facility shall maintain accurate contact information for federal state, regional, or local emergency preparedness staff; the State Licensing and Certification Agency; the Office of the State Long-Term Care Ombudsman, and other agencies or entities that may be sources of assistance to the facility during an emergency.
    a. The Administrator, or designee, shall maintain a list of contact information for the above entities.
    b. A copy of the list and contact information shall be placed in the emergency preparedness binder for easy access during an emergency.
    c. The information shall be reviewed and updated at least annually.

3. The facility shall establish primary and alternate means of communicating with the facility's staff as well as with federal, state, regional, or local emergency management agencies.
    a. Communication with staff members
        i. The primary method of communication with staff members shall be made through facility telephone or cellular phones. The facility shall call the staff member's primary phone number as listed on file, followed by any secondary contact numbers.
        ii. Alternative methods of communication with staff members shall include:
            1. Cell phones for in-house communications when in-house phone lines and paging systems are out of order.
            2. Use of personal cellular phones to make relevant, outside phone calls or text messages.
            3. Email communication via company email, if staff member has access to company-owned internet-enabled devices (i.e. smart phones, tablets, laptops).
            4. Email communication via personal email, if staff member has provided this information.
            5. E-blast communication via *NDDoH HAN call back*

iii. The Incident Commander will make the final decision regarding communications with staff members during an emergency, including which staff to notify and by what means.

b. Communication with federal, state, regional, or local emergency management agencies
   i. The Administrator, or Incident Commander, is responsible for communicating with the above entities and/or designating responsibility during the emergency.
   ii. The primary method of communication with the above entities shall be made through facility telephone or cellular phones by calling the listed contact number.
   iii. Alternative methods of communication with the above entities shall include:
      1. Email communication
      2. Radio system (*list the system, compatible with state and local officials*)
      3. VOIP phone
      4. BTWAN
      5. Ambulance Radios

4. In the event of an evacuation, the facility shall release information in accordance with HIPAA privacy protections.
   a. A recorded message from, or approved by, the Administrator shall be integrated into the facility's phone system alerting callers, such as family members and other interested parties, of the decision to evacuate and the location to which the residents/patients will be evacuated.

   b. As time permits, business office personnel shall begin making phone calls to resident/patient representatives to alert them of the decision to evacuate and the location to which the residents/patients will be evacuated.

   c. A resident tracking log will be generated on each nursing unit, specifying the location of each resident/patient, so that accurate information about the general condition and location of residents/patients can be provided in a timely manner.

   d. HIPAA privacy protections are not waived in an emergency, so only minimum information necessary shall be disclosed.

5. The facility shall communicate information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee in accordance with established procedures for the facility's Incident Command System.

6. The facility shall share information from the emergency plan with residents/patients and their representatives in accordance with established procedures.

7. The facility shall review these communication procedures annually, and associated contact information, at least annually and revise as needed.

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	SAFETY	01/10/18		Emergency Preparedness Resident/Patient/Staff Tracking	1 OF 1

POLICY: The facility will track the location of all residents and staff during and after an emergency to ensure accurate location during and after the emergency.

PROCEDURE:

1. In the event of an emergency situation, the nurse in charge will enter all residents/patients and staff that are transferred to another facility in the Resident/Patient and Staff Emergency Tracking Tool.

2. The tracking will consist of all on duty staffing and all residents/patients residing within the facility when the emergency occurs.

3. The tracking will continue until the facility returns to its normal operation status. All emergency preparedness policy and procedures will be based on the facility's risk assessment and updated annually and/or as needed.

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	SAFETY	1/10/18		Emergency Water Supply	1 OF 1

POLICY: It is the policy of this facility to establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

PROCEDURE:

1. The volume of water kept on hand will be based on a total of 70 staff/patients/residents within the facility for a period not less than 72 hours. The water will be for drinking, cooking, and miscellaneous purpose.

2. The water will be kept in 16 oz. water bottles, 1-gallon jugs, and 5-gallon containers. They will be kept in Provider's lounge and in purchasing.

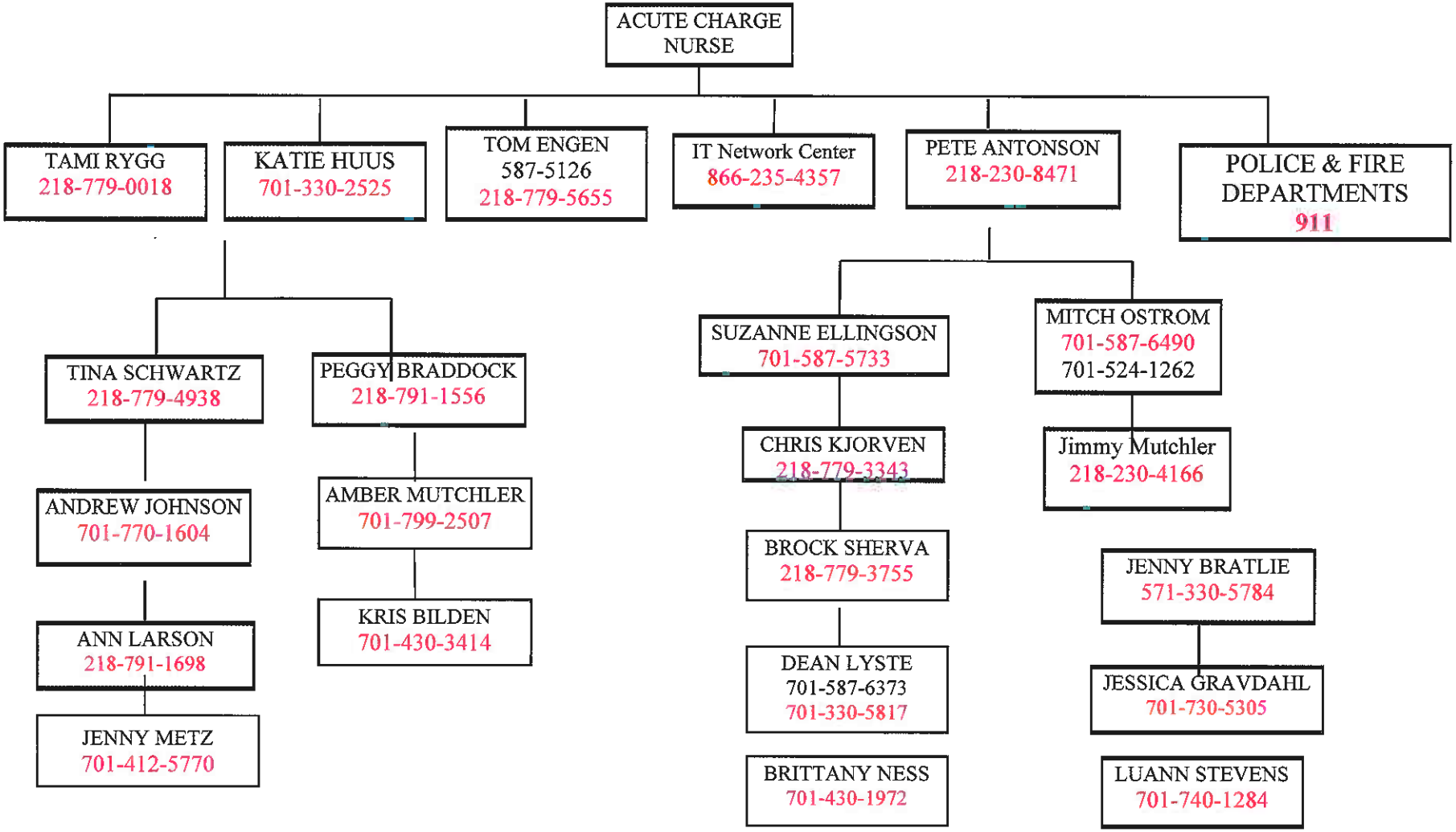
3. The Administrator, or designee shall maintain contact with State Health Department of additional water needs.

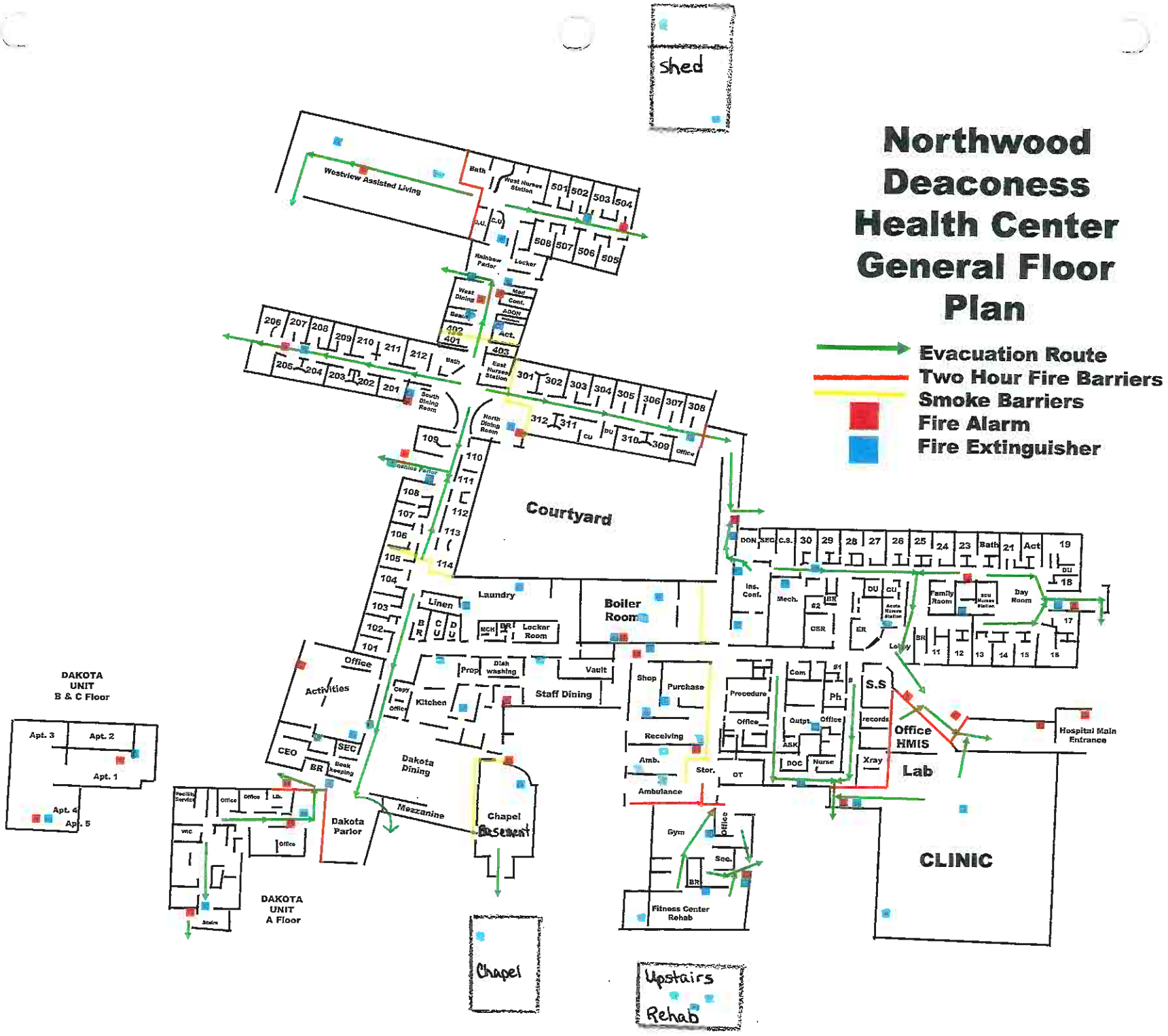
4. If there is any known weather event, construction or repairs that may result in loss of normal water supply, the increased water needs will be purchased in advance if possible.

5. Connection to fire hydrant is possible for non-drinking water needs.

REVISED 4/30/21

RECALL TREE




Shed
Northwood Deaconess Health Center General Floor Plan
Evacuation Route
Two Hour Fire Barriers
Smoke Barriers
Fire Alarm
Fire Extinguisher
Westview Assisted Living
Courtyard
Boiler Room
Laundry
Linen
Locker Room
Activities
Office
Kitchen
Staff Dining
Dakota Dining
Dakota Parlor
Mezzanine
Chapel Basement
Chapel
Upstairs Rehab
Shop
Purchase
Receiving
Ambulance
Gym
Fitness Center Rehab
Procedure
Office
Lab
Office HMIS
Xray
CLINIC
Hospital Main Entrance
DAKOTA UNIT B & C Floor
Apt. 1
Apt. 2
Apt. 3
Apt. 4
Apt. 5
DAKOTA UNIT A Floor

NORTHWOOD DEACONESS HEALTH CENTER
PATIENT/RESIDENT CARE POLICIES

DEPT. AFFECTED	BY	APPROVED DATE	REVISION DATE	SUBJECT	PAGE
ALL AND PUBLIC	CEO	4/88	7/95, 7/98 4/04, 2/08 2/13, 9/13 10/16, 09/17 12/17	VISITORS/RESIDENTS/ PATIENTS SMOKING POLICY	1 OF 2

Policy:

This facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. All guidelines shall be compliant with North Dakota state law.

Procedure:

1. Smoking is prohibited in all areas except the designated smoking areas, outside the Sunshine Parlor, north of the hospital entrance and not within 20 feet of the building.
2. Safety measures for the designated smoking area will include, but not limited to:
    a. Clothing appropriate for weather conditions.
    b. Provision of ashtrays made of noncombustible material and safe design.
    c. Accessible metal containers with self-closing covers into which ashtrays can be emptied.
    d. Accessible fire extinguisher.
    e. Prohibition of oxygen use in the smoking area.
3. No smoking signs will be maintained on the door or gate where oxygen is used or stored.
4. Electronic cigarettes will be treated the same as any other smoking product.
5. All residents and family members will be notified of this policy during the admission process, and as needed.
6. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process.
7. Residents who smoke will be further assessed, using the *Resident Smoking Assessment Form*, to determine whether supervision is required for smoking, or if resident is safe to smoke at all. The resident who smokes will sign the smoking agreement.
8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan.
9. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated.
10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan.

DEPT. AFFECTED	BY	APPROVED DATE	REVISION DATE	SUBJECT	PAGE
ALL AND PUBLIC	CEO	4/88	7/95, 7/98 4/04, 2/08 2/13, 9/13 10/16, 09/17 12/17	VISITORS/RESIDENTS/ PATIENTS SMOKING POLICY	2 OF 2

11. Family members or visitors that do not abide by this policy or the resident's plan of care will not be permitted to supervise resident's smoking.
12. If a resident or family member does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional measures such as room searches, prohibited smoking, or even discharge.
13. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.
14. The interdisciplinary team, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking by:
    a. Including the resident, family, and/or resident representative in discussions regarding the risks associated with smoking.
    b. Offering pharmacological and/or behavioral interventions to assist with smoking cessation.
    c. Providing educational materials regarding smoking and smoking cessation.
    d. Developing a safe smoking plan, or an individualized plan to quit smoking.
15. Documentation to support decision making will be included in the medical record, including but not limited to:
    a. Resident's wishes, or those of the resident's representative.
    b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely.
    c. Response to smoking cessation interventions.
    d. Compliance with smoking policy.
16. Hospital and swing bed patients that are able to independently smoke safely without supervision may do so in designated smoking area.
17. Long term care, assisted living, and independent living residents shall follow the policy when in the hospital.
18. Dakota Unit and Assisted Living tenants may smoke at the designated area south of the nursing home by the Sunshine Parlor, or north of the Hospital Entrance.

Northwood Deaconess Health Center
4 N. Park St. / P.O. Box 190
Northwood, ND 58267
(701) 587-6060
www.ndhc.net

At Northwood Deaconess Health Center we are supplied with water by the city of Northwood. The city of Northwood has two sources of water. The first source is rural water. This one is used the majority of the time. The second source is a city well, used mainly as a backup.

If the city water main feeding this facility breaks or becomes inoperable, there is a three valve system that will be used. Three different water mains would have to break at the same time before we would be without water. If this were to happen, we have an alternative water supply hookup at this facility. A fire hose connection in the hospital tunnel would be hooked to a fire hydrant or fire truck to supply this facility with water.

Notify Public Works Supervisor at 701-587-6291, Ext. 13; after hours, 701-550-9286.

Mitchell Ostrom
Facility Services Department Manager
Northwood Deaconess Health Center

Northwood Deaconess Health Center

WATER LOSS OR CONTAMINATION

This policy identifies guidelines to follow if the normal supply of domestic (drinking) water is not available or becomes contaminated.

Policy:
In the event that the normal source of drinking water is not available or should become contaminated, the following procedure will outline alternate domestic water sources, transportation options, and methods of contamination and distribution.

Procedure:

1. Upon notification of the loss of, or contamination of, the normal domestic water source, Facility Service will notify all affected areas that the domestic water is temporarily out of service, emergency contingencies have been implemented, and alternate water sources will be available shortly.

2. **Employees must use alternate methods of hand washing such as the use of alcohol-based hand hygiene products.**

3. Facility Service will distribute the stored drinking water, 5-gallon Premium Portable Water, stored in Purchasing Room (Joe's Room).

4. All affected areas will be cautioned to conserve what water supplies they receive.

5. There is also a supply of distilled water in Purchasing (Joe's) Room.

6. If necessary to have water hauled in, contact Grand Forks County Emergency Operation Center.

Northwood Deaconess Health Center
EMERGENCY FUEL PLAN

1. The outside fuel tank will always have at least 5,000 gallons of fuel.

2. The 3 inside tanks will always be kept at 75% full; when they reach that level an alarm will sound.

3. If fuel is needed in an emergency Baseview Petroleum will be called at 218-779-9179. They are located in Northwood.

4. Our daily usage of fuel in the winter is between 200 and 500 gallons per day. We should be able to shelter in place one week with the fuel level at their lowest.

Northwood Deaconess Health Center
Policies & Procedure

Policy: Chemical, Biological and Radioactive Decontamination
Effective: 10/07

POLICY

In response to identified chemical, biological, and radioactive hazards, Northwood Deaconess Health Center is prepared to manage contaminated individuals who have come in contact with biohazardous materials and to meet the care needs of those individuals.

NDHC staff has been trained and maintains equipment for handling decontamination of individuals, depending on the severity of the event.

Facility Services, with local law enforcement assistance, will maintain isolation of the contaminated area until it is announced safe by trained personnel.

Contaminated individuals, supplies, and contaminated building areas will be isolated and assistance will be provided by North Dakota Department of Health.

Healthcare Incident Management System Command Staff will direct the Facility Service to contact a contractor, experienced in the isolation and decontamination process, if the facility is contaminated.

PROCEDURE

1. Emergency Department Preparation

Emergency Department staff should be familiar with the hospital's hazardous materials response plan and participate in scheduled drills.

Preparation for arrival of a contaminated patient should include: notification of all services involved (Security, Maintenance, Environmental Services, Infection Control for Biological contamination, Radiation Safety for Radiation Contamination), set up of Decontamination Shower System located in Ambulance garage, and donning of appropriate Personal Protective Equipment of the decontamination response team.

The decontamination shower system and all support equipment are maintained by Emergency Department staff. All necessary equipment and materials are easily accessible in the ambulance garage in the decontamination areas.

2. **Emergency Department Mobilization**

The person receiving a call of incoming victims should notify the Emergency Departmental staff who will in turn notify trained personnel. The Charge Nurse should be instructed to announce "Ready Alert??" which automatically results in a response from the setup team (Maintenance, Environmental Services, Security, Emergency Outpatient Department and Ambulance). NDHC establishes and maintains a lockdown until proper decontamination of individuals an

d building.

3. **Decontamination Area Preparation**

Any victim of a hazardous materials incident must be considered as contaminated until demonstrated otherwise. Therefore, any such patient should be directed to the decontamination area and this is accomplished through the use of barricades (i.e. plastic covered areas that were previously contaminated are secured with tape and caution tape is used to redirect people) to prevent patients from directly entering any part of the building.

Security personnel should be stationed at the main entrances of the emergency department nearest to the decontamination area to prevent unauthorized entry, to control the entrance of the contaminated patient into the department, and to direct the vehicle transporting the patient to the appropriate area.

A triage area should be set up just outside the emergency department entrance, where arriving contaminated patients can be screened for adequate decontamination before entering the department.

The decontamination area should be large enough to facilitate decontamination of more than one patient and accommodate the many staff involved in patient treatment and contamination reduction.

The ventilation system in the ambulance garage should be shut off to prevent any spread of contamination.

4. **Decontamination Processes in General**

Whenever practical, all decontamination should be done at the site of contamination, and patient transported after decontamination at the site. The ambulance garage will be the primary area of decontamination of individuals who present with contamination.

A. The Shower System can be set up in the second ambulance garage or can be set up at the area of contamination.

B. With large amounts of concentrated corrosives or very oily materials, such as diesel fuel, or pesticides, disposable, chemical resistant jumpsuits and gloves will offer additional protection. Gloves should be taped onto the sleeves of the jumpsuits to minimize chemical contact.

C. To prevent unnecessary contamination, all nonessential and non-disposable equipment should be removed from the decontamination area and placed in plastic bags.

D. Personnel should not enter the area unless in proper personal protection, and no personnel or equipment may leave the area until properly decontaminated. A "clean" member of the staff should stand on the clean side of the entrance to hand in supplies and receive medical specimens.

5. Decontamination Response Preparation

A. A decontamination team should be pre-designated and trained in appropriate personal protection equipment and procedures. The team should consist of:

- Emergency department nurses
- Ambulance paramedics (as available depending on extent of remote event)

Support personnel

- Environmental Services
- Recorder (May be in the clean area, Performs Triage Tagging)

B. The decontamination responders should be equipped with appropriate personal protective equipment (Level C).

C. Appropriate dress for the decontamination team may include (depending on the hazard:

- A chemical resistant jumpsuit and gloves complete with foot covers; boots to be worn over these, taped in place with the zipper on the suit should also be taped.

6. Decontamination Basics

A. The triage personnel wearing personal protective equipment should meet the vehicle/patient/ambulance upon arrival and assess the condition of the patients as well as the degree of contamination. Personnel should keep in mind that the actual contamination may be (or become) a life-threatening condition.

B. Triage procedures should also be initiated at this point, if necessary. During initial patient survey and stabilization, decontamination should simultaneously be performed if possible, to reduce the hazard to both patient and staff. This consists of cutting away and otherwise removing all suspected contaminated clothing, including jewelry and watches, and brushing or wiping off any surface contamination. Care should be taken to protect any open wounds from contamination. Emergency department personnel should make every effort to avoid contact with any potentially hazardous substance.

C. Ideally, decontamination should be performed before patient transport; however, if field decontamination facilities are limited, emergency department personnel should consider that all hazardous materials patients need decontamination. This may be so, even if field decontamination was done at the site. If a patient's clothing was not removed at the incident site, it should be removed outside the ambulance but before entry into the emergency department. Contaminated clothing should be removed as soon as possible and placed in plastic bags, sealed in an out bag, and labeled. The decontamination team should use a backboard to transfer the patient, and take him or her directly to the decontamination area along the pre-designated route. Any area throughout the facility that came in contact with the contaminated person should have plastic placed over it and taped. Signs should be placed identifying the contaminated area.

D. Priority should be given to the ABC (Airway, Breathing, and Circulation) and simultaneous contamination reduction. Once life-threatening matters have been addressed, emergency department personnel can then direct attention to thorough decontamination and secondary patient assessment. Other trained personnel may simultaneously perform identification of hazardous materials involved. It is important to remember that appropriate personal protective clothing must be worn until personnel are no longer in danger. Therefore, the sooner the patient becomes decontaminated the sooner personnel may reduce protective measures.

E. Effective decontamination consists of making the patient as clean as possible. This means that the contamination has been reduced to a level that is no longer a threat to the patient or the health care workers.

The recorder may note the areas on the patient that are found to be contaminated, to assist treatment.

7. Decontamination of Patient

A. The purpose of decontamination is to reduce external contamination, contain the contamination present, and prevent the further spread of potentially dangerous substances. Remove what you can and contain what you can't. With a few exceptions, intact skin is more resistant to hazardous materials than injured flesh, mucous membranes, or eyes. Therefore, decontamination should begin at the head of the patient and proceed downward with early attention to eyes and open wounds. Once wounds have been cleaned, care should be exercised so that the wounds are not re-contaminated. This can be aided by covering the wounds with a water-proof dressing. For some chemicals, such as strong alkali, it may be necessary to flush exposed skin and eyes with water or normal saline for longer than 20 minutes.

B. External decontamination should be performed using the least aggressive layer methods. Mechanical or chemical irritation to the skin should be limited to prevent damage to the epidermal layer, which would result in increased permeability. Contaminated areas should be gently washed under a spray of water, with a sponge and a mild soap. Warm, never hot, tap water should be used. Care should be taken so that contaminants are not introduced into open wounds.

C. The first priority in the process of decontamination should be contaminated open wounds. Wounds should be irrigated with copious amounts of water or normal saline, and deep debridement and excision should be performed only when particles or pieces of material have been embedded in the tissues. Decontamination of eyes should also have high priority. Gentle irrigation of the eyes should be performed with the stream of normal saline diverted away from the medial canthus so that it does not force material into the lacrimal duct, or with specialized eye washing equipment. Contaminated nares and ear canals should also be gently irrigated with frequent suction to prevent any material being forced deeper into those cavities. Washing with simple soap and tepid water is usually all that is needed to remove contamination. Hot water, stiff brushes, or vigorous scrubbing should never be used because they cause vasodilation and abrasion. This increases the chances for absorption of hazardous materials through the skin.

D. Once primary decontamination is complete, the patient should be washed again, ideally in an adjacent area, to assure that the contaminant is as fully cleared as possible. If the patient is erect and

mobile, they may assist in these washings, if provided with a stool or chair (water resistant materials).

E. Where practical, such as with radioactive contaminated patients, means will be used to assure decontamination is complete. .

F. Once all victims/patients have been decontaminated, the staff that has been doing decontamination must decontaminate themselves and each other. The external suits should be washed down with soapy water, and brushes or surgical scrub sponges, and rinsed with water. After the second decontamination the suits are removed, without removal of the respiratory protection. Only after all clothing is removed and the person showered again, should the respiratory protection be removed.

G. The decontamination area should be washed and wastewater collected for later disposal. Tubs and tarps that contained the wastewater may be recycled, if they can be demonstrated to be clean, or may be discarded as contaminated wastes. The suits and disposable clothing should also be packaged in plastic and held for disposal. Cleanable equipment should be cleaned prior to dismantling the decontamination site, and may be returned for servicing. This should only take place after the equipment is declared clean by a designated safety and health person.

H. Contaminated water should be tested, and discharged to the sewer, if allowable, or removed as chemical or other hazardous wastes. The residual materials and contaminated clothing, etc. should be removed as hazardous wastes based on the original hazard of the contaminant. Victims clothing and possessions may be returned for appropriate cleaning by trained personnel. It may also be held as evidence, if so directed by police authority. If not held or returned, it should be included in the contaminated wastes for disposal.

I. Areas of the facility that were contaminated by the victims/patients upon arrival, prior to decontamination should be blocked and covered with tape and plastic bags from access until decontaminated. Trained personnel should be instructed to clean areas.

8. **Considerations for Patient Treatment**

A. Primary goals for emergency department personnel in handling a contaminated patient include termination of exposure to the patient, patient stabilization, and patient treatment—while not jeopardizing the safety of emergency department personnel. Termination of exposure

can best be accomplished by removing the patient from the area of exposure and by removing contaminants from the patient.

B. Personnel must first address life-threatening issues and then decontamination and supportive measures. Priority should be given to the ABC with simultaneous contamination reduction. Once life-threatening matters have been addresses, emergency department personnel can then direct attention to thorough decontamination, secondary patient assessment, and identification of materials involved. It is important to remember that appropriate personal protective clothing must be worn until personnel are no longer in danger. Therefore, the sooner the patient becomes decontaminated the sooner personnel may reduce protective measures or downgrade the level of protection.

C. Primary and secondary surveys should be completed as conditions allow. In treating patients, personnel should consider the chemical-specific information received from the hazardous materials response resources. In multiple patient situations, proper triage procedures should be implemented. Presenting signs and symptoms should be treated as appropriate and when conditions allow. The sooner a patient has been decontaminated the sooner he or she can be treated like a "normal" patient. Orders of the designated poison control center and attending physician should be administered. Invasive procedures, such as IVs or intubation, should be performed only for life-threatening conditions, until decontamination is performed. These procedures may create a direct route for introducing the hazardous material into the patient. The patient should be frequently re-assessed because many hazardous materials have latent physiological effects.

NORTHWOOD DEACONESS HEALTH CENTER

DEPT. AFFECTED	BY	APP. DATE	REV. DATE	SUBJECT	PAGE
ALL	SAFETY	12/14/11		DECONTAMINATION OPERATIONS	1 OF 3

POLICY: When a patient presents to EMS requiring decontamination, decontamination operations will open.

PROCEDURE:

1. Patient presentation

   a. If possible, hospital should be in lock down to keep the facility from contamination. This would be ideal.
   b. If ambulatory, refer to ambulance garage.
   c. EMS would bring to ambulance garage.
   d. If contaminated patient arrives without prior knowledge, avoid direct contact and redirect outside to the decon area. If the patient cannot ambulate, cover patient with sheet and move outside to decon area per cart or wheelchair.

2. Ambulance transport

   a. Early notification to ER.
   b. Decontaminate at scene per firemen, if possible.
   c. Hold patients in ambulance until decon team is ready.
   d. Ambulances need to be removed from garage.

3. Type of contamination

   a. Base type of decon is determined by the contamination - no decon, clothing removed only, clothing removal plus washing.
   b. When in doubt be conservative and strip and sort.
   c. When you know the name of the chemical, these sources can be checked for type of decon: container label, MSDS, Poison Control.

4. First Steps

   a. Notify members of decon team.
      1) Training interested staff, housekeepers and laundry personnel
      2) Recall tree at nurses station
      3) Page throughout facility if during day time hours when facility personnel are at work.

5. Donning and Doffing

   a. See attached sheets.

6. Decontamination process – perform in the warm zone

   a. Remove clothing: 80-90 % of contaminant is removed.
   b. Residual usually primarily in hair; have patient bend over so that washwater falls away from body.
   c. Soap and water wash
   d. Prevent clean areas from becoming contaminated.
   e. collect waste water and clothing safely. If washwater goes down the drain, make sure Department of Health & Public Works are notified as soon as possible.

7. Dry decontamination

   a. If exposure was to gas only and patient is stable and no evidence of small pupils with secretions with respiratory symptoms, THEN only need to remove clothing and seal in plastic bag.
   b. If not sure it's a gas, perform soap and water wash.

8. Directed self-decon

   a. Telling a patient what to do so they can perform their own decon.
   b. Can be done from a safe distance without PPE.

9. Back Board victim

   a. Back boards can be set up across sawhorses.
   b. At least three (3) staff are needed for this – one to wash and two to stabilize the patient board.
   c. Remember the floor will be slick.
   d. The board and straps would also have to be cleaned.
   e. Pass the clean patient on the board into the clean zone to a waiting cart.
   f. If okay to remove the board, do so, and pass back into the warm zone.

10. Contaminated areas

    a. Prevent or reduce contamination to ambulance garage.
    b. If contaminated, attempt to cordon off area.
    c. Areas trod upon by contaminated patient can be mopped with 1:10 bleach to water solution.
    d. If can't be mopped, cover area with heavy plastic sheeting until info can be obtained on cleanup.

11. Decon Pearls

    a. Protects you and the hospital.
    b. Do NOT skp decon with critical patients.
    c. Contain clothing always and washwater, if possible.
    d. Soap and water cures most evil.
    e. Contact and inhalation primary threats.
    f. Keep clean areas (patient and hospital) clean and isolate the dirty areas.
    g. Know your responsibilities!
    h. Limit your role to what you are trained for and comfortable with.
    i. Wear PPE unless CLEARLY not indicated.
    j. Triage/decon areas should be secured, visible and accessible.

12. Universal language when suited up

    a. Shrugging shoulders = "What???"
    b. Thumb up = OK
    c. Arms across chest = HELP

Hospital Decontamination General Recommendations

1. Hospitals must regularly assess the risks to the community and perform a hazards vulnerability analysis. The level of equipment and staff protection must be based on this analysis.

2. Hospitals are encouraged to establish relationships and notification procedures with appropriate local agencies (e.g. local EMS agencies, public health) to:

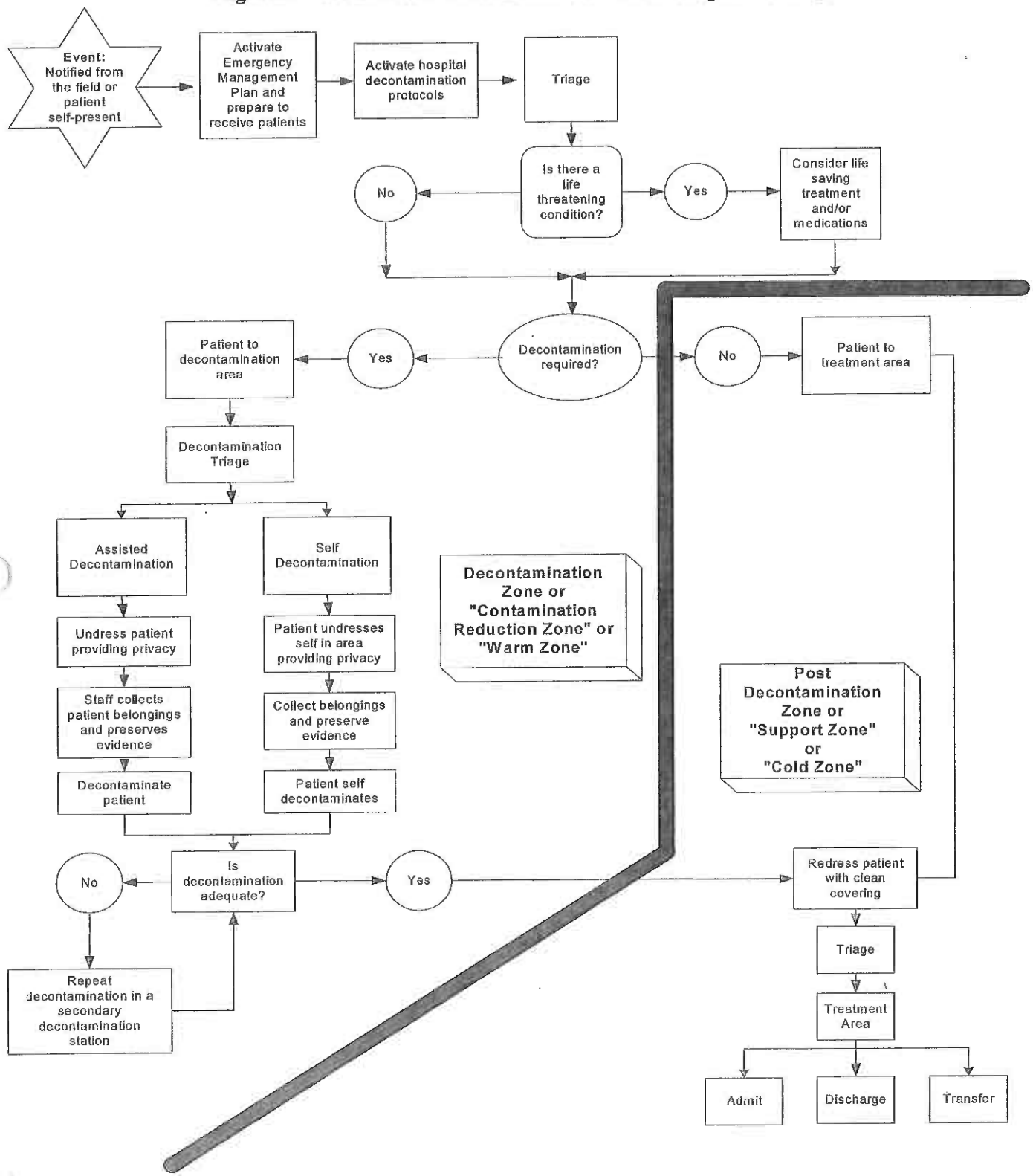
    a. Ensure communication between the field and the hospital of events and to allow for facility preparation.
    b. Ensure that properly trained and equipped field/prehospital responders decontaminate patients in the field to protect the hospital.
    c. Understand the local protocols and capabilities for field decontamination of patients.
    d. Ensure notification of an event to appropriate local agencies.

3. The primary role of the hospital in a hazardous materials event is to triage, treat, decontaminate and medically screen patients as necessary.

    a. An influx of contaminated patients will overwhelm <u>any</u> hospital and therefore hospitals must work collaboratively with community hospitals and local government to meet the challenges of a surge of contaminated patients.
    b. Hospitals must be prepared for patients who self refer and present to the hospital and may be contaminated.
    c. Additional planning considerations may include:
        i. Establishing a "fast track" decontamination line for patients with severe or life threatening symptoms, delivering the basic life saving treatment before decontamination.
        ii. Establishing a separate decontamination area for patients that require secondary and /or technical decontamination if primary decontamination is not adequate.
        iii. Establish a separate "lane" for patients arriving by EMS transport that have been decontaminated on scene so that these patients can be quickly assessed for adequacy of decontamination and be triaged to medical screening more quickly.

4. These recommendations, developed for hospitals by hospital experts, and will be revised and updated as indicated by practice or need.

Algorithm for Chemical Decontamination in a Hospital Setting



Directed Self Decontamination

PATIENT:
You have been or possibly been exposed to a hazardous substance. For your own health and safety as well as others, you must be thoroughly cleaned before we can safely treat you. This is what you must do. Please read all the steps. Then proceed to follow them. We will be waiting for you at the end with towels to dry you off.

1. Go to the designated area.
2. Prepare to undress behind the privacy curtain.

3. Open the plastic bags.
4. Place all of your valuables (wallet, keys) into the small plastic bag and seal it. If you have prescription glasses or hearing aids, keep them with you.
5. Remove ALL your clothing.
6. Put clothes into large plastic bag.
7. Put the small valuables bag and large clothes bag in the designated place.
8. Put on the wristband or neck identification.
9. Now step into the shower / tub area.

Shower Area
10. Wet yourself all over in the shower.
11. Thoroughly wash with soap and water, paying attention to hair, ears, etc.
12. Rinse for at least one minute.
13. Step out of the shower area and we will have a towel and covering for you.

14. We will keep you covered.
15. Then we will take you to the treatment area.
16. If it is safe, we will give you back your clothes and valuables.

Ambulatory Patients

1. Direct patient to Decon Sector
2. Children should be kept with their parents if at all possible; if no parent or older sibling is available then a Decon Team member should provide needed assistance to a child
3. Patient should be given Personal Decon set as soon as it is available and be given rapid instructions on its' use.
    - The kit stays with you as you proceed through the process
    - Open up the bag – it has three parts
    - Take out the plastic bags now
4. Patient should quickly remove all clothing putting valuables into the clear plastic bag and clothing into large bag then put both bags into 3rd bag and cinch tight w/ tag number in pak. Patient should put numbered tag around their neck and wear it through decon and treatment
5. The clothing bag should be set aside in secure area
6. If staff available, patients name and number should be recorded on Patient Decon Record
7. Patient should continue forward into the Decon Sector with remaining part of Personal Decon Kit
8. Patient should quickly rinse themselves from head to toe with water using either the hand held sprayer, garden hose or shower head
9. Patient should next wash with soap and wash cloth or brush from the kit in a systematic fashion cleaning open wounds first and then in a head to toe fashion for 5 minutes when the agent is non persistent and 8 minutes when a persistent or unknown agent is involved. Discourage the patient from rubbing too vigorously while washing. Eye irritation may require the use of a topical anesthetic first before irrigating
10. The Decon Team should closely observe each victim to ensure they are thorough in washing themselves. Particular attention should be made to ensure they wash the axilla, creases, folds and hair . Help should be offered as necessary
11. Once the washing is completed then each patient should thoroughly rinse themselves (this should require about a minute to complete)
12. Decon soap bars, wash cloths, brushes and sponges should be put into a nearby trashcan and NOT carried into the Cold Zone
13. After the rinse/wash/rinse cycle is complete the patient should next proceed to the towel off area and complete drying off and leave towel in trashcan
14. Following drying off the patient should put on the patient gown and proceed to the Triage Officer for rapid assessment and assignment to a Treatment Sector
15. Additional treatment will be limited only to those interventions deemed life saving by the Decon Officer. Antidote administration should be done via the IM route after cleaning the affected area first
16. Decon Team members should be alert to the possibility that an ambulatory patient may clinically deteriorate and require immediate removal to the Non Ambulatory Sector via backboard, stretcher or wheelchair

Non-Ambulatory Patients

1. Patient should be brought to the Decon Sector and tended to by a minimum of 4 decon personnel
2. Each patient should be put onto a backboard or EMS stretcher w/ the pad removed
3. All patient clothing should be removed and valuables put into the clear plastic bag and clothing into large bag then put both bags into 3rd bag and cinch tight w/ tag number in pak. Clothing should be cut away where necessary.
4. Attention should be paid to minimizing the aerosolization spread of particulate matter by folding clothing inside out as removal is being done and dabbing the skin with sticky tape and or vacuuming
5. Patient should have their clothing bag tag around their neck and wear it through decon and treatment
6. The clothing bag should be set aside in secure area If staff available, patients name and number should be recorded on Patient Decon Record
7. While resting the backboard on saw horses or other device or with patient on EMS stretcher the patient should quickly be rinsed from head to toe with water using either the hand held sprayer, garden hose or shower head; protection from aspiration of the rinse water should be initiated
8. Next the patient should be washed with soap and either a brush or wash cloth in a systematic fashion cleaning airway first followed by open wounds then in a head to toe fashion for 5 minutes when the agent is non persistent and 8 minutes when a persistent or unknown agent is involved. Avoid rubbing too vigorously.
9. The patient should be rolled on their side for washing of the posterior head, neck, back, buttocks and lower extremities by 2- 4 personnel; attention to a possible neck injury should be given
10. Careful attention should be given to washing the voids and creases such as the ears, eyes axilla, groin .
11. Topical eye anesthetic maybe required for effective eye irrigation to be done
12. The patient should then be rinsed in a head to toe fashion that minimizes contamination spread for about one minute. Overspray or holding the rinsing devise too close so as to irritate the skin should be avoided.
13. Decon Team members should be alert to the probability that the non-ambulatory patient may require ABC's support (airway positioning, suctioning, O2 administration, spinal stabilization etc.) and administration of life saving antidote administration by IM injection. If IV therapy is needed the extremity site for the IV should be deconned quickly before the IV is started. If IV therapy is needed the patient should be pulled out of line in the Decon Corridor but remain in the Decon Sector. **CPR or ACLS intervention should not be started unless there are no other patients awaiting decontamination**
14. The patient should be dried off, put into a hospital gown and transferred to a clean backboard (or clean off and dry the board they are on if additional boards are not available). Patients on an EMS stretcher should be transferred to a clean backboard

15. Decon soap bars, brushes and sponges should be put into a trashcan and not carried into the Cold Zone. O2 materiel should remain in the Decon Sector
16. The patient should be taken to the Triage Officer for rapid assessment and assignment to area in the Treatment Sector

Patients with Special Needs

Glasses/Contact Lenses

1. Patients with glasses should keep them if they cannot see without them. They must be washed and rinsed thoroughly during the decon process before being worn. Otherwise, the glasses should be placed in the valuables portion of the clothing bag.

2. Contact lenses should be removed and placed in the valuables portion of the clothing bag.

Canes/ Walkers

1. Patients who use walking assist devices may retain them but, the devise must be washed with soap and water during the decon process before being allowed into the Treatment Sector.

2. Patients who are unsteady standing and or walking should be given a walker upon entry into the Decon Corridor. The walker should be used to assist with ambulation until they get to the end of the line when it should be retrieved, deconned and returned to the front of the Decon Corridor for the next patient who needs it.

PIC Lines/ Saline Locks/

1. Unless contaminated PIC lines and saline locks should be covered with Tegoderm or Saran wrap before the area is decontaminated.

2. Contaminated PIC lines or saline locks should be removed before being decontaminated. After the area is cleaned a dressing should be applied until in The Treatment Sector where antibiotic ointment and a new bandage should be applied.

Hearing Aids

1. Hearing aids CANNOT be immersed or otherwise be soaked with water. Thus, they should either be removed and placed in the valuables portion of the patient's clothing bag or if they must be used by the patient because there is no hearing without them they should be carefully wiped off with a slightly saline moistened 4x4 gauze, dried off, put into a clear plastic bag and handed to the patient. The cleaned hearing aid is NOT to be worn until the patient has completed the decon process (including washing the ears) and is in the Treatment Sector.

Dentures

1. Unless the oral cavity is contaminated dentures should remain in place and no decontamination is necessary.

2. If the oral cavity is contaminated then the dentures should be removed, placed in a clear plastic bag with the patient's name or clothing identification number placed on it. The dentures should later be decontaminated in accordance with instructions received from the Poison Center and/or a dentist. The patient's mouth should be decontaminated with mouthwash or saline that is gargled and safely spit out into a bio-hazard bag.

Law Enforcement Officers with Weapons

1. In most cases law enforcement personnel who have been injured on the scene will have had their gun(s) removed before arrival and given to a fellow officer. However, if that is not the case the weapon should be left in the holster and the gun belt removed by a Decon Team member and placed in a clear plastic bag labeled with the patient's name and/or clothing number. The bag should then be passed to the Treatment Sector where it should be given to a fellow officer or hospital Security Officer for safe keeping until it can be given to a representative of the injured officers department. **THE GUN SHOULD BE LEFT IN THE HOLSTER IF AT ALL POSSIBLE.** If the gun must be removed it should be handled by a Decon Team member familiar with firearms, rendered safe, placed in a clear plastic bag marked with the patient's name and/or clothing identification number and given to a fellow officer or hospital Security Officer in the Treatment Sector.

2. Decon Team personnel should be aware that often times an officer may have a backup weapon usually found in a holster near the ankle, in their pocket, in a ballistic vest or near an armpit. The holster with the weapon in place should be removed and secured as described above.

3. An officer's gun belt may also contain items that could prove dangerous if allowed to get in the wrong hands. Thus, the belt should be collected and separately bagged ASAP and passed to a fellow officer or hospital Security Officer in the Treatment Sector. **DECONNING OF AN OFFICER'S WEAPON AND/OR GUN BELT WILL BE THE RESPONSIBILITY OF THE POLICE DEPARTMENT.**

4. If the Officer is wearing a ballistic vest it must be removed prior to undergoing decon. The vest is usually easily removed by loosening the Velcro straps and then pulling the vest apart and then off the patient. It should then be placed in a large plastic bag identified with the patient's name and /or clothing number on it and then passed to a fellow officer or Hospital Security Officer in the Treatment Sector.

Evidence Collection

The evidence collection appendix serves as a foundation for hospitals and first responders to collect and maintain the chain of evidence. In the event of a suspected or actual criminal event including CBRNE events, a variety of responders, ranging from health care providers to law enforcement and federal authorities, will play a role in the coordinated response. The identification of victims as well as the collection of evidence will be a critical step in these efforts.

- The health care provider's first duty is to the patient; however interoperability with other response agencies is strongly encouraged.
- The performance of evidence collection while providing required patient decontamination, triage and treatment should be reasonable for the situation.
- Information gathered from the victims and first responders may aid in the epidemiological investigation and ongoing surveillance.

It is imperative that individual healthcare providers work with the local law enforcement agencies and prosecutors in the development and customization of these policies.

Recommended Procedure

Collection of Belongings

Valuables:

- ✓ Ambulatory and non-ambulatory patients who are able to undress without assistance will be directed to place their valuables (wallets, jewelry, cell phones, etc.) in a clear, pre-labeled, plastic re-sealable bag.
- ✓ Direct the person to place a form of picture identification in the bag so that it is visible from the outside.
- ✓ Assistive devices such as glasses, canes, hearing aids, etc. and car/house keys should be kept by the patient and be decontaminated with him/her.

Clothing:

- ✓ Ambulatory and non-ambulatory patients who are able to undress without assistance will be directed to place their clothing in a pre-labeled plastic bag.
- ✓ Place the labeled patient's valuables bag in the clothing bag.
- ✓ If the clothing is contaminated with chemical agent that may pose a risk of secondary contamination, the bag should be placed in a large clear, pre-labeled, plastic re-sealable bag.
- ✓ Label the bag with patient identification and event information.
  - Patient name

- DOB
- Medical record #
- Date and Time
- Valuables list (if known and time allows)
- Geographical site where contamination occurred. (This information is critical to the epidemiological surveillance of the event and causative agent. Information may include proximity to the release site, location at time of the event, etc,)

Other Considerations:

- ✓ If **time and staffing allow**, a picture of the patient taken with an instant developing camera prior to clothing removal should be taken and attached to or inserted into the labeled bag. This will enhance identification of belongings with patients post event. The use of digital cameras is not recommended due to the ability to modify the pictures.

- ✓ A hospital security personnel, hospital police officer or city police officer should oversee the collection of clothing and valuables. Efforts should be made to store each bag separately (i.e., not touching each other) in order to maintain the chain of evidence.

- ✓ Release of patient belongings and valuables to law enforcement authorities should be according to local law enforcement and hospital policy.

II. Decontamination of Valuables and Belongings

1. In the event that law enforcement determines that the patient valuables and belongings are not needed as evidence, the property should be released to the patient upon discharge in accordance with hospital policy.
2. The designated decontamination leader will determine the need for decontamination of the clothing and valuables. If valuables and/or belongings are released to law enforcement, it will be their responsibility to decontaminate the articles.

Biological Decontamination

Decontamination of Patients and Environment[1]

The need for decontamination depends on the suspected exposure and in most cases will not be necessary. The goal of decontamination after a potential exposure to a biological agent is to reduce the extent of external contamination of the patient and contain the contamination in order to prevent further spread. Decontamination should only be considered in instances of gross contamination. Decisions regarding the need for decontamination should be made in consultation with state and local health departments. Decontamination of exposed individuals prior to receiving them in the healthcare facility may be necessary to ensure the safety of patients and staff while providing care. When developing Bioterrorism Readiness Plans, facilities should consider available locations and procedure for patient decontamination prior to facility entry.

Depending on the agent, the likelihood for re-aerosolization or the risk associated with cutaneous exposure, clothing of exposed persons may need to be removed. After removal of contaminated clothing, patients should be instructed (or assisted if necessary) to immediately shower with soap and water. **Potentially harmful practices, such as bathing patients with bleach solutions, are unnecessary and should be avoided.** Clean water, saline solution, or commercial ophthalmic solutions are recommended for rinsing eyes. If indicated, after removal at the decontamination site, patient clothing should be handled only by personnel wearing appropriate personal protective equipment, and placed in an impervious bag to prevent further environmental contamination.

Development of Bioterrorism Readiness Plans should include coordination with the FBI field office. The FBI may require collection of exposed clothing and other potential evidence for submission to FBI or Department of Defense laboratories to assist in exposure investigations.

Preferred Staff Protection in Biological Decontamination

The following includes recommendations for patient decontamination when the contaminate is a biological agent. Preferred staff protection for biological decontamination is generally at PPE Level D (described on page six of this document) with the addition of N95 masks (or greater).

Gloves

- Gloves should be worn when contact with blood or body fluids is anticipated.
- Gloves should be worn when touching environmental surfaces and/or patient care articles likely to be contaminated or soiled with blood or body fluids.

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[1] *Bioterrorism Readiness Plan: A Template for healthcare Facilities [Prepared by: APIC Bioterrorism Task Force and the CDC Hospital Infections Program Bioterrorism Working Group] pg 8*

- Gloves should be put on just prior to performing a patient care task that involves contact with blood or body fluids.

- Gloves should be removed immediately, without touching non-contaminated surfaces, as soon as the patient care task is complete.

- When performing multiple procedures on the same patient, gloves should be changed after contact with blood and body fluids that contain high concentrations of microorganisms (e.g., feces, wound drainage or oropharyngeal secretions) and before contact with a clean body site such as non-intact skin and vascular access sites.

Facial Protection

Facial protection should be worn when performing patient care tasks likely to generate splashing or spraying of blood and body fluids onto the mucous membranes of the face. Facial protection may include:

- Disposable, fluid-resistant masks

- Eye shields (goggles with side-shields)

- Face shield

- N95 mask

Gowns

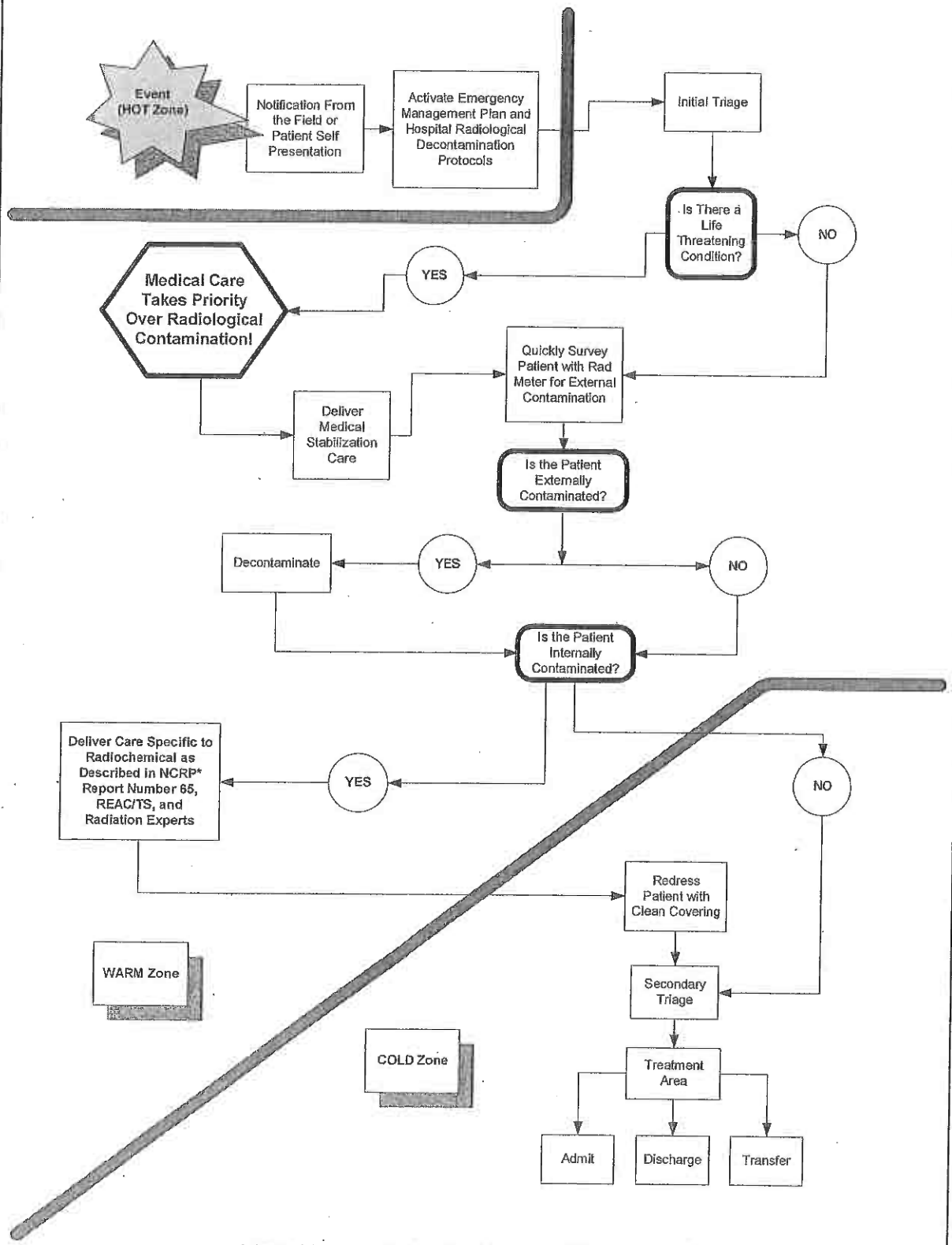
- Disposable fluid-repelling gowns should be worn to protect skin and clothing when performing procedures likely to generate splashing or spraying of blood and body fluids.

- Plastic aprons may be worn for procedures likely to soil clothing but are unlikely to generate splashing or spraying of blood or body fluids (e.g., cleaning incontinent patients).

- The material composition of the gown should be appropriate to the amount of fluid penetration likely to be encountered.

- Soiled gowns must be removed after patient contact.

Algorithm for Treatment of Radioactive Contamination



Adapted from the University of California (Davis) Health System

RECOMMENDED EQUIPMENT FOR RADIOLOGICAL DECONTAMINATION

Staff Personal Protective Equipment (PPE)

- ❑ Full face shield or surgical mask (note: Respiratory protection is not needed. Masks are for inadvertent facial contact contamination.)
- ❑ Hood or hair covering
- ❑ Gloves
- ❑ Water-repellant gown
- ❑ Personal dosimeters (and self-reading dosimeters if available)
- ❑ Shoe covers

Equipment

Patient Identification and Belongings

- ❑ Waterproof triage tags
- ❑ Sealable plastic bags, size small & large to accommodate belongings & clothing
- ❑ Labels with Permanent marker
- ❑ Labels for belongings such as "Caution Radioactive Materials"

Decontamination Supplies:

- ❑ Mild soap
- ❑ Sponges / sterile gauze (for potential localized decon)
- ❑ Sterile Saline to irrigate wounds
- ❑ Buckets / plastic bowls

Water Sources/Containment Devices:

- ❑ Hoses with gentle flow, controlled nozzles with hot and cold water
- ❑ Shower: Single with flex head (minimum); Multiple heads (recommended)

Patient Privacy:

- ❑ Gowns and/or suits for patient to don post decontamination
- ❑ Towels and blankets
- ❑ Self Decon "trash bag" kits (optional)
- ❑ Tents or pre-fabricated decon tents
- ❑ Modesty screens, portable screens
- ❑ Ropes and tarps, barrier tapes

Miscellaneous Supplies:

- ❑ Radiation meters and probes, including pancake probe
- ❑ Radiation survey data sheets
- ❑ Radiation caution signs and caution tape
- ❑ Lead-lined collection containers
- ❑ Long-handled tongs
- ❑ Duct tape, scissors
- ❑ Non-skid plastic floor covering (e.g. Herculite)
- ❑ Traffic cones, megaphones
- ❑ Plastic totes for hospital equipment

Patient Education:

- ❑ Laminated decon instructions in different languages (community specific) ***and*** interpreter services

Radiological Decontamination

Treatment of Radiological Contamination

The following provides an algorithm for the triage and processing of patients, who are **radiological contaminated**, and recommendations for personal protection of hospital staff during treatment of these patients.

Radiological emergencies have always been an area of great concern for healthcare providers, resulting in many misconceptions about the care of the contaminated patient and protection of the healthcare provider. This section of *Patient Decontamination Recommendations for Hospitals* is meant to assist hospitals in developing an appropriate and effective radiological emergency annex in their Emergency Management Plan.

This information is intended for patients contaminated with radiological materials. If there are multiple hazards or other concerns, refer to the recommendations earlier in this document regarding chemical decontamination or other appropriate guidance.

[Note: No special precautions are required for the treatment of patients who are only **exposed** to radiation and not **contaminated** with radioactive material.]

Planning recommendations for hospitals:

1. The Radiological contamination algorithm in this document is not intended to stand alone, but is part of an overall emergency management plan. This algorithm is a general guide for care of the radiological contaminated patient and should be customized to meet the needs of the facility.

2. Radioactive contamination (whether internal or external) is generally not life threatening and therefore, a radiological assessment or decontamination should never take precedence over life-threatening acute medical conditions. Medical stabilization of the patient is the top priority of the health care provider, even though the patient is contaminated.

   Radiological contaminated patients with **life-threatening acute medical conditions should be transported to treatment areas without delay** (e.g. Emergency Department, Radiology Department, Surgery Suite) despite the presence of contamination. Cover gurney with two clean sheets wrapping one around the patient to minimize the spread of contamination.

3. To minimize staff risks from exposure to ionizing radiation, all healthcare providers should carry out their responsibilities keeping in mind these principles:

   a. Removing patients' clothing generally removes up to 90-95% of the contamination.
   b. If available, have a radiological health specialist (e.g. health physicist, radiation safety officer, medical physicist, nuclear medicine personnel) assist with detecting the sources of radioactive contamination and the effectiveness of decontamination efforts.

c. Minimize time spent in a radiological environment and maintain the maximum distance from sources of radiation consistent with appropriate patient care.
d. All personnel responding to the care of a radiological contaminated patient should be given a personal dosimeter (film badge or TLD) and a self-reading dosimeter, if available.
e. Medical personnel who will be handling potentially contaminated patients should use PPE Level D as recommended on page six of this document.

4. Initial activities to prepare for patient arrival should include:

a. Ascertain from the scene the type of radiological incident, number of victims and types of injuries.
b. Obtain and test radiation survey meters
c. Obtain radiation decontamination supplies. These supplies are easily accessed if they are organized and labeled and are in a separate container or cart.
d. Request assistance of radiological health specialist, if available.
e. Don PPE, including surgical mask or face-shield.
f. Provide personal dosimeters (film badge or TLD) and self-reading dosimeters to staff, if available
g. Cover floor of treatment room with non-skid plastic covering (e.g. Herculite or other appropriate floor covering) to aid in facility decontamination following the event (if there is sufficient time and if external contamination is expected).
h. A step-off-pad or boundary line should be established to distinguish clean areas from potentially contaminated areas.
i. Cover gurney with two clean sheets
j. Label waste containers for radioactive waste
k. Upon arrival of the patient (as early as possible without delaying appropriate medical care) perform a very quick survey to ascertain presence of radioactivity and exposure rate.
l. Patients without life-threatening conditions should receive effective decontamination prior to receiving medical care.

5. Decontamination measures should include the following considerations:

a. Remove and bag clothing carefully to prevent spread of contamination
b. Locate the contamination by surveying the patient with a GM survey meter with a "pancake" probe or other suitable device.
c. Record the location of contamination, including the counts per minute (CPM) on the GM survey meter at one inch above the location.
d. Collect samples as appropriate:

- Nasal (each nostril separately), oral
- Skin wipes of contaminated areas
- Foreign objects
- Blood
- Urine and/or feces (suspected internal contamination)
- Contaminated wound exudates
- Vomitus

e. Cover uncontaminated wounds with waterproof dressings.
f. Decontaminate skin by cleaning carefully with soap and tepid water, wiping toward the highest contaminated area to limit spread. Do not abrade skin.
g. If radioactive fragments are discovered on the patient, use long-handled tongs or forceps to remove the fragment(s). Place the fragment in a shielded container, if available.
h. Irrigate contaminated wounds with room temperature sterile saline and gently wash with surgical sponges. Collect run-off in plastic bowls or absorb using gauze or sponges to minimize the spread of contamination.
i. While it is desirable to obtain samples during the decontamination effort that can be used for analysis to determine the radionuclide present, it is not necessary to attempt to contain all the fluids generated during decontamination. The amount of radioactive material released to the sanitary sewer will likely be below the levels that are of regulatory concern.
j. Gently rinse contaminated burns (do not scrub).
k. Stop decontamination of skin and wounds when either:

   - The contamination is less than 2 to 3 times the normal background levels
     or
   - Attempts to decontaminate are not significantly reducing contamination levels.

l. Control contamination by placing all potentially contaminated material in waste containers labeled with a "caution radioactive materials" sign.

6. In a large scale event with multiple victims, prepare for the arrival of contaminated victims and establish a separate area for the uninjured ("worried well") so that the patients can be quickly assessed and triaged to medical screening. This area may be set up outside, separate from the ED so that the entrance to the ED remains easily accessible to injured victims.

7. In the case of a medical radiation emergency, response and recovery radiation exposure limits should be established to preserve lifesaving capabilities while taking into consideration risk to staff and facility operation. Radiation dose limits to staff performing emergency procedures should be established. Additionally contamination limits for facilities should be established to avoid shutting down the facility or taking rooms out of service because of radioactive contamination.

   a. Dose to staff should be as low as reasonably achievable (ALARA) and should not exceed 50 rem total dose equivalent for lifesaving procedures.
   b. Pregnant staff are discouraged from providing direct patient care to radiological contaminated patients.
   c. During recovery, facilities should be decontaminated to the extent possible. Areas of fixed contamination (radioactive material that cannot be easily removed from surfaces) may exist in patient care areas and shall be identified.
   d. Engineering controls such as barriers or lead shielding should be used to reduce exposure to staff from fixed contamination to less than 2 mrem/hr while decontamination efforts are completed. The goal should be to keep dose to staff to less than 100 mrem from fixed contamination while allowing the facility to remain operational.

8. The hospital's Radiological Emergency Plan (an annex of the Emergency Management Plan) should include the procedures and methods for obtaining expert consultation in the care of the patient.

9. Staff protective clothing should be removed in the following order:

    a. Outer gloves
    b. Face shield or surgical mask
    c. Water repellant gown
    d. Cap
    e. Shoe covers
    f. Inner gloves

10. After removal, all PPE should be placed in designated waste containers labeled with a "caution radioactive materials" sign. Each staff member should be surveyed with a GM survey meter for contamination, and all personal, self-reading dosimeters should be collected and radiation doses recorded. Staff should cross over from the contaminated zone to the clean area (cold zone) after they have been monitored with GM survey instrument and readings are less than two times background.

These recommendations were developed for hospitals by hospital experts, and will be revised and updated as indicated by practice or need.

Water Containment Procedures in Hospital Decontamination

It is recognized that each facility has different capacities to manage varying numbers of contaminated victims. For example, based on a current Hazard Vulnerability Assessment (HVA), some facilities may plan for decontaminating a single victim and appropriately containing the waste water. In this case, two or more victims would exceed the capacity of the facility.

There is currently no legislative or regulatory mandate to describe the details on decontamination facilities' containment procedures and capacities. Each hospital facility, however, must establish water containment capacities based on a facility hazard vulnerability assessment (HVA) for determining the potential number of patients that may require decontamination. In addition, hospitals should consider community hazardous materials risks to identify potential numbers of victims that may present to the facility.

The intent of the attached matrix is to provide hospitals with planning guidance for managing the waste water and runoff generated by decontamination of victims presenting to the facility for emergency care and treatment.

Hospitals should plan for decontamination operations that will not exceed their capacity, but should also develop a contingency plan for mass decontamination when patient numbers do exceed their capacity. It is critical that hospitals develop decontamination and waste water containment plans in collaboration with proper local regulatory authorities.

This document was developed to assist hospitals in planning for the management of waste water runoff during decontamination of victims at the facility. A glossary is provided at the end of the document.

The State of North Dakota Department of Health recognizes that the priorities for hospitals during a chemical, biological, radiological or nuclear event requiring decontamination are those of life safety, protection of the facility and finally protection of the environment. There is no exception to the letter of the law; however, circumstances are always a major consideration by the regulators when an emergency requires actions that technically violate the standards. All reasonable measures must be taken by hospitals to capture waste water runoff.

Addressing Water Containment and Run Off During Decontamination Operations

Tier	Description	Recommendations
Decontamination Operations for Planned Capacity	Decontamination operations for the planned capacity is the provision of patient decontamination and containment of waste water based on the facility hazard vulnerability assessment. Each facility must provide plans and procedures for: · Victim/patient decontamination · Waste water containment · Waste water disposal for planned facility capacity.	Waste water from decontamination must be contained. Considerations to address in hospital policy and procedure include: · Identification of the agent o Field/Fire/Haz Mat reports o Laboratory testing of waste water · Waste water containment. · Waste water disposal that may include contracts with waste pumping and disposal companies. · Facility clean up and readiness for return to normal operations.

Mass Decontamination Operations	Mass decontamination is defined as an incident that involves increased numbers of victims exceeding the planned capability of the facility to decontaminate those victims. Attempts must be made to contain waste water. Life safety of victims, current patients and personnel is the primary mission. Protection of the environment is a secondary consideration. Local fire and/or hazmat resources may not be able to respond to the facility to assist in the decontamination efforts. The facility must anticipate decontamination requirements that exceed the planned capacity. Large quantities of water are required to safely and completely decontaminate victims, resulting in large quantities of waste water with dilute contaminants. The facility must work closely with the Public Works and Department of Health to plan for decontamination that exceeds the planned facility capabilities and investigate the options for containment of mass quantities of waste water and runoff during the process. In consultation with local authorities, berm the decontamination area and dike the waste water runoff to the extent possible as follows: · Containment · Diverting to sanitary sewer · Diverting to storm drains · Diverting to ground leaching. Notification of proper regulatory authorities when waste water cannot be contained	Due to the location of the decontamination area and the large quantities of runoff produced, the sanitary sewer may not be an option to route the runoff of waste water and the storm drain or ground leaching may be necessary in an emergency. Considerations to address in hospital policy and procedure include: · Involve the proper regulatory authorities and first responders providing decontamination services in planning for mass decontamination and waste water issues. Make reasonable efforts to contain the excess waste water including the use of berms and dikes. · Ensure large quantities of water are available for decontamination to dilute the agent as much as possible. · Direct excess waste water to the sanitary sewer and immediately notify public works and Department of Health. · Should the sanitary sewer not be available, immediately notify the proper regulatory authorities · Investigate procedures for containment and disposal of the contained waste water: o Contracts with waste pumping and disposal companies · Agreements with Public Works to allow waste water to flow into sanitary sewer. · Identification of the agent o Field/Fire/Haz Mat reports o Laboratory testing of excess waste water. · Establish procedures for facility clean up and readiness for return to normal operations.

Fire Procedure

NORTHWOOD DEACONESS

HEALTH CENTER

FIRE PROCEDURE

Implemented 4-1-87
Approved 8-25-87
Revised 1-14-98
1-13-99
5-17-00
11-20-01
2-11-02
3-18-03
11-26-03
11-29-04
4-13-06
5-16-07
5-12-08
5-21-09
9-29-09
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INTRODUCTION

Fires in hospitals and homes don't just happen -- they are caused -- and we must guard against them constantly. Most hospitals and homes are kept clean and in good repair, but every precaution must be taken to avoid fires from spontaneous ignition, bad wiring, or similar preventable causes.

It is the duty of every employee to prevent patients or residents from being unnecessarily frightened in any emergency. If there is a fire in the Hospital or Home, every effort must be made to confine it to the immediate section in which it starts.

All Hospital and Home personnel will be notified immediately should there be a fire anywhere in the building so that they can move promptly to their regular stations and be prepared to take whatever steps are thought best by those in charge. This notification will be made by announcing over the intercom system by stating "FIRE", and then the location of the fire.

All patient/resident rooms will be checked to determine if the room is occupied. Patients/residents may stay in the safety of their room unless it is determined that an evacuation is necessary. Close the room doors and mark with masking tape if the patient or resident is occupying the room.

REMEMBER!!! BE CALM... Fear and panic can do as much damage as the fire itself. Assure any patients or residents who are aware of the fire that there will be plenty of help to assist them, if necessary.

After each fire or drill, all staff must be accounted for. It is the responsibility of the supervisor/acting supervisor in each area department to account for each staff member on duty at the time of the fire or drill.

EVACUATION OF PATIENTS

The CEO, Director of Nursing, or Charge Nurse will order an evacuation of patients/residents -- **ONLY** if they are considered to be in immediate danger. **ELEVATORS ARE NOT TO BE USED!!!** When moving patients/residents, **KEEP TO THE RIGHT AT ALL TIMES.** If patients/residents must be evacuated outside of the Health Center, they will be taken to the Northwood School Gymnasium. If more space is needed, then the local churches will be utilized. **(PLEASE REFER TO THE FLOOR PLANS POSTED AND IN MANUALS TO LEARN WHAT EVACUATION ROUTE SHOULD BE FOLLOWED FOR ALL PATIENTS AND RESIDENTS.)**

Anytime a fire alarm is sounded, all wheeled equipment in the hallways must be relocated to a non-evacuation area (utility rooms, closets, etc.). This is everyone's responsibility.

MAINTENANCE DEPARTMENT FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Sound fire alarm.
2. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
3. Close doors and windows.
4. Shut down main oxygen supply valve if fire is in Hospital.
5. If possible, attempt to extinguish fire.

FOR FIRE IN ANOTHER AREA:

1. See number four above!
2. Report to the location of the fire.
3. Help with the evacuation of residents/patients as necessary.
4. Assist with the silencing and resetting of fire alarms.

LAUNDRY DEPARTMENT
FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Sound fire alarm.
2. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
3. Close doors and windows.
4. Turn off equipment.
5. If possible, attempt to extinguish fire.

FOR FIRE IN ANOTHER AREA:

1. Close doors and windows.
2. Report to Dietary for further instructions.

HOUSEKEEPING DEPARTMENT
FIRE PROCEDURE

FOR FIRE IN YOUR CLEANING AREA:

1. Remove residents/patients in immediate danger.
2. Sound fire alarm.
3. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
4. Close all doors and windows.
5. Remove carts and buckets from the halls.
6. Leave lights on.
7. If possible, attempt to extinguish fire.

FOR FIRE IN ANOTHER AREA:

1. Close all doors and windows.
2. Remove all carts and buckets from the halls.
3. Report to the charge nurse of the station you are on to receive further instructions.

ACTIVITIES DEPARTMENT
FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Remove residents in immediate danger. Call Dietary for help if needed.
2. Sound fire alarm.
3. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
4. Close all doors and windows.
5. Leave lights on.
6. If possible, attempt to extinguish fire.

FOR FIRE IN ANOTHER AREA:

1. Report to Activities (if you are not in the immediate fire area).
2. Close all doors and windows.
3. Remain with residents in your area until "all clear" is sounded. Take fire precautions as necessary.
4. Have list of residents in your area available for charge nurse's information when she/he calls.

ADMINISTRATION AND OFFICE PERSONNEL FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Sound fire alarm.
2. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
3. Close all doors and windows.
4. If fire or water threatens the Hospital or Home Business Offices, remove cash and checks from file drawer.

FOR FIRE IN ANOTHER AREA:

1. Close all doors and windows.
2. Refer to step 4 above.
3. Office personnel remain at desk to answer phone and to direct responding departments to fire and be available as needed.
4. CEO to supervise all steps to assure completion as per policy.

CLINICAL SUPPORT SERVICES, REHAB SERVICES, SOCIAL SERVICES, A-FLOOR OFFICES FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Remove residents/patients in immediate danger.
2. Sound fire alarm.
3. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
4. Close all doors and windows.
5. Leave lights on.
6. If possible, attempt to put out fire.

FOR FIRE IN ANOTHER AREA:

CLINICAL SUPPORT SERVICES

1. Report to the nearest Nurses Station.

REHABILITATION SERVICES

1. Close all doors and windows.
2. Remain with residents in therapy until "all clear" is sounded, or further information is received.
3. If there are no residents in therapy, report to Acute Nurses Station for further information.
4. Secretary to alert Chiropractor's Office.

SOCIAL SERVICES/ A-FLOOR OFFICES

1. Report to the nearest Nurses Station and receive orders from the charge nurse.

CHAPLAIN

1. Report to nearest Nurses Station and take directions from the charge nurse.

DIETARY DEPARTMENT
FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Remove residents in immediate danger.
2. Sound fire alarm.
3. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
4. If possible, get fire extinguishers and attempt to put out the fire.
5. Turn off gas, range burners and fans.
6. Close all doors and windows.
7. Leave light on.
8. If fire is on stove or compressors above walk-in coolers and freezer, then pull handle on the extinguisher system which is mounted on the wall. Fight fire with CO_2 extinguishers.

FOR FIRE IN ANOTHER AREA:

1. Station one person at telephone and everyone remain in Department to await further instructions.
2. When a request for assisting other departments is received, do the above before leaving your department.
3. Have a list of residents in your area ready to give to charge nurse when she/he calls for information.

VISITORS/ORGANIZED GROUPS FIRE PROCEDURE

VISITORS

1. Visitors are to remain with the resident/patient that they are visiting at the time of the alarm and wait for instructions from Nursing.

ORGANIZED GROUPS

1. If fire is in immediate area of meeting:
   a. Remove everyone from immediate danger.
   b. Sound fire alarm.
   c. Report to the closest Nurses Station to report the location and type of fire.
   d. Follow the instructions of the charge nurse.

2. If fire is in another area:
   a. Close all doors and windows.
   b. Remain calm -- **DON'T PANIC**.

NURSING DEPARTMENT
GENERAL INSTRUCTIONS

1. Make sure that all corridor and room doors are closed (wet blankets under doors to keep out smoke, if necessary.
2. Keep someone at the telephone for instructions.
3. Keep list of patients/residents convenient and see that all are accounted for.
   - Charge nurse assign someone to call Activities, Beauty Shop, and Dietary to account for missing residents.
4. Possible exits should be checked at once to be sure that there will be free access in case of evacuation.
5. Keep your unit evacuation routes open and refer to the posted schedule of these routes. Don't memorize one route of evacuation only -- know all possible routes.
6. Considering our three institutions are under one plant operation, keep the **Acute Care charge nurse** informed of your plans, and if additional help is needed. Include location and route of entry to all needing help within the Nursing Home or Dakota Unit.
7. If authorization is received that patients/residents are to be removed, then the following schedule will be observed:
   First: Those closest to danger.
   Second: Walking cases -- wrap in blankets to let walk to exit.
   Third: Wheelchair patients/residents -- wrap in blankets and wheel to exit.
   Fourth: Helpless patients/residents -- use stretchers or roll them in top covers and carry with help by grasping blanket under patient/resident.
8. A blanket is the best thing to have to fight a fire or to remove patients/residents. (Do not use thermal blankets.)
9. Each charge nurse should keep the other charge nurse informed during the emergency situation.
10. Phone lines may become out of order; therefore, contact fire department and activate Recall Tree immediately.
11. Nurse aides will make a list of patients/residents not in their rooms -- this will be brought to the Nurses Station and one staff member will be assigned to check on where they are and their safety.
12. Afterwards, account for each staff member on duty.

NURSING DEPARTMENT
FIRE PROCEDURE
FOR LONG TERM CARE

FOR FIRE IN YOUR AREA:

1. Remove residents in immediate danger.
2. Sound fire alarm.
3. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
4. If possible, attempt to put out the fire.
5. Close all doors and windows.
6. Turn off oxygen.
7. Leave lights on
8. When all done, report to your Nurses Station for further instructions.
9. Remove Kardex upon evacuation of station to help account for all residents.
10. Refer to "Nursing Department - General Instructions".

FOR FIRE IN ANOTHER AREA:

1. Close all doors and windows.
2. Turn off oxygen.
3. Residents and visitors must remain within the fire door area, but need not be placed in their rooms unless in danger of wandering.
4. Remain on station with residents.
5. Follow charge nurse's instructions.

AFTERWARDS:

1. Reset the fire pull station when Facility Services or Fire Chief gives permission.
2. Long Term Care is responsible to reset any pull station in Long Term Care including Dietary, Activities, Facility Service, and Dakota Unit.
3. Notify Acute charge nurse when pull station is reset.
4. Account for all nursing staff on duty.

* When fire alarm sounds, the security doors unlock until alarm is reset. Residents must be watched closely.

DAKOTA UNIT / WESTVIEW ASSISTED LIVING FIRE PROCEDURE

GENERAL:

1. One staff member to report to unit with every fire.
2. Keep apartment renters aware of situation and assist them with evacuation, if necessary.

IF SMOKE DETECTOR SOUNDS: (In Dakota Unit)

1. Silence alarm by pushing the silence button.
2. Acute charge nurse to send someone to fire location to assess the fire. If false alarm, assist with whatever is needed. If true emergency, assist with evacuation of renters that are in immediate danger.
3. Pull fire alarm.
4. Call extension 6443 and report fire location. Acute Care staff will announce fire location throughout the facility.
5. Designated CNA will go to Dakota Unit.
6. Alarm to be reset when smoke is cleared out.

IF HEAT DETECTOR SOUNDS:

1. It will show up on fire panel.
2. One East Unit CNA go to Dakota Unit. West Unit CNA to check Assisted Living
3. Acute charge nurse will follow proper protocol according to fire policy.
4. Acute charge nurse to send someone to C-Floor or B-Floor to assess and then assist where necessary. Notify Acute charge nurse of anything pertinent to pass on to the firemen.

NURSING DEPARTMENT
FIRE PROCEDURE
FOR ACUTE CARE

FOR FIRE IN YOUR AREA:

1. Remove residents/patients in immediate danger.
2. Sound fire alarm.
3. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
4. If possible, attempt to put out the fire.
5. Close all doors and windows.
6. Remove charts to a safe area.
7. Turn off main oxygen supply (if Maintenance is not here).
8. Leave lights on
9. Remove Kardex upon evacuation of station.
10. Refer to "Nursing Department - General Instructions".

FOR FIRE IN ANOTHER AREA:

1. Close all doors and windows.
2. Turn off O_2 supply to fire area.
3. Turn off main oxygen supply (if Facility Service is not here).
4 Residents/patients/visitors must remain within the fire door area, but need not be placed in their rooms unless in danger of wandering.
5. Remain on station with residents/patients.
6. Follow charge nurse's instructions.

ACUTE CHARGE NURSE:

1. **IMMEDIATELY CHECK THE FIRE PANEL FOR LOCATION OF THE FIRE UPON HEARING THE FIRE ALARM. Check for (the door number is in parenthesis after area) which door the firemen should use – notify firemen.**
   a. Push lighted ACK button
2. Silence alarm by pushing silence button on the red board.
3. ANNOUNCE "FIRE AT_____" THREE TIMES.

4. When call comes in from staff person who found the fire...
   a. Get the staff person's name.
   b. Determine nearest door for firemen to use if different from board.
   c. Let firemen know via their pagers which door, by number, to use.
   d. Have someone meet firemen at door with directions to fire.

NURSING DEPT. FIRE PROCEDURE FOR HOSPITAL (Cont'd):

   e. If specific location was not announced initially, give announcement again, stating the specific location three times.
5. Afterwards, the fire alarm pull station must be reset. (Facility Service or Fire Chief will give the okay.)
   a. The "B" key is on the key ring.
   b. To reset, open with "B" key and re-lock.
6. To reset the fire alarm system....
   a. Push system reset.
   b. It will show up on the panel when the system has reset (it takes 45 seconds).
   c. **DO NOT RESET THE FIRE ALARM SYSTEM UNTIL THE OKAY HAS BEEN GIVEN TO YOU BY THE FIRE CHIEF OR FACILITY SERVICE.**
7. If trouble light goes on .....
   a. Push ACK button to silence.
   b. In the event of power failure, trouble light will go off, but will also reset itself when the generator kicks in.
   c. If, after the trouble light has been silenced, if the light stays on, Facility Service is to be called **IMMEDIATELY**.

PRAIRIE ROSE
FIRE PROCEDURE
OBSOLETE 2020

FOR FIRE IN YOUR AREA:

1. Remove residents from immediate danger.
2. Alert others by pulling fire alarm.
3. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
4. Contain fire by closing doors and windows.
5. Extinguish - if possible.

FOR FIRE IN ANOTHER AREA:

1. Alarm will sound.
2. Acute charge nurse will notify S.C.U. of exact location.
3. Someone to man telephone.
4. Account for all residents.
5. Close all doors and windows.

* **When fire alarm sounds, the security doors unlock until alarm is reset. Residents must be watched closely.**

NORTHWOOD DEACONESS HEALTH CENTER CLINIC
FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Remove anyone in immediate danger. Make sure all exam rooms and bathrooms are empty.
2. Pull the nearest fire alarm which is located near the entrance. Call the Acute Care nurses station, ext. 6443, to give the type and exact location of the fire.
3. Contain the fire by closing all doors and windows.
4. Extinguish the fire if possible.
5. Leave the clinic by one of two routes depending on the location of the fire.
6. If safe to do so, gather the Rolodexes and the appointment books.

FOR FIRE IN ANOTHER AREA:

1. Turn off all electrical equipment.
2. Close all doors and windows.
3. Office personnel remain at desk to cover phone and be available as needed.
4. Be sure all patients are accounted for and are ready to evacuate if necessary.
5. Remain calm, don't panic, and be on standby if needed in other areas.

* **Lab will notify DMS Imaging of any fires when they are here.**

LAB / X-RAY
FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Remove anyone in immediate danger.
2. Pull the nearest fire alarm.
3. Go to or call the Acute Nurses Station, ext. 6443, to give the type and exact location of the fire if the information is available.
4. Turn off any equipment.
5. Close doors and windows.
6. If possible, attempt to put out fire.
7. Remove any registers.

FOR FIRE IN ANOTHER AREA:

1. Close doors and windows.
2. Keep patients in waiting area until fire location is known.
3. If able, report to Acute Nurses Station and assist where needed.

* Lab will notify DMS Imaging of any fires when they are here

NORTHWOOD DEACONESS HEALTH CENTER
OFF SITE CLINICS
FIRE PROCEDURE

FOR FIRE IN YOUR AREA:

1. Remove anyone in immediate danger. Make sure all exam rooms and bathrooms are empty.
2. Call 911
3. Contain the fire by closing all doors and windows.
4. Extinguish the fire if possible.
5. Leave the clinic by one of two routes depending on the location of the fire.
6. If safe to do so, gather the pertinent supplies, i.e. computer, charts, etc.
7. Turn off all electrical equipment.
8. Remain calm, don't panic, and be on standby.
9. Notify clinic manager and/or CEO.

Fire Watch Tour

Fire Alarm System or Sprinkler System outages can occur during construction, maintenance, renovation, electrical storms or other unplanned events, which eliminates part or all of the Fire Alarm or Sprinkler System. A Fire Watch Tour is a periodic walking tour of the entire facility by one or more assigned and trained staff. The tour monitors the facility through direct observation of all rooms for possible signs of fire. Each Tour is recorded with findings noting date, time and staff initials. (See attached)

Procedure:

1. Contact the maintenance person on call and maintenance manager when any problems are encountered with the Fire Alarm System or Sprinkler System. The administrator, maintenance manager or charge person will determine if a fire watch is required.
2. The Maintenance Department will contact the fire alarm company (Simplex) at 1-800-342-4668 and/or the sprinkler company (Dakota Fire Protection) at 701-772-8820 should the maintenance department be unable to correct the problem.
3. Notify the Northwood Fire Department and Grand Forks County Dispatch (911) if the Fire Alarm System is not working.
4. If the Fire Alarm System is inoperable for a period of 4 hours or more or Sprinkler System is inoperable for a period of 10 hours or more, notify the North Dakota Department of Health at 701-328-2352.
5. Personnel shall be assigned to perform the Fire Watch.
6. Fire Watch Tours shall occur at one (1) hour intervals, 24 hours a day.
7. A Fire Watch Tour should check for problems in all rooms in your designated area.
8. Maintenance staff shall be available on site or on call for equipment emergency shutdown situations.
9. Additional fire extinguishers shall be distributed, and staff will be informed of locations.

FIRE

In the event a potential fire situation is identified behind a door:

1. **DO NOT OPEN THE DOOR.**
2. Touch door handle and door leaf and verify raised temperature.
3. Smell for smoke or fumes.
4. Implement **"RACE"** program: **R**escue, **A**larm, **C**ontain and **E**xtinguish/**E**vacuate.
5. Rescue/remove residents from immediate danger.
6. Activate a call to local Fire Department for Northwood at 911.
7. Contain fire by shutting doors.
8. Extinguish and/or evacuate area.

FIRE WATCH LOG

A Manual Fire Watch has been initiated by the facility Administrator or Maintenance Manager or designated charge person.

Directions: Record the times of observation in the first row of boxes below, then initial the areas assigned to you after providing direct observation during that time. Return the Log to the Fire Watch Chief at the end of your assigned watch period.

Time of Observation:															
Resident rooms															
Resident bathrooms															
Dining rooms															
Activity rooms															
Lounge areas															
Common bathrooms															
Rehab areas															
Kitchen															
Laundry															
Housekeeping															
Utility rooms															
Storage areas															
All offices															
Beauty parlor															
Basement areas															
Mechanical rooms															
Electrical rooms															
Attic areas															
Stairwells															
Receiving dock															
Outside areas															

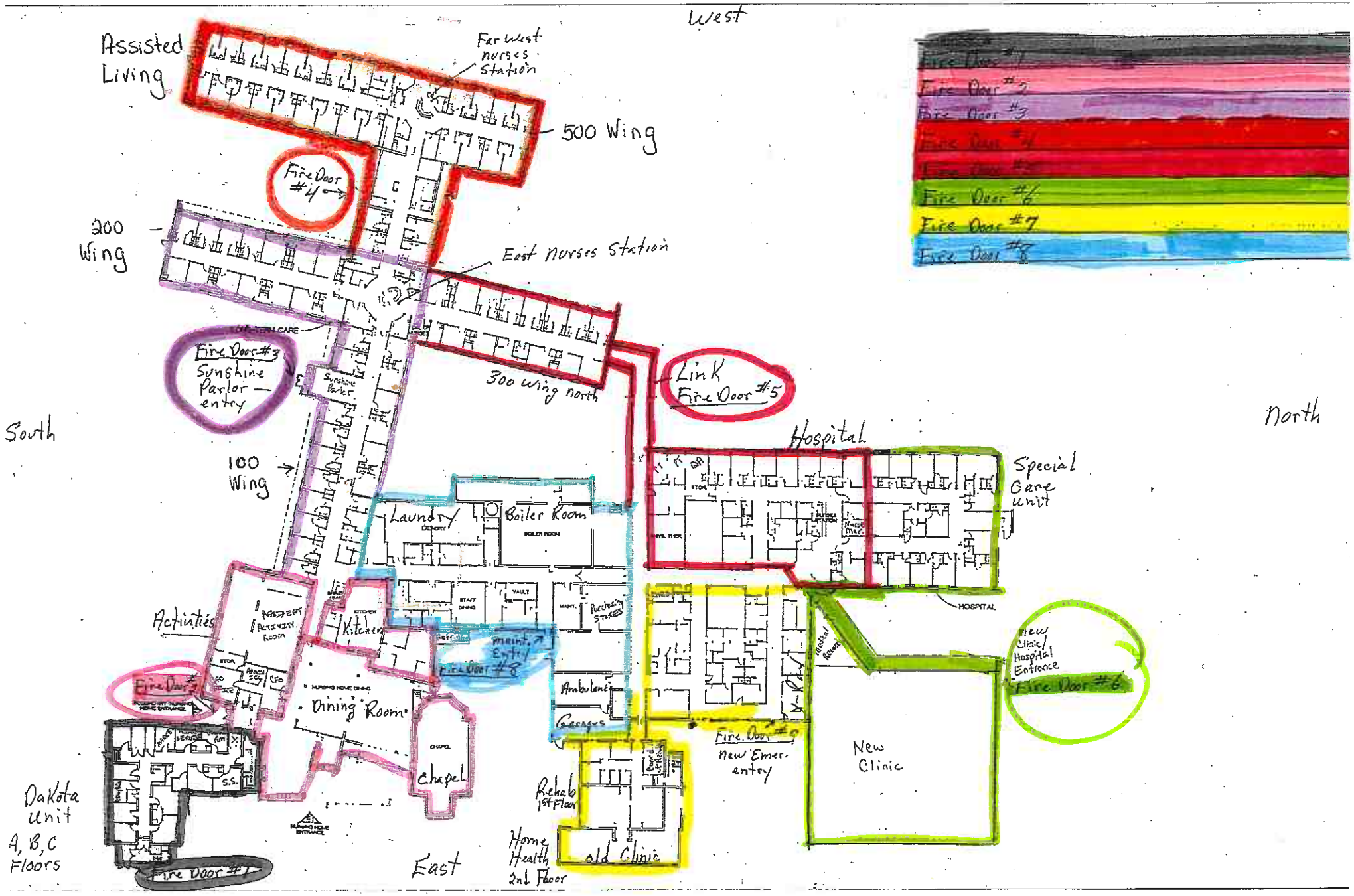
Signature:_____ Title:_____ Initials:_____ Watch Period Began:_____ Ended:_____

Signature:_____ Title:_____ Initials:_____ Watch Period Began:_____ Ended:_____

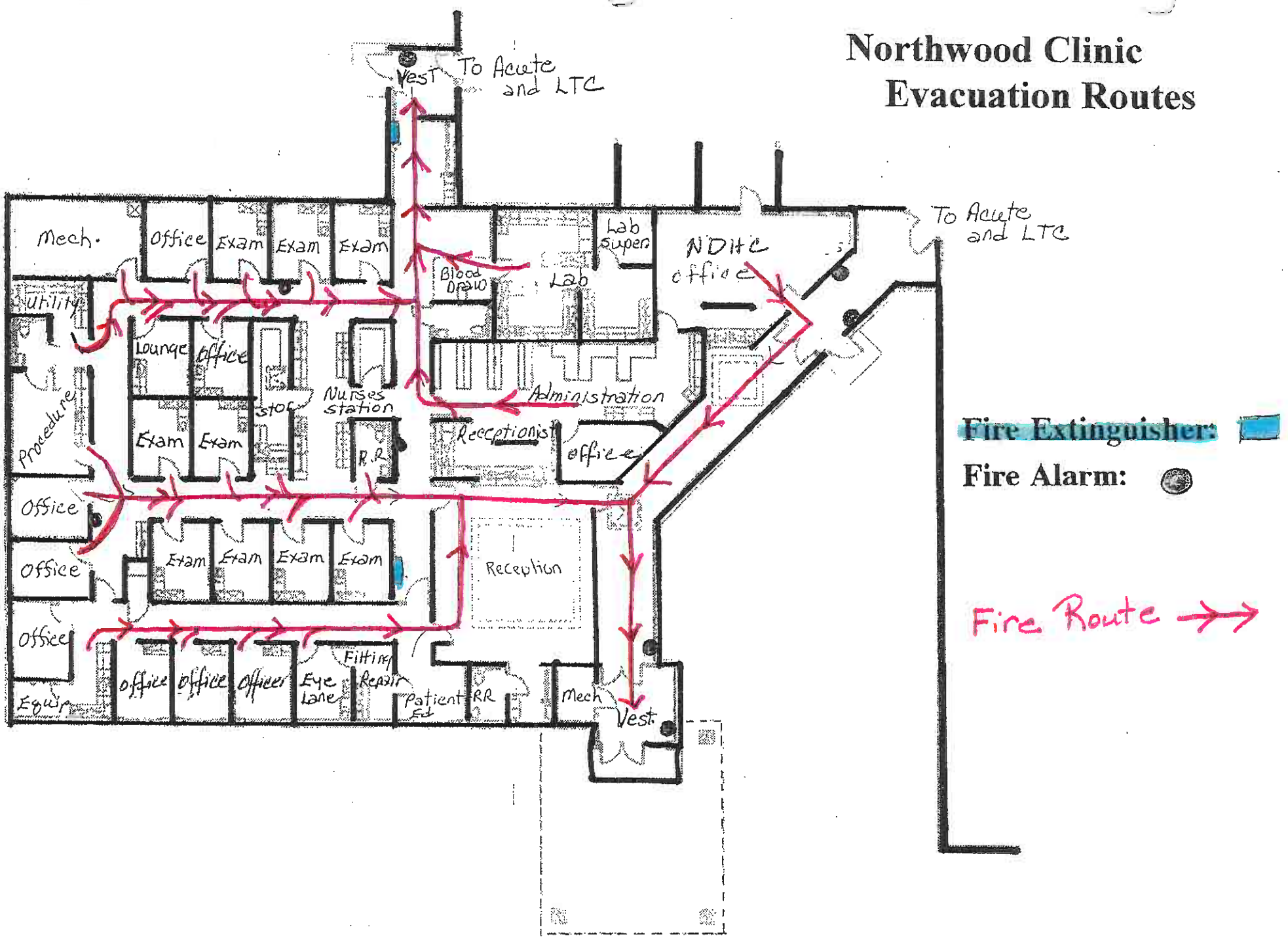
Signature:_____ Title:_____ Initials:_____ Watch Period Began:_____ Ended:_____

Signature:_____ Title:_____ Initials:_____ Watch Period Began:_____ Ended:_____

Fire Watch Chief Signature:_____ Title:_____ Date and Time Received:_____


West
Assisted Living
Far west nurses station
500 Wing
Fire Door #4
200 Wing
East nurses station
Fire Door #3
Sunshine Parlor entry
300 wing north
Link
Fire Door #5
South
North
100 Wing
Hospital
Special Care unit
Laundry
Boiler Room
Activities
Kitchen
maint. Entry
Fire Door #8
Fire Door #2
Dining Room
Chapel
Ambulance Garages
Purchasing Stores
HOSPITAL
New Clinic/ Hospital Entrance
Fire Door #6
Fire Door #9
New Emer. entry
New Clinic
Rehab 1st Floor
old Clinic
Home Health 2nd Floor
DaKota unit
A, B, C Floors
Fire Door #1
East
Fire Door #1
Fire Door #2
Fire Door #3
Fire Door #4
Fire Door #5
Fire Door #6
Fire Door #7
Fire Door #8

Northwood Clinic
Evacuation Routes



updated 12-07

WRITTEN HAZARD COMMUNICATION PROGRAM

NORTHWOOD DEACONESS HEALTH CENTER

THE
WRITTEN HAZARD COMMUNICATION PROGRAM

For Compliance with Federal Code of Regulations General Rules & Regulations
to meet 29 CFR 1910 and 1026 OSHA Standards

Reviewed & Revised

06-02-93
08-02-94
07-11-95
12-03-96
01-14-98
01-13-99
05-17-00
11-20-01
3-18-03
1-15-04
4-13-06
4-16-07
5-12-08
5-21-09
7-20-11
9-12-12
3-10-14
07-22-15
10-29-15
10-25-16
11-20-17
2-18-19
3-12-20

CONTENTS

PURPOSE:

The primary purpose of this Written Hazard Communication Program is to inform you, the employee, how Northwood Deaconess Health Center plans to meet requirements of chemical identification and container labeling of hazardous chemicals and provide Safety Data Sheets (SDS) and program training.

This program will inform you as to the location of the hazardous chemicals list in your work place.

The Chairman of the Safety Committee at Northwood Deaconess Health Center is responsible for the Hazard Communication Program.

LIST OF HAZARDOUS CHEMICALS:

A chemical inventory of hazardous materials will be maintained by the employer and kept with the SDS and this program.

LABELING OR OTHER FORMS OF WARNING:

Each Department Manager is in charge of the labeling portion of this program, to verify that all containers received for and used by NDHC:

1. Be clearly labeled as to the contents.
2. A label that includes a harmonized signal work, pictogram, and hazard statement for each hazard class and category. Attachment C illustrates the mandatory pictograms and their associated hazards.

3. Precautionary statement. (e.g. "Keep away from fire source")

No containers will be released for use until the above data is verified. As part of the chemical survey, all illegible labels will be replaced. If an illegible or unlabeled container is found, please notify the Safety Committee.

SAFETY DATA SHEETS:

It will be the responsibility of the department manager to obtain necessary SDS for hazardous materials so a comprehensive SDS file can be maintained. All employees will be informed of the location of the written hazard communication program and the SDS.

1. Copies of the SDS for all hazardous chemicals to which employees may be exposed will be kept at Acute Nurses Station and will be available for review to all employees during each work shift. Copies will be kept in each department also.
2. Subcontractors working on the job site are required to bring copies of all SDS for hazardous materials they are bringing on the job site to the employer's office so the information is accessible to all employees. It would be preferable to have each subcontractor bring their hazardous material program and SDS in a binder labeled with the contractor's name and identified as a hazardous material communication program. Upon leaving the job site and the removal of all hazardous materials, they may take their information with them.

3. A recommendation to all employees to take a copy of the applicable SDS to the medical facility if emergency treatment is necessary due to exposure. If it is NDHC's ER, copies are available there.
4. The list of chemicals will be updated whenever a new chemical is introduced or at the annual review.

All new SDS or revisions to existing SDS will be sent to the Nursing Secretary and Safety Director. Master file will then be updated. If problems arise in obtaining SDS from suppliers, a phone call will be logged and a letter will be sent the same day. We will maintain a written record of all efforts to obtain an SDS. If these efforts fail to produce an SDS, the Area Office of OSHA will be contacted for assistance.

It is understood than an SDS must be available before a chemical is used.

CONTROLS:

1. If non-routine work must be performed using hazardous chemicals, or the non-routine work may create hazardous chemicals, employees will be appraised of the situation by their supervisor.

2. Procurement has been instructed when ordering new chemicals that an SDS must accompany shipment. A statement requesting the SDS will be on the purchase order.

3. Besides the training which will be given to all employees or when new hazardous chemicals are introduced:

   A. New Employees: As part of the orientation program, new employees will receive training as outlined in the Training section.

   B. Transferred Employees: Whenever an employee is transferred to a position or work area that has hazardous chemicals different from those in which trained, training will be provided.

   C. New Hazardous Chemicals: Whenever the Department Manager receives an updated or new SDS for a hazardous chemical, the manager will determine if additional training is required. If additional training is required, all employees exposed will be appraised of the changed or new SDS and review the SDS.

TRAINING:

Employees will be provided information and training on hazardous chemicals in their work area at the time of initial assignment, whenever a new hazardous chemical is introduced into their work area, and annually thereafter.

The Department Manager is responsible for the training portion of this program.

Employees at Northwood Deaconess Health Center will be advised and informed of the existence of Required Standards, the locations

of the written program, the locations of the hazardous chemical list, and the locations of the Safety Data Sheet by the Department Manager.

Employees exposed to hazardous chemicals in their work area will be trained on each chemical or group of common chemicals. This training will use the SDS as the primary teaching aid. Also, the labeling system used will be explained and examples shown. How to handle the chemical and how to detect its presence will be stressed.

Personal Protective Equipment required by SDS will be explained and shown during training. Each employee attending training will sign a form stating the date.

If an employee is instructed to use a hazardous material for which he has not been trained, it will be his/her responsibility to inform the employer prior to handling such material, so proper training can be given. It will be the employer's responsibility to notify the employee as to his/her responsibilities.

RECORD KEEPING:

Safety Data Sheets

A. Master file is kept in the Nurses Station at the Hospital.

B. Each Department Manager has SDS's for that department.

C. Company SDS requests will be documented whether by telephone or written.

Employee Training

A. Employee attendance sheets will be kept by the Safety Committee and by each department, if desired.

Effective Completion Date	Requirement(s)	Who
December 1, 2013	Train employees on the new label elements and safety data sheet (SDS) format.	Employers
June 1, 2015* December 1, 2015	Compliance with all modified provisions of this final rule, except: The Distributor shall not ship containers labeled by the chemical manufacturer or importer unless it is a GHS label	Chemical manufacturers, importers, distributors and employers
June 1, 2016	Update alternative workplace labeling and hazard communication program as necessary, and provide additional employee training for newly identified physical or health hazards.	Employers
Transition Period to the effective completion dates noted above	May comply with either 29 CFR 1910.1200 (the final standard), or the current standard, or both	Chemical manufacturers, importers, distributors, and employers

ATTACHMENT B– Hazard Communication Standard Label

SAMPLE LABEL

CODE_____
Product Name_____

} **Product Identifier**

Company Name_____
Street Address_____
City_____ State_____
Postal Code_____ Country_____
Emergency Phone Number_____

} **Supplier Identification**

Hazard Pictograms

Signal Word
Danger

Highly flammable liquid and vapor.
May cause liver and kidney damage.

} **Hazard Statements**

Keep container tightly closed. Store in a cool, well-ventilated place that is locked.
Keep away from heat/sparks/open flame. No smoking.
Only use non-sparking tools.
Use explosion-proof electrical equipment.
Take precautionary measures against static discharge.
Ground and bond container and receiving equipment.
Do not breathe vapors.
Wear protective gloves.
Do not eat, drink or smoke when using this product.
Wash hands thoroughly after handling.
Dispose of in accordance with local, regional, national, international regulations as specified.

In Case of Fire: use dry chemical (BC) or Carbon Dioxide (CO_2) fire extinguisher to extinguish.

First Aid
If exposed call Poison Center.
If on skin (or hair): Take off immediately any contaminated clothing. Rinse skin with water.

} **Precautionary Statements**

Supplemental Information

Directions for Use

_____
_____
_____

Fill weight:_____ Lot Number:_____
Gross weight:_____ Fill Date:_____
Expiration Date:_____

ATTACHMENT C– HCS Pictograms and Hazards

Health Hazard 	**Flame** 	**Exclamation Mark** 
• Carcinogen • Mutagenicity • Reproductive Toxicity • Respiratory Sensitizer • Target Organ Toxicity • Aspiration Toxicity	• Flammables • Pyrophorics • Self-Heating • Emits Flammable Gas • Self-Reactives • Organic Peroxides	• Irritant (skin and eye) • Skin Sensitizer • Acute Toxicity (harmful) • Narcotic Effects • Respiratory Tract Irritant • Hazardous to Ozone Layer (Non Mandatory)
Gas Cylinder 	**Corrosion** 	**Exploding Bomb** 
• Gases under Pressure	• Skin Corrosion/ burns • Eye Damage • Corrosive to Metals	• Explosives • Self-Reactives • Organic Peroxides
Flame over Circle 	**Environment (Non Mandatory)** 	**Skull and Crossbones** 
• Oxidizers	• Aquatic Toxicity	• Acute Toxicity (fatal or toxic)

BIOTERRORISM

Northwood Deaconess Health Center

Bioterrorism Readiness Plan

Reviewed & Revised

03-18-03
11-29-04
05-21-09
07-20-11
03-10-14
07-22-15
10-25-16
11-20-17
2-18-19
3-12-20
4-26-21

<u>Please note</u>: This document will be updated to reflect public health guidelines and new information as they become available.

Section I: General Categorical Recommendations for Any Suspected Bioterrorism Event

A. Reporting Requirements and Contact Information

Healthcare facilities may be the initial site of recognition and response to bioterrorism events. If a bioterrorism event is suspected, local emergency response systems should be activated. Notification should immediately include local infection control personnel and the healthcare facility administration, and prompt communication with the local and state health departments, FBI field office, local police, CDC, and medical emergency services.

INTERNAL CONTACTS:
INFECTION CONTROL: Ext. 440, Home: 701-524-2756
ADMINISTRATION: Ext. 459, Home: 587-6212

EXTERNAL CONTACTS:
GRAND FORKS PUBLIC HEALTH DEPARTMENT: 701-746-2525
STATE HEALTH DEPARTMENT: 701-328-2372
FBI FIELD OFFICE:
BIOTERRORISM EMERGENCY NUMBER, CDC Emergency Response Office: 770-488-7100
CDC HOSPITAL INFECTIONS PROGRAM: 404-639-6413

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* *Telephone numbers for FBI field offices are listed in Appendix 1 and 2.*

B. Potential Agents

Four diseases with recognized bioterrorism potential (anthrax, botulism, plague, and smallpox) and the agents responsible for them are described in Section II of this document. The CDC does not prioritize these agents in any order of importance or likelihood of use. Subsequent installments of this document will address additional agents with bioterrorism potential, including those that cause tularemia, brucellosis, Q fever, viral hemorrhagic fevers, and viral encephalitis, and disease associated with staphylococcal enterotoxin B.

C. Detection of Outbreaks Caused by Agents of Bioterrorism

Bioterrorism may occur as covert events, in which persons are unknowingly exposed and an outbreak is suspected only upon recognition of unusual disease clusters or symptoms. Bioterrorism may also occur as announced events, in which persons are warned that an exposure has occurred. A number of announced bioterrorism events have occurred in the United States during 1998-1999, but these were determined to have been "hoaxes;" that is, there were no true exposures to bioterrorism agents. The possibility of a bioterrorism event should be ruled out with the assistance of the FBI and state health officials.

1. Syndrome-based criteria

Rapid response to a bioterrorism-related outbreak requires prompt identification of its onset. Because of the rapid progression to illness and potential for dissemination of some of these agents, it may not be practical to await diagnostic laboratory confirmation. Instead, it will be necessary to initiate a response based on the recognition of high-risk syndromes. Each of the agent-specific plans in Section II includes a syndrome description (i.e., typical combination of clinical features of the illness at presentation), that should alert healthcare practitioners to the possibility of a bioterrorism-related outbreak.

2. **Epidemiologic features**

Epidemiologic principles must be used to assess whether a patient's presentation is typical of an endemic disease or is an unusual event that should raise concern. Features that should alert healthcare providers to the possibility of a bioterrorism-related outbreak include:

- A rapidly increasing disease incidence (e.g., within hours or days) in a normally healthy population.
- An epidemic curve that rises and falls during a short period of time.
- An unusual increase in the number of people seeking care, especially with fever, respiratory, or gastrointestinal complaints.
- An endemic disease rapidly emerging at an uncharacteristic time or in an unusual pattern.
- Lower attack rates among people who had been indoors, especially in areas with filtered air or closed ventilation systems, compared with people who had been outdoors.
- Clusters of patients arriving from a single locale.
- Large numbers of rapidly fatal cases. [2]
- Any patient presenting with a disease that is relatively uncommon and has bioterrorism potential (e.g., pulmonary anthrax, tularemia, or plague). [3]

D. Infection Control Practices for Patient Management

The management of patients following suspected or confirmed bioterrorism events must be well organized and rehearsed. Strong leadership and effective communication are paramount.

1. **Isolation Precautions**

Agents of bioterrorism are generally not transmitted from person to person; re-aerosolization of these agents is unlikely.[4] **All** patients in healthcare facilities, including symptomatic patients with suspected or confirmed bioterrorism-related illnesses, should be managed utilizing **Standard Precautions**. Standard Precautions are designed to reduce transmission from both recognized and unrecognized sources of infection in healthcare facilities, and are recommended for all patients receiving care, regardless of their diagnosis or presumed infection status.[5] **For certain diseases or syndromes (e.g., smallpox and pneumonic plague), additional precautions may be needed to reduce the likelihood for transmission.** See Section II for specific diseases and requirements for additional isolation precautions.

Standard Precautions prevent direct contact with all body fluids (including blood), secretions, excretions, nonintact skin (including rashes), and mucous membranes. Standard Precautions routinely practiced by healthcare providers include:

- **Handwashing**

  Hands are washed after touching blood, body fluids, excretions, or items contaminated with such body fluids, whether or not gloves are worn. Hands are washed immediately after gloves are removed, between patient contacts, and as appropriate to avoid transfer of microorganisms to other patients and the environment. Either plain or antimicrobial-containing soaps may be used.
- **Gloves**

  Clean, non-sterile gloves are worn when touching blood, body fluids, excretions, secretions, or items contaminated with such body fluids. Clean gloves are put on just before touching mucous membranes and nonintact skin. Gloves are changed between tasks and between procedures on the same patient if contact occurs with contaminated material. Hands are washed promptly after removing gloves and before leaving a patient care area.

- **Masks/Eye Protection of Face Shields**
  A mask and eye protection (or face shield) are worn to protect mucous membranes of the eyes, nose, and mouth while performing procedures and patient-care activities that may cause splashes of blood, body fluids, excretions, or secretions.
- **Gowns**
  A gown is worn to protect skin and prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, excretions, or secretions. Selection of gowns and gown materials should be suitable for the activity and amount of body fluid likely to be encountered. Soiled gowns are removed promptly and hands are washed to avoid transfer of microorganisms to other patients and environments.

2. **Patient Placement**
   In small-scale events, routine facility patient placement and infection control practices should be followed. However, when the number of patients presenting to a healthcare facility is too large to allow routine triage and isolation strategies (if required), it will be necessary to apply practical alternatives. These may include cohorting patients who present with similar syndromes, i.e., grouping affected patients into a designated section of NDHC. Areas that can be utilized are procedure room, rehab, and conference rooms. The triage or cohort site should have controlled entry to minimize the possibility for transmission to other patients at the facility and to staff members not directly involved in managing the outbreak. At the same time, reasonable access to vital diagnostic services, e.g., radiography departments, should be maintained.

3. **Patient Transport**
   Most infections associated with bioterrorism agents cannot be transmitted from patient-to-patient. Patient transport requirements for specific potential agents of bioterrorism are listed in Section II. In general, the transport and movement of patients with bioterrorism-related infections, as for patients with any epidemiologically important infections (e.g., pulmonary tuberculosis, chickenpox, measles), should be limited to movement that is essential to provide patient care, thus reducing the opportunities for transmission of microorganisms within healthcare facilities.

4. **Cleaning, Disinfection, and Sterilization of Equipment and Environment**
   Principles of Standard Precautions should be generally applied for the management of patient-care equipment and environmental control.
   - Follow infection control procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces and equipment, and should ensure that these procedures are being followed.
   - Facility-approved germicidal cleaning agents should be used for cleaning spills of contaminated material and disinfecting non-critical equipment.
   - Used patient-care equipment soiled or potentially contaminated with blood, body fluids, secretions, or excretions should be handled in a manner that prevents exposures to skin and mucous membranes, avoids contamination of clothing, and minimizes the likelihood of transfer of microbes to other patients and environments.
   - Reusable equipment should not be used for the care of another patient until it has been appropriately cleaned and reprocessed. Single-use patient items should be appropriately discarded.

- Sterilization is required for all instruments or equipment that enter normally sterile tissues or through which blood flows.
- Rooms and bedside equipment of patients with bioterrorism-related infections should be cleaned using the same procedures that are used for all patients as a component of Standard Precautions, unless the infecting microorganism and the amount of environmental contamination indicates special cleaning. In addition to adequate cleaning, thorough disinfection of bedside equipment and environmental surfaces may be indicated for certain organisms that can survive in the inanimate environment for extended periods of time.
- Patient linen should be handled in accordance with Standard Precautions. Although linen may be contaminated, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms to other patients, personnel and environments.
- Contaminated waste should be sorted and discarded in accordance with federal, state and local regulations.
- Follow the policies for the prevention of occupational injury and exposure to bloodborne pathogens in accordance with Standard Precautions and Universal Precautions. See Exposure Control Plan.

5. Discharge Management

Ideally, patients with bioterrorism-related infections will not be discharged from the facility until they are deemed noninfectious. However, consideration should be given to developing home-care instructions in the event that large numbers of persons exposed may preclude admission of all infected patients. Depending on the exposure and illness, home care instructions may include recommendations for the use of appropriate barrier precautions, handwashing, waste management, and cleaning and disinfection of the environment and patient-care items.

6. Post-Mortem Care

Pathology departments and clinical laboratories should be informed of a potentially infectious outbreak prior to submitting any specimens for examination or disposal. All autopsies should be performed carefully using all personal protective equipment and standards of practice in accordance with Standard Precautions, including the use of masks and eye protection whenever the generation of aerosols or splatter of body fluids is anticipated.

E. Post Exposure Management

1. Decontamination of Patients and Environment

The need for decontamination depends on the suspected exposure and in most cases will not be necessary. The goal of decontamination after a potential exposure to a bioterrorism agent is to reduce the extent of external contamination of the patient and contain the contamination to prevent further spread. Decontamination should only be considered in instances of gross contamination. Decisions regarding the need for decontamination should be made in consultation with state and local health departments. Decontamination of exposed individuals prior to receiving them in the healthcare facility may be necessary to ensure the safety of patients and staff while providing care.

Depending on the agent, the likelihood for re-aerosolization, or a risk associated with cutaneous exposure, clothing of exposed persons may need to be removed. After removal

of contaminated clothing, patients should be instructed (or assisted if necessary) to immediately shower with soap and water. **Potentially harmful practices, such as bathing patients with bleach solutions, are unnecessary and should be avoided.** Clean water, saline solution, or commercial ophthalmic solutions are recommended for rinsing eyes. If indicated, after removal at the decontamination site, patient clothing should be handled only be personnel wearing appropriate personal protective equipment, and placed in an impervious bag to prevent further environmental contamination. Decontamination requirements for specific potential agents of bioterrorism are listed in Section II.[6]
Development of Bioterrorism Readiness Plans should include coordination with the FBI field office. The FBI may require collection of exposed clothing and other potential evidence for submission to FBI or Department of Defense laboratories to assist in exposure investigations.

2. Prophylaxis and Post-Exposure Immunization

Recommendations for prophylaxis are subject to change. Current recommendations for post-exposure prophylaxis and immunization are provided in Section II for relevant potential bioterrorism agents. However, up-to-date recommendations should be obtained in consultation with local and state health departments and CDC.

3. Triage and Management of Large Scale Exposures and Suspected Exposures

Triage and management planning for large-scale events may include:

- Establishing networks of communication and lines of authority required to coordinate on-site care.
- Planning for cancellation of non-emergency services and procedures.
- Identifying sources able to supply available vaccines, immune globulin, antibiotics, and botulinum anti-toxin (with assistance from local and state health departments).
- Planning for the efficient evaluation and discharge of patients.
- Developing discharge instructions for patients determined to be non-contagious or in need of additional on-site care, including details regarding if and when they should return for care or if they should seek medical follow-up.
- Determining availability and sources for additional medical equipment and supplies (e.g., ventilators) that may be needed for urgent large-scale care.
- Planning for the allocation or re-allocation of scarce equipment in the event of a large-scale event (e.g., duration of ventilator support or terminally afflicted individuals).
- With assistance from the Pathology service, identifying the institution's ability to manage a sudden increase in the number of cadavers on site. [3,7]

4. Psychological Aspects of Bioterrorism

Following a bioterrorism-related event, fear and panic can be expected from both patients and healthcare providers. Psychological responses following a bioterrorism event may include horror, anger, panic, unrealistic concerns about infection, fear of contagion, paranoia, social isolation, or demoralization.

Address patient and general public fears:

- Minimize panic by clearly explaining risks, offering careful but rapid medical evaluation/treatment, and avoiding unnecessary isolation or quarantine.
- Treat anxiety in unexposed persons who are experiencing somatic symptoms (e.g., with reassurance, or diazepam-like anxiolytics as indicated for acute relief of those who do not respond to reassurance).

Consider the following to address healthcare worker fears:

- Provide bioterrorism readiness education, including frank discussion of potential risks and plans for protecting healthcare providers.
- Invite active, voluntary involvement in the bioterrorism readiness planning process.
- Encourage participation in disaster drills.

Fearful or anxious healthcare workers may benefit from their usual sources of social support, or by being asked to fulfill a useful role (e.g., as a volunteer at the triage site).

- EAP is also available.

F. Laboratory Support and Confirmation

This part of the document is subject to updates due to current work underway to improve the diagnostic capacity of laboratories to isolate and identify these agents. Facilities should work with local, state and federal public health services to tailor diagnostic strategies to specific events. Currently the **Bioterrorism Emergency Number at the CDC is at the Emergency Response Office, NCEH, 770-488-7100**.

1. Obtaining Diagnostic Samples

See specific recommendations for diagnostic sampling for each agent. Sampling should be performed in accordance with Standard Precautions. In all cases of suspected bioterrorism, collect an acute phase serum sample to be analyzed, aliquotted, and saved for comparison to a later convalescent serum sample.

2. Laboratory Criteria for Processing Potential Bioterrorism Agents

To evaluate laboratory capacity in the United States, a proposal is being made to group laboratories into one of four levels, according to their ability to support the diagnostic needs presented by an event. The proposed laboratory levels in the planning stages are:

- Level A: Clinical laboratories – minimal identification of agents
- Level B: County/State/other laboratories – identification, confirmation, susceptibility testing
- Level C: State and other large facility laboratories with advanced capacity for testing – some molecular technologies
- Level D: CDC or select Department of Defense laboratories, such as U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID) – Bio Safety Level (BSL) 3 and 4 labs with special surge capacity and advanced molecular typing techniques.

3. Transport Requirements

Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office, 770-488-7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

G. Patient, Visitor, and Public Information

Clear, consistent, understandable information should be provided (e.g., via fact sheets) to patients, visitors, and the general public. During bioterrorism-related outbreaks, visitors may be strictly limited.

Section II: Agent-Specific Recommendations

A. Anthrax

1. Description of Agent/Syndrome

a. Etiology: Anthrax is an acute infectious disease caused by *Bacillus anthracis*, a spore forming, gram-positive bacillus. Associated disease occurs most frequently in sheep, goats, and cattle, which acquire spores through ingestion of contaminated soil. Humans can become infected through skin contact, ingestion, or inhalation of *B. anthracis* spores from infected animals or animal products (as in "woolsorter's disease" from exposure to goat hair). Person-to-person transmission of inhalational disease does not occur. Direct exposure to vesicle secretions of cutaneous anthrax lesions may result in secondary cutaneous infection.[1]

b. Clinical features: Human anthrax infection can occur in three forms: pulmonary, cutaneous, or gastrointestinal, depending on the route of exposure. Of these forms, pulmonary anthrax is associated with bioterrorism exposure to aerosolized spores. Clinical features for each form of anthrax include:

Pulmonary

- Non-specific prodome of **flu-like symptoms** follows inhalation of infectious spores.
- Possible brief interim improvement.
- Two to four days after initial symptoms, **abrupt onset of respiratory failure** and hemodynamic collapse, possibly accompanied by thoracic edema and a **widened mediastinum on chest radiograph** suggestive of mediastinal lymphadenopathy and hemorrhagic mediastinitis.
- Gram-positive bacilli on blood culture, usually after the first two or three days of illness.
- Treatable in early prodromal stage. Mortality remains extremely high despite antibiotic treatment if it is initiated after onset of respiratory symptoms.

Cutaneous

- Local skin involvement after direct contact with spores or bacilli.
- Commonly seen on the head, forearms or hands.
- Localized itching, followed by a papular lesion that turns vesicular, and within 2-6 days develops into a depressed black eschar.
- Usually non-fatal if treated with antibiotics.

Gastro-intestinal

- Abdominal pain, nausea, vomiting, and fever following ingestion of contaminated food, usually meat.
- Bloody diarrhea, hematemesis.
- Gram-positive bacilli on blood culture, usually after the first two or three days of illness.
- Usually fatal after progression to toxemia and sepsis.

c. Modes of transmission: The spore form of B. anthracis is durable. As a bioterrorism agent, it could be delivered as an aerosol. The modes of transmission for anthrax include:
   - Inhalation of spores.
   - Cutaneous contact with spores or spore-contaminated materials.
   - Ingestion of contaminated food.

d. Incubation period: The incubation period following exposure to *B. anthracis* ranges from 1 day to 8 weeks (average 5 days), depending on the exposure route and dose:
   - 2-60 days following pulmonary exposure.
   - 1-7 days following cutaneous exposure.
   - 1-7 days following ingestion.

e. Period of communicability: Transmission of anthrax infections from person to person is unlikely. Airborne transmission does not occur, but direct contact with skin lesions may result in cutaneous infection.[6]

2. Preventive Measures

a. Vaccine availability:
   - Inactivated, cell-free anthrax vaccine (Bioport Corporation 517-327-1500, formerly Michigan Biologic Products Institute*) – limited availability.

* Use of trade names and commercial sources is for identification only and does not constitute endorsement by CDC or the U.S. Department of Health and Human Services

b. Immunization recommendations:
   - Routinely administered to military personnel. Routine vaccination of civilian populations not recommended.[1,10-12]

3. Infection Control Practices for Patient Management

Symptomatic patients with suspected or confirmed infections with *B. anthracis* should be managed according to current guidelines specific to their disease state. Recommendations for chemotherapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact the local and state health department and the Bioterrorism Emergency Number at the CDC Emergency Response Office, 770-488-7100.

a. Isolation precautions: Standard Precautions are used for the care of patients with infections associated with *B. anthracis*. Standard Precautions include the routine use of gloves for contact with nonintact skin, including rashes and skin lesions.

b. Patient placement: Private room placement for patients with anthrax is not necessary. Airborne transmission of anthrax does not occur. Skin lesions may be infectious, but requires direct skin contact only.

c. Patient transport: Standard Precautions should be used for transport and movement of patients with *B. anthracis* infections.

d. Cleaning, disinfection, and sterilization of equipment and environment: Principles of Standard Precautions should be generally applied for the management of patient-care equipment and for environmental control (see Section I for more detail).

e. Discharge management: No special discharge instructions are indicated. Home care providers should be taught to use Standard Precautions for all patient care (e.g., dressing changes).

f. Post-mortem care: Standard Precautions should be used for post-mortem care. Standard Precautions include wearing appropriate personal protective equipment, including masks and eye protection, when generation of aerosols or splatter of body fluids is anticipated.[5]

4. Post Exposure Management

a. Decontamination of patients/environment:
The risk for re-aerosolization of *B. anthracis* spores appears to be extremely low in settings where spores were released intentionally or were present at low or high levels. In situations where the threat of gross exposure to *B. anthracis* spores exists, cleansing of skin and potentially contaminated fomites (e.g., clothing or environmental surfaces) may be considered to reduce the risk for cutaneous and gastrointestinal forms of disease. The plan for decontaminating patients exposed to anthrax may include the following:

- Instructing patients to remove contaminated clothing and store in labeled, plastic bags.
- Handling clothing minimally to avoid agitation.
- Instructing patients to shower thoroughly with soap and water (and providing assistance if necessary).
- Instructing personnel regarding Standard Precautions and wearing appropriate barriers (e.g., gloves, gown, and respiratory protection) when handling contaminated clothing or other contaminated fomites.
- Decontaminating environmental surfaces using an EPA-registered, facility-approved sporicidal/germicidal agent or 0.5% hypochlorite solution (one part household bleach added to nine parts water).[5,6]

b. Prophylaxis and post-exposure immunization:
Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC. Prophylaxis should be initiated upon confirmation of an anthrax exposure (Table 1).

Table 1. Recommended post-exposure prophylaxis for exposure to *Bacillus anthracis*

Antimicrobial agent	Adults	Children §
Oral Fluoroquinolones		
One of the following:		
Ciprofloxacin	500 mg twice daily	20-30 mg per kg of body mass daily, divided into two doses
Levoflaxacin	500 mg once daily	Not recommended
Ofloxacin	400 mg twice daily	Not recommended
If fluoroquinolones are not available or are contraindicated		
Doxycycline	100 mg twice daily	5 mg per kg of body mass per day divided into two doses

§ Pediatric use of fluoroquinolones and tetracyclines is associated with adverse effects that must be weighed against the risk of developing a lethal disease. If *B. anthracis* exposure is confirmed, the organism must be tested for penicillin susceptibility. If susceptible, exposed children may be treated with oral amoxicillin 40 mg per kg of body mass per day divided every 8 hours (not to exceed 500 mg, three times daily).

Prophylaxis should continue until *B. anthracis* exposure has been excluded. If exposure is confirmed, prophylaxis should continue for 8 weeks. In addition to prophylaxis, post-exposure immunization with an inactivated, cell-free anthrax vaccine is also indicated following anthrax exposure. If available, post-exposure vaccination consists of three doses of vaccine at 0, 2 and 4 weeks after exposure. With vaccination, post-exposure antimicrobial prophylaxis can be reduced to 4 weeks.[1]

c. Triage and management of large scale exposures/potential exposures:

Advance planning should include identification of:

- Sources of prophylactic antibiotics and planning for acquisition on short notice.
- Locations, personnel needs and protocols for administering prophylactic post-exposure care to large numbers of potentially exposed individuals.
- Means for providing telephone follow-up information and other public communications services.

Intensive care unit managers will need to consider in advance:

- How limited numbers of ventilators will be distributed in the event of a large number of patients arriving with abrupt pulmonary decompensation.
- How additional ventilators can be obtained.
- In the event of severely limited ventilator availability, whether and when ventilator support will be discontinued for a terminally ill individual.[3,10,11]

See Section I for additional general details regarding planning for large-scale patient management.

5. Laboratory Support and Confirmation

Diagnosis of anthrax is confirmed by aerobic culture performed in a BSL-2 laboratory.

a. Diagnostic samples:

Diagnostic samples to obtain include:

- Blood cultures.
- Acute serum for frozen storage.
- Stool culture if gastrointestinal disease is suspected.

b. Laboratory selection:

Handling of clinical specimens should be coordinated with local and state health departments, and undertaken in BSL –2 or –3 laboratories. The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

c. Transport requirements:

Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office, 770-488-7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

6. Patient, Visitor, and Public Information

Fact sheets for distribution should be prepared, including explanation that people recently exposed to *B. anthracis* are not contagious, and antibiotics are available for prophylactic therapy along with the anthrax vaccine. Dosing information and potential side effects should be explained clearly. Decontamination procedures, i.e., showering thoroughly with

soap and water; and environmental cleaning, i.e., with 0.5% hypochlorite solution (one part household bleach added to nine parts water), can be described.

B. Botulism

1. Description of Agent/Syndrome

a. Etiology:

Clostridium botulinum is an anaerobic gram-positive bacillus that produces a potent neurotoxin, botulinum toxin. In humans, botulinum toxin inhibits the release of acetylcholine, resulting in characteristic flaccid paralysis. *C. botulinum* produces spores that are present in soil and marine sediment throughout the world. Foodborne botulism is the most common form of disease in adults. An inhalational form of botulism is also possible.[13] Botulinum toxin exposure may occur in both forms as agents of bioterrorism.

b. Clinical features:

Foodborne botulism is accompanied by gastrointestinal symptoms. Inhalational botulism and foodborne botulism are likely to share other symptoms including:

- Responsive patient with absence of fever.
- **Symmetric cranial neuropathies (drooping eyelids), weakened jaw clench, difficulty swallowing or speaking).**
- **Blurred vision** and diplopia due to extra-ocular muscle palsies.
- **Symmetric descending weakness in a proximal to distal pattern** (paralysis of arms first, followed by respiratory muscles, then legs).
- **Respiratory dysfunction** from respiratory muscle paralysis or upper airway obstruction due to weakened glottis.
- No sensory deficits.

c. Mode of transmission:

Botulinum toxin is generally transmitted by ingestion of toxin-contaminated food. Aerosolization of botulinum toxin has been described and may be a mechanism for bioterrorism exposure.[11]

d. Incubation period:

- Neurologic symptoms of foodborne botulism begin 12-36 hours after ingestion.
- Neurologic symptoms of inhalation botulism begin 24-72 hours after aerosol exposure.

e. Period of communicability:

Botulism is not transmitted from person to person.[10]

2. Preventive Measures

a. Vaccine availability:

A pentavalent toxoid vaccine has been developed by the Department of Defense. This vaccine is available as an investigational new drug (contact USAMRIID, 301-619-2833). Completion of a recommended schedule (0, 2, 12 weeks) has been shown to induce protective antitoxin levels detectable at 1-year post vaccination.

b. Immunization recommendations:

Routine immunization of the public, including healthcare workers, is not recommended.[11]

3. Infection Control Practices for Patient Management

Symptomatic patients with suspected or confirmed botulism should be managed according to current guidelines.[14] Recommendations for therapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact CDC or state health department.

a. Isolation precautions: Standard Precautions are used for the care of patients with botulism.

b. Patient placement: Patient-to-patient transmission of botulism does not occur. Patient room selection and care should be consistent with facility policy.

c. Patient transport: Standard Precautions should be used for transport and movement of patients with botulism.

d. Cleaning, disinfection, and sterilization of equipment and environment: Principles of Standard Precautions should be generally applied to the management of patient-care equipment and environmental control (see Section I for more detail).

e. Discharge management: No special discharge instructions are indicated.

f. Post-mortem care: Standard Precautions should be used for post-mortem care.[5]

4. Post Exposure Management

Suspicion of even single cases of botulism should immediately raise concerns of an outbreak potentially associated with shared contaminated food. In collaboration with CDC and local/state health departments, attempts should be made to locate the contaminated food source and identify other persons who may have been exposed.[13] Any individuals suspected to have been exposed to botulinum toxin should be carefully monitored for evidence of respiratory compromise.

a. Decontamination of patients/environment: Contamination with botulinum toxin does not place persons at risk for dermal exposure or risk associated with re-aerosolization. Therefore, decontamination of patients is not required.

b. Prophylaxis and post-exposure immunization: Trivalent botulinum antitoxin is available by contacting state health departments or by contacting CDC (404-639-206 during office hours, 404-639-2888 after hours). This horse serum product has a < 9% rate of hypersensitivity reactions. Skin testing should be performed according to the package insert prior to administration.[14]

c. Triage and management of large-scale exposures/potential exposures: Patients affected by botulinum toxin are at risk for respiratory dysfunction that may necessitate mechanical ventilation. Ventilatory support is required, on average, for 2 to 3 months before neuromuscular recovery allows unassisted breathing. Large-scale exposures to botulinum toxin may overwhelm an institution's available resources for mechanical

ventilation. Sources of auxiliary support and means to transport patients to auxiliary sites, if necessary, should be planned in advance with coordination among neighboring facilities.[6,10] See Section I for additional general details regarding planning for large-scale patient management.

5. Laboratory Support and Confirmation

a. Obtaining diagnostic samples: Routine laboratory tests are of limited value in the diagnosis of botulism. Detection of toxin is possible from serum, stool samples, or gastric secretions. For advice regarding the appropriate diagnostic specimens to obtain, contact state health authorities or CDC (Foodborne and Diarrheal Diseases Branch, 404-639-2888).

b. Laboratory selection: Handling of clinical specimens should be coordinated with local and state health departments. The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

c. Transport requirements: Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office, 770-488-7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

6. Patient, Visitor, and Public Information

Fact sheets for distribution should be prepared, including explanation that people exposed to botulinum toxin are not contagious. A clear description of symptoms including blurred vision, drooping eyelids, and shortness of breath should be provided with instructions to report for evaluation and care if such symptoms develop.

C. Plague

1. Description of Agent/Syndrome

a. Etiology: Plague is an acute bacterial disease caused by the gram-negative bacillus *Yersinia pestis*, which is usually transmitted by infected fleas, resulting in lymphatic and blood infections (bubonic and septicemia plague). A bioterrorism-related outbreak may be expected to be airborne, causing a pulmonary variant, pneumonic plague.[3,10]

b. Clinical features: Clinical features of pneumonic plague include:

- Fever, cough, chest pain.
- Hemoptysis
- Muco-purulent or watery sputum with gram-negative rods on gram stain.
- Radiographic evidence of bronchopneumonia.[10]

c. Modes of transmission:

- Plague is normally transmitted from an infected rodent to man by infected fleas.
- Bioterrorism-related outbreaks are likely to be transmitted through dispersion of an aerosol.

- Person-to-person transmission of pneumonic plague is possible via large aerosol droplets.[6]

d. Incubation period: The incubation period for plague is normally 2-8 days if due to flea-borne transmission. The incubation period be shorter for pulmonary exposure (1-3 days).[10]

d. Period of communicability: Patients with pneumonic plague may have coughs productive of infectious particle droplets. Droplet precautions, including the use of a mask for patient care, should be implemented until the patient has completed 72 hours of antimicrobial therapy.[3,6]

2. Preventive Measures

a. Vaccine availability: Formalin-killed vaccine exists for bubonic plague, but has not been proven to be effective for pneumonic plague. It is not currently available in the United States.

b. Immunization recommendations: Routine vaccination requires multiple doses given over several weeks and is not recommended for the general population.[3] Post-exposure immunization has no utility.

3. Infection Control Practices for Patient Management

Symptomatic patients with suspected or confirmed plague should be managed according to current guidelines. Recommendations for specific therapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact CDC or state health department.

a. Isolation precautions: For pneumonic plague, Droplet Precautions should be used in addition to Standard Precautions.

- Droplet Precautions are used for patients known or suspected to be infected with microorganisms transmitted by large particle droplets, generally larger than 5μ in size, that can be generated by the infected patient during coughing, sneezing, talking, or during respiratory-care procedures.
- Droplet Precautions require healthcare providers and others to wear a surgical-type mask when within 3 feet of the infected patient. Based on local policy, some healthcare facilities require a mask be worn to enter the room of a patient on Droplet Precautions.
- Droplet Precautions should be maintained until patient has completed 72 hours of antimicrobial therapy.

b. Patient placement: Patients suspected or confirmed to have pneumonic plague require Droplet Precautions. Patient placement recommendations for Droplet Precautions include:

- Placing infected patient in a private room.
- Cohort in symptomatic patients with similar symptoms and the same presumptive diagnosis (i.e., pneumonic plague) when private rooms are not available.
- Maintaining spatial separation of at least 3 feet between infected patients and others when cohorting is not achievable.
- Avoiding placement of patient requiring Droplet Precautions in the same room with an immunocompromised patient.

- Special air handling is not necessary and doors may remain open.

c. Patient transport:
   - Limit the movement and transport of patients on Droplet Precautions to essential medical purposes only.
   - Minimize dispersal of droplets by placing a surgical-type mask on the patient when transport is necessary.[5,6]

d. Cleaning disinfection, and sterilization of equipment and environment: Principles of Standard Precautions should be generally applied to the management of patient-care equipment and for environmental control (see Section I for more detail).[5]

e. Discharge management: Generally, patients with pneumonic plague would not be discharged from a healthcare facility until no longer infectious (completion of 72 hours of antimicrobial therapy) and would require no special discharge instructions. In the event of a large bioterrorism exposure with patients receiving care in their homes, home care providers should be taught to use Standard and Droplet Precautions for all patient care.

f. Post-mortem care: Standard Precautions and Droplet Precautions should be used for post-mortem care.[5]

4. Post Exposure Management

a. Decontamination of patients/environment: The risk for re-aerosolization of *Y. pestis* from the contaminated clothing of exposed persons is low. In situations where there may have been gross exposure to *Y. pestis*, decontamination of skin and potentially contaminated fomites (e.g., clothing or environmental surfaces) may be considered to reduce the risk for cutaneous or bubonic forms of the disease.[3] The plan for decontaminating patients may include:
   - Instructing patients to remove contaminated clothing and storing in labeled, plastic bags.
   - Handling clothing minimally to avoid agitation.
   - Instructing to patients to shower thoroughly with soap and water (and providing assistance if necessary).
   - Instructing personnel regarding Standard Precautions and wearing appropriate barriers (e.g., gloves, gown, face shield) when handling contaminated clothing or other contaminated fomites.
   - Performing environmental surface decontamination using an EPA-registered, facility-approved sporicidal/germicidal agent or 0.5% hypochlorite solution (one part household bleach added to nine parts water.[5,6]

b. Prophylaxis: Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC.

Post-exposure prophylaxis should be initiated following confirmed or suspected bioterrorism *Y. pestis* exposure, and for post-exposure management of healthcare workers and others who had unprotected face-to-face contact with symptomatic patients (Table 2).

Table 2. Recommended post-exposure prophylaxis for exposure to *Yersinia pestis.*

Antimicrobial agent	Adults	Children §
First choice		
Doxycycline	100 mg twice daily	5 mg per kg of body mass daily, divided into two doses
Second choice		
Ciprofloxacin	500 mg once daily	20-30 mg per kg of body mass daily, divided into two doses

§ Pediatric use of fluoroquinolones and tetracyclines is associated with adverse effects that must be weighed against the risk of developing a lethal disease.

Prophylaxis should continue for 7 days after last known or suspected &. Pestis exposure, or until exposure has been excluded.[10]

Facilities should ensure that policies are in place to identify and manage health care workers exposed to infectious patients. In general, maintenance

c. Triage and management of large-scale exposures/potential exposures: Advance planning should include identification of sources for appropriate masks to facilitate adherence to Droplet Precautions for potentially large numbers of patients and staff. Instruction and reiteration of requirements for Droplet Precautions (as opposed to Airborne Precautions) will be necessary to promote compliance and minimize fear and panic related to an aerosol exposure.

Advance planning should also include identification of:

- Sources of bulk prophylactic antibiotics and planning for acquisition on short notice.
- Locations, personnel needs and protocols for administering prophylactic post-exposure care to large numbers of potentially exposed individuals.
- Means for providing telephone follow-up information and other public communications services.

See Section I for additional general details regarding planning for large-scale patient management.

5. Laboratory Support and Confirmation

Laboratory confirmation of plague is by standard microbiologic culture, but slow growth and misidentification in automated systems are likely to delay diagnosis. For decisions regarding obtaining and processing diagnostic specimens, contact state laboratory authorities or CDC.

a. Diagnostic samples: Diagnostic samples to obtain include:

- Serum for capsular antigen testing
- Blood cultures
- Sputum or tracheal aspirates for Gram's, Wayson's, and fluorescent antibody staining.

- Sputum or tracheal aspirates for culture.

b. Laboratory selection: Handling of clinical specimens should be coordinated with local and state health departments, and undertaken in Bio-Safety Level (BSL) –2 or –3 laboratories.[3] The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

c. Transport requirements: Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office, 770-488-7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

6. Patient, Visitor, and Public Information

Fact sheets for distribution should be prepared, including a clear description of Droplet Precautions, symptoms of plague, and instructions to report for evaluation and care if such symptoms are recognized. The difference between prophylactic antimicrobial therapy and treatment of an actual infection should be clarified. Decontamination by showering thoroughly with soap and water can be recommended.

D. Smallpox

1. Description of Agent/Syndrome

a. Etiology: Smallpox is an acute viral illness caused by the variola virus.[11] Smallpox is a bioterrorism threat due to its potential to cause severe morbidity in a nonimmune population and because it can be transmitted via the airborne route.[10] A single case is considered a public health emergency.

b. Clinical features: Acute clinical symptoms of smallpox resemble other acute viral illnesses, such as influenza. Skin lesions appear, quickly progressing from macules to papules to vesicles. Other clinical symptoms to aid in identification of smallpox include:

- 2-4 day, non-specific prodrome of **fever, myalgias**
- **rash most prominent on face and extremities** (including palms and soles) in contrast to the truncal distribution of varicella
- **rash scabs over in 1-2 weeks**
- In contrast to the rash of varicella, which arises in "crops," **variola rash has a synchronous onset**.[10]

c. Mode of transmission: Smallpox is transmitted via both large and small respiratory droplets. Patient-to-patient transmission is likely from airborne and droplet exposure, and by contact with skin lesions or secretions. Patients are considered more infectious if coughing or if they have a hemorrhagic form of smallpox.

d. Incubation period: The incubation period for smallpox is 7-17 days; the average is 12 days.

e. Period of communicability: Unlike varicella, which is contagious before the rash is apparent, patients with smallpox become infectious at the onset of the rash and remain infectious until their scabs separate (approximately 3 weeks).[6,10]

2. Preventive Measures

a. Vaccine availability: A live-virus intradermal vaccination is available for the prevention of smallpox.[12]

b. Immunization recommendations: Since the last naturally acquired case of smallpox in the world occurred more than 20 years ago, routine public vaccination has not been recommended.[3] **Vaccination against smallpox does not reliably confer lifelong immunity. Even preciously vaccinated persons should be considered susceptible to smallpox.**

3. Infection Control Practices for Patient Management

Symptomatic patients with suspected or confirmed smallpox should be managed according to current guidelines. Recommendations for specific therapy are beyond the scope of this document. For up-to-date information and recommendations for therapy, contact the CDC or state health department.

a. Isolation precautions: For patients with suspected or confirmed smallpox, both Airborne and Contact Precautions should be used in addition to Standard Precautions.

- Airborne Precautions are used for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small particle residue, 5μ or smaller in size) of evaporated droplets containing microorganisms that can remain suspended in air and can be widely dispersed by air currents.
- Airborne Precautions require healthcare providers and others to wear respiratory protection when entering the patient room. (Appropriate respiratory protection is based on facility selection policy; must meet the minimal NIOSH standard for particulate respirators, N95).[5,15]
- Contact Precautions are used for patients known or suspected to be infected or colonized with epidemiologically important organisms that can be transmitted by direct contact with the patient or indirect contact with potentially contaminated surfaces in the patient's care area.
- Contact precautions require healthcare providers and others to:
  - Wear clean gloves upon entry into patient room.
  - Wear gown for all patient contact and for all contact with the patient's environment. Based on local policy, some healthcare facilities require a gown be worn to enter the room of a patient on Contact Precautions. Gown must be removed before leaving the patient's room.
  - Wash hands using an antimicrobial agent.

b. Patient placement: Patients suspected or confirmed with smallpox require placement in rooms that meet the ventilation and engineering requirements for Airborne Precautions, which include:

- Monitored negative air pressure in relation to the corridor and surrounding areas
- 6-12 air exchanges per hour
- Appropriate discharge of air to the outdoors, or monitored high efficiency filtration of air prior to circulation to other areas in the healthcare facility
- A door that must remain closed

Healthcare facilities without patient rooms appropriate for the isolation and care required for Airborne Precautions should have a plan for transfer of suspected or confirmed smallpox patients to neighboring facilities with appropriate isolation rooms.

Patient placement in a private room is preferred. However, in the event of a large outbreak, patients who have active infections with the same disease (i.e., smallpox) may be cohorted in rooms that meet appropriate ventilation and airflow requirements for Airborne Precautions.[5,6]

c. Patient transport:
- Limit the movement and transport of patients with suspected or confirmed smallpox to essential medical purposes only.
- When transport is necessary, minimize the dispersal of respiratory droplets by placing a mask on the patient, if possible.[5]

d. Cleaning, disinfection, and sterilization of equipment and environment: A component of Contact Precautions is careful management of potentially contaminated equipment and environmental surfaces.
- When possible, noncritical patient care equipment should be dedicated to a single patient (or cohort of patients with the same illness).
- If use of common items is unavoidable, all potentially contaminated, reusable equipment should not be used for the care of another patient until it ahs been appropriately cleaned and reprocessed. Policies should be in place and monitored for compliance.[5]

e. Discharge management: In general, patients with smallpox will not be discharged from a healthcare facility until determined they are no longer infectious. Therefore, no special discharge instructions are required.

f. Post-mortem care: Airborne and Contact Precautions should be used for post-mortem care.[5]

4. Post Exposure Management

a. Decontamination of patients/environment:
- Patient decontamination after exposure to smallpox is not indicated.
- Items potentially contaminated by infectious lesions should be handled using Contact Precautions.[6]

b. Prophylaxis and post-exposure immunization: Recommendations for prophylaxis are subject to change. Up-to-date recommendations should be obtained in consultation with local and state health departments and CDC.

Post-exposure immunization with smallpox vaccine (vaccinia virus) is available and effective. Vaccination alone is recommended if given within 3 days of exposure. Passive immunization is also available in the form of vaccinia immune-globulin (VIG) (0.6 ml/kg IM). If greater than 3 days has elapsed since exposure, both vaccination and VIG are recommended.[12] VIG is maintained at USAMRIID, 301-619-2833.[10,11]

Vaccination is generally contraindicated in pregnant women, and persons with immunosuppression, HIV-infection, and eczema, who are at risk for disseminated vaccinia disease. However, the risk of smallpox vaccination should be weighed against the likelihood for developing smallpox following a known exposure. VIG should be given concomitantly with vaccination in these patients.[11]

Following prophylactic care, exposed individuals should be instructed to monitor themselves for development of flu-like symptoms or rash during the incubation period (i.e., for 7 to 17 days after exposure) and immediately report to designated care sites selected to minimize the risk of exposure to others.

Facilities should ensure that policies are in place to identify and manage health care workers exposed to infectious patients. In general, maintenance of accurate occupational health records will facilitate identification, contact, assessment, and delivery of post-exposure care to potentially exposed healthcare workers.

c. Triage and management of large-scale exposure/potential exposures: Advance planning must involve IC professionals in cooperation with building engineering staff, to identify sites within the facility that can provide necessary parameters for Airborne Precautions. See Section I for additional general details regarding planning for large-scale patient management.

5. Laboratory Support and Confirmation

a. Diagnostic samples to obtain: For decisions regarding obtaining and processing diagnostic specimens, contact state laboratory authorities or CDC.

b. Laboratory selection: Handling of clinical specimens must be coordinated with state health departments, CDC, and USAMRIID. Testing can be performed only in BSL – 4 laboratories.[11] The FBI will coordinate collection of evidence and delivery of forensic specimens to FBI or Department of Defense laboratories.

c. Transport requirements: Specimen packaging and transport must be coordinated with local and state health departments, and the FBI. A chain of custody document should accompany the specimen from the moment of collection. For specific instructions, contact the **Bioterrorism Emergency Number at the CDC Emergency Response Office, 770-488-7100**. Advance planning may include identification of appropriate packaging materials and transport media in collaboration with the clinical laboratory at individual facilities.

6. Patient, Visitor, and Public Information

Fact sheets for distribution should be prepared, including a clear description of symptoms and where to report for evaluation and care if such symptoms are recognized. Details about the type and duration of isolation should be provided. Vaccination information that details who should receive the vaccine and possible side effects should be provided. Extreme measures such as burning or boiling potentially exposed materials should be discouraged.

HOW TO REPORT A SUSPICIOUS CASE OF ANTHRAX:

Call the NDDoH immediately at 1-800-472-2180 toll free. This number is available 24 hours a day, 7 days a week. Disease Control epidemiologists will be available for questions, recommendations or consultation.

Please have the following information available:

- Patient name
- Patient contact information
- Medical history
- Illness onset date
- Characteristics and progression of skin lesion
- Presence of systemic symptoms
- Treatment history
- Laboratory and radiologic data
- Detailed exposure and employment history

This information will be used to help determine the patient's risk for anthrax infection. When you call to report a case, we will help to determine whether further testing is necessary.

HOW TO ARRANGE FOR TESTING:

A. If it is determined that the patient is a SUSPICIOUS CASE OF CUTANEOUS ANTHRAX, the patient should be evaluated and the specimens detailed below should be requested. Initial laboratory testing for cases should be performed using local clinical reference laboratories.

1. Cultures and gram stains for testing at your routine microbiology laboratory:
   a. Synthetic (non-cotton) swab with non-wooden stick for culture and gram stain of material swabbed from the exudate or the most actively inflamed area of the eschar.
   b. Sterile punch biopsy specimen sent in sterile saline for culture.
   c. Blood culture.
   d. All specimens should be sent to local clinical reference laboratory. If suspicious *Bacillus species* is identified, contact NDDoH immediately.

B. If it is determined that the patient is a SUSPICIOUS CASE OF INHALATION ANTHRAX, the diagnostic workup should include the tests listed below. Initial laboratory testing for cases should be performed using local clinical reference laboratories.

1. Gram stain and routine blood cultures
2. If meningeal signs are present, gram stain and culture of CSF.
3. If pleural fluid is present, gram stain and culture of pleural fluid
4. Chest X-ray and/or chest CT to assess for mediastinal and hilar adenopathy

TEST RESULTS

All test results will be reported to the physician immediately.

Reference List

4/13/99

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5. Centers for Disease Control and Prevention, the Hospital Infection Control Practices Advisory Committee (HICPAC). Recommendations for isolation precautions in hospitals. Am J Infect Control 1996;24:24-52.

6. American public health association. Control of communicable diseases in man. Washington, DC: American public health association; 1995.

7. Tucker JB. National health and medical services response to incidents of chemical and biological terrorism. JAMA 1997; 278:362-8.

8. Holloway HC, Norwood AE, Fullerton CS, Engel CC Jr, Ursano RJ. The threat of biological weapons. Prophylaxis and mitigation of psychological and social consequences. JAMA 1997; 278:425-7.

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10. Franz D, Jahrling PB, Friedlander AM, McClain DJ, Hoover DL, Bryne WR, et al. Clinical recognition and management of patients exposed to biological warfare agents. JAMA 1997;278:399-411.

11. U.S. Army medical research institute of infectious diseases. Medical management of biological casualties. Fort Detrick: USAMRIID; 1998.

12. Anonymous. Drugs and vaccines against biological weapons. Med Lett Drugs Ther 1999; 41:15-6.

13. Shapiro RL, Hathaway C, Becher J, Swerdlow DL. Botulism surveillance and emergency resopnse. JAMA 1997; 278:433-5.

14. Shapiro RL, Hathaway C, Swerdlow DL. Botulism in the United States: A clinical and epidemiological review. Arch Intern Med 1998;129:221-8.

15. Federal Register. Respiratory protective devices; final rules and notice. 1995.

Appendix 1: Federal Bureau of Investigation (FBI) Field Offices

Revised FBI 1/5/99

FIELD OFFICE	STREET ADDRESS	ZIP CODE	TELEPHONE No.
Albany, NY	200 McCarty Avenue	12209	518-465-7551
Albuquerque, NM	415 Silver Avenue, SW, Suite 300	87102	505-224-2000
Anchorage, AK	101 East 6th Avenue	99501	907-258-5322
Atlanta, GA	2635 Century Parkway, NE; Suite 400	30345	404-679-9000
Baltimore, MD	7142 Ambassador Road	21244	410-265-8080
Birmingham, AL	2121 8th Avenue N, Room 1400	35203	205-326-6166
Boston, MA	One Center Plaza, Suite 600	02108	617-742-5533
Buffalo, NY	One FBI Plaza	14202	716-856-7800
Charlotte, NC	400 S. Tryon Street, Suite 900 Wachovia Blvd.	28285	704-377-9200
Chicago, IL	219 S. Dearborn Street, Room 905	60604	312-431-1333
Cincinnati, OH	550 Main Street, Room 9000	45202	513-421-4310
Cleveland, OH	1240 East 9th Street, Room 3005	44199	216-522-1400
Columbia, SC	151 Westpark Blvd.	29210	803-551-1200
Dallas, TX	1801 N. Lamar, Suite 300	75202	214-720-2200
Denver, CO	1961 Stout Street, Room 1823, FOB	80294	303-629-7171
Detroit, MI	477 Michigan Avenue, P.V. McNamara FOB, 26th Floor	48226	313-965-2323
El Paso, TX	Suite 3000, 660 South Mesa Hills Drive	79912	915-832-5000
Honolulu, HI	300 Ala Moana Blvd., Room 4-230, Kalanianaole FOB	96850	808-521-1411
Houston, TX	2500 East T.C. Jester	77008	713-693-5000
Indianapolis, IN	575 N. Pennsylvania St., Room 679, FOB	46204	317-639-3301
Jackson, MS	100 W. Capitol Street, Suite 1553, FOB	39269	601-948-5000
Jacksonville, FL	7820 Arlington Expy, Suite 200	32211	904-721-1211
Kansas City, MO	1300 Summit Street	64105	816-221-6100
Knoxville, TN	710 Locust Street, Suite 600	37902	423-544-0751
Las Vegas, NV	John Lawrence Bailey Bldg., 700 E. charleston Blvd.	89104	702-385-1281
Little Rock, AR	10825 Financial Centre Pksy., Suite 200	72211	501-221-9100
Los Angeles, CA	11000 Wilshire Blvd., Suite 1700 FOB	90024	310-477-6565
Louisville, KY	600 Martin Luther King Jr. Pl, Room 500	40202	502-583-3941
Memphis, TN	225 North Humphreys Blvd., Suite 3000, Eagle Crest Bldg.	38120	901-747-4300
Miami, FL	16320 NW 2nd Avenue, N. Miami Beach	33169	305-944-9101
Milwaukee, WI	330 E. Kilbourn Avenue, Suite 600	53202	414-276-4684
Minneapolis, MN	111 Washington Avenue South, Suite 1100	55401	612-376-3200
Mobile, AL	One St. Louis Street, 3rd Floor, One St. Louis Centre	36602	334-438-3674
New Haven, CT	150 Court Street, Room 535 FOB	06510	203-777-6311
New Orleans, LA	1250 Poydras Street, Suite 2200	70113	504-522-4671
New York City, NY	26 Federal Plaza, 23rd Floor	10278	212-384-1000
Newark, NJ	One Gateway Center, 22nd Floor	07102	973-622-5613
Norfolk, VA	150 Corporate Blvd.	23502	757-455-0100
Oklahoma City, OK	50 Penn Place, Suite 1600	73118	405-290-7770
Omaha, NE	10755 Burt Street	68114	402-493-8688
Philadelphia, PA	600 Arch Street, 8th Floor, William J. Green, Jr., FOB	19106	215-418-4000
Phoenix, AZ	201 E. Indianola Avenue, Suite 400	85012	602-279-5511
Pittsburgh, PA	700 Grant Street, Suite 300 USPO	15219	412-471-2000
Portland, OR	1500 S.W. 1st Avenue, Suite 400; Crown Plaza Bldg.	97201	503-224-4181
Richmond, VA	111 Greencourt Road	23228	804-261-1044
Sacramento, CA	4500 Orange Grove Avenue	95841	916-481-9110
Salt Lake City, UT	257 East 200 South, Suite 1200	84111	801-579-1400
San Antonio, TX	615 E. Houston Street, Suite 200; US Post Office & Courthouse Bldg.	78205	210-225-6741
San Diego, CA	9797 Aero Drive	92123	619-565-1255
San Francisco, CA	450 Golden Gate Avenue, 13th Floor	94102	415-553-7400
San Juan, PR	150 Carlos Chardon, Room 526; U.S. Federal Building, Hato Roy, PR	00918	787-754-6000
Seattle, WA	915 Second Avenue, Room 710	98174	206-622-0460
Springfield, IL	400 W. Monroe Street, Suite 400	62704	217-522-9675
St. Louis, MO	2222 Market Street	63103	314-231-4324
Tampa, FL	500 E. Zack Street, Suite 610 FOB	33602	813-273-4566
Washington, D.C.	601 4th Street, NW	20535	202-278-2000

Appendix 3: **Websites Relevant to Bioterrorism Readiness**

http://www.apic.org

http://www.cdc.gov/ncidod/diseases/bioterr.htm

http://www.cdc.gov/ncidod/dbmd/anthrax.htm

http://www.cdc.ncidod/diseases/foodborn/botu.htm

http://www.cdc.gov/ncidod/srp/drugservice/immuodrugs.htm

http://www.nbc-med.org/SiteContent/HomePage/WhatsNew/anthraxinfo/Anthraxinfo3.htm

http://www.defenselink.mil/specials/Antrhax/anth.htm

http://www.hopkins-id.edu/bioterr/bioterr_1.html

http://www.who.int/emc-documents/zoonoses/docs/whoemczdi986.html

http://www.hopkins-biodefense.org

Appendix 4: **Other Sources of Information**

USAMRIID 301-619-2833

BIOPORT (producers of anthrax vaccine) 517-327-1500

AMERICAN RED CROSS ___/_____-_____

SALVATION ARMY 1-888-321-03433

US PUBLIC HEALTH SERVICE 1-800-872-6367

DOMESTIC PREPAREDNESS INFORMATION LINE 1-800-368-6498

NATIONAL RESPONSE CENTER 1-800424-8802

Northwood Deaconess Health Center

Mass Prophylaxis / Treatment Plan

A cache of doxycyline and amoxicillin for acute staff, first responders, and their families is maintained by ND Department of Health. ND Department of Health can deliver the pharmaceuticals across the state within 4-6 hours of a request. Following is the protocol to follow:

A. Requesting antibodies for prophylaxis or treatment of healthcare providers:

1. Contact person is James Mutchler and in his absence Tami Rygg or Katie Huus.

2. Notify the N.D. Department of Health Case Manager via State Radio (1-800-472-2121).

B. Medical Orders:

1. The Medical Director will provide orders to treat staff and family according to the directions of the N.D. Department of Health Case Manager.

C. Receiving the Pharmaceuticals:

1. The above names mentioned as contact person are the only ones who can receive the pharmaceuticals from Dakota Drug.

D. Dispensing:

1. Dispensing will be done within 48 hours of receiving the drugs.

2. The contact individuals will be responsible for dispensing of the drug. They are all RNs.

3. Staff will be notified either by phone or in person that medication is available.

4. The medication will be kept in Pharmacy, which is locked at all times.

5. Staff will come to Acute Nurses Station to receive the medication. They will need to provide one form of identification, preferably a driver's license.

6. Staff will be allowed to pick up medication for family members.

E. Documentation:

1. With any incident, a summary will be documented as to why the medication needed and who should receive it.

2. Documentation form will be completed for each staff member coming for medication. They will all be attached to the main summary.

F. Alternative Treatment:

1. If anyone is unable to take either of the drugs provided by the emergency cache, the Medical Director will be consulted.

G. Signs and Symptoms:

1. Depending on the exposure, staff will be monitored at the beginning of each shift for signs and symptoms that would require exclusion from work.

2. A check sheet will be developed according to the exposure, and it will be the responsibility of the acute charge nurse along with assistance from the Infection Control Nurse.

Northwood Deaconess Health Center

Documentation Form

Name:_____

Date:_____

Allergies:_____

_____

Medication given/directions: _____

_____

_____

Family members	Allergies	Meds given/directions

CITY DISASTER PLAN

EMERGENCY PHONE NUMBERS

NAME	TITLE	WORK	CELL/HOME
Gerald Uglem	Mayor		218-779-0780
Shelly Radke	City Auditor	587-5370	
Jim Gorres	Public Works Dept.	587-6291	701-331-9572
	Police Chief	587-5651	
Jason Korsmo	Fire Chief		218-791-0859
Mark Pollert	Asst. Fire Chief		701-330-2897
Shane Azure	Supt. of Schools	587-5221	701-238-4254
	Squad Leader		
	Ambulance		
Tom Engen	NDHC / Ambulance	587-6485	218-779-5655
Pete Antonson	Hospital Administrator	587-6459	218-230-8471
Tom Engen	NDHC Personnel	587-6485	218-779-5655
	City Health Officer		
Nurses Station	Nurses Station	701-587-6443	701-587-6443
Swanson & Warcup	City Attorney	701-772-3407	
Amber Gudajtes	City Tax Assessor	701-780-8259	
Patrick Askew	Mortician	587-6191	701-370-3706

Northwood City Phone Numbers

Utility Clerk	587-6301
City Auditor	587-5370
Public Works Supervisor	587-6291
Police Department	587-5651 or 218-779-6888
Fire Department	911
Ambulance	911

Public Works Employees

Scott Bullert	701-215-8744
Sam Spear	701-587-6291
Robert Heinrich	605-415-8420
In case of Cyber terrorism call FBI	701-772-0812

CITY OF NORTHWOOD

NATURAL DISASTER EMERGENCY OPERATIONS PLAN

INTRODUCTION

The City of Northwood Natural Disaster Emergency Operations Plan is made up of a basic document which contains background and general information concerning the threats of various types of natural disasters and actions to be taken if this threat should become reality. In addition to the basic document, nine emergency functions have been identified. Supporting resources and staff lists should be identified for each emergency function and attached to this plan or placed in a separate operational reference book (or books) which are then referenced in the basic document.

Each department, agency, or individual assigned specific responsibilities under this plan should have a broad understanding of the basic document and a thorough understanding of their specific tasks as assigned under each emergency function.

This is intended to be a working plan, so you are encouraged to include additional information if it will help you in fulfilling your responsibilities as outlined in the plan. Suggestions for improvement are solicited and should be submitted to the Northwood City Council and the Grand Forks County Disaster Emergency Services Coordinator.

RESOLUTION

By virtue of the authority vested in the City Council of the City of Northwood by the North Dakota Disaster Act of 1973, NDCC 37-17.1-21, we do approve and issue the Natural Disaster Emergency Operations Plan.

Upon approval, this plan shall have the full force and effect of law.

Dated this _____ day of _____, 19 _____.

_____

Mayor, City of Northwood

Witnesses:

_____
Auditor
City of Northwood

_____
Disaster Emergency Services Coordinator
Grand Forks County

AUTHORITIES

North Dakota Century Code, Chapter 37-17-02, Northwood City Council Dated: _____

PURPOSE

The purpose of this plan is to:

1. Provide a coordinated effort for saving lives and protecting property in the event of a natural disaster.

2. Define the responsibilities of agencies and departments of city government in preparation for, response to, and recovery from a natural disaster emergency.

ASSUMPTIONS

A disaster emergency is not a situation dealt with in the daily activities of city government. A disaster emergency is the occurrence of imminent threat of widespread or severe property damage, injury, or loss of life resulting from any natural or man-made cause.

The greater hazards to the City of Northwood are summer storms, tornadoes, floods, blizzards, hazardous materials, structural fires, and national emergencies.

County, state, and federal assistance is a supplement to, but not a substitute for, City of Northwood disaster emergency efforts.

CONCEPT OF OPERATIONS

This plan is in effect when a disaster emergency is declared by the City Council or a disaster emergency occurs or is imminent in the City of Northwood. It is the responsibility of city government to respond to disaster emergency situations.

The Northwood City Council has the overall responsibility for control of city government operations to save lives and protect property and to report disaster emergency information to the Grand Forks County Disaster Emergency Services Coordinator.

All agencies/individuals assigned by this plan are responsible for:

1. Providing equipment and other administrative needs to perform their assigned emergency functions.

2. Maintain necessary records, especially financial, to support their assigned emergency function.

3. Supervising the functions for which they are responsible.

Disaster Emergency Operations will be directed from the City of Northwood Emergency Operations Center (EOC) located at City Hall at 12 North Raymond Street in Northwood. When this plan is put into effect, the Emergency Operations Center will be activated and individuals having the primary responsibility for each of the following emergency functions will relocate to the EOC to direct response operations.

COORDINATION AND CONTROL.....	Mayor/City Council
ADMINISTRATION.....	City Auditor
WARNING.....	Fire Chief/Police Chief
COMMUNICATIONS.....	Police Chief
PUBLIC WORKS & ENGINEERING.....	Public Works Supervisor
DAMAGE ASSESSMENT.....	City Tax Assessor
HEALTH & MEDICAL.....	City Health Officer
PUBLIC SAFETY.....	Police Chief/Fire Chief
INDIVIDUAL & FAMILY ASSISTANCE.....	Mayor/City Council/
.....	G.F. County DES Coord.

Disaster Emergency Operations will be conducted in two phases:

1. Response to the disaster: When a disaster emergency is imminent or occurs, the main response of the City of Northwood is to save lives and protect property. When Northwood City officials determine that response to the disaster emergency situation is warranted, they will activate this plan. Agencies/departments of city government who have a response function will perform tasks as outlined under their assigned functions until such time that there is no longer any threat to lives and property.

2. Recovery from the disaster: Once the threat of the disaster emergency situation has passed, saving lives and protecting property is no longer the prime consideration. Agencies/departments of city government who have a recovery function will perform tasks as outlined under their assigned function until the City Council determines that normal day-to-day government operations can resume.

The relationship between the departments of city government and the functional areas is portrayed on the Department/Function Chart on the following page.

COORDINATION AND CONTROL

PRIMARY RESPONSIBILITY: MAYOR / CITY COUNCIL
PURPOSE: To provide for coordination of City resources during disaster emergency operations.

RESPONSE TASKS	RESPONSIBILITY
Activate disaster headquarters	Mayor / City Council
Coordinated disaster operations	City DES Coordinator
Prepare initial report to State DES	City Auditor
Assign on-scene disaster coordinator (s)	Mayor / City Council
Evaluate disaster or emergency situation	Mayor / City Council
Initiate record keeping and documentation	City Auditor
Determine appropriate actions to save lives and protect property	Mayor / City Council
Prepare situation report to State Government	City Auditor
Review and/or utilize mutual aid agreements	Mayor / City Council
Provide disaster related public information	Mayor / City Council
Declare a local disaster emergency	Mayor / City Council

RESPONSE TASKS	RESPONSIBILITY
Establish curfews, policies and other controls	Mayor / City Council
Request specific assistance from State government to save lives and protect property	Mayor / City Council
Direct utilization of support resources provided by state government	Mayor / City Council
Continually reassess the disaster situation	Mayor / City Council
Call for Damage assessment to begin	Mayor / City Council

RECOVERY TASKS	RESPONSIBILITY
Continue damage assessment	Mayor / City Council
Declare a local disaster emergency	Mayor / City Council
Request assistance from County and/or State government to restore property and recover from the disaster	Mayor / City Council

ADMINISTRATION

PRIMARY RESPONSIBILITY: CITY AUDITOR

PURPOSE: To provide a system for handling disaster emergency related legal, fiscal, and administrative matter in the City.

RESPONSE TASKS	RESPONSIBILITY
Provide administrative support to disaster operations (record keeping, documentation, and fiscal)	City Auditor
Provide legal advice to support disaster operations	City Attorney
Provide clerical support for disaster headquarters	City Auditor
Provide necessary equipment and supplies for operation of the disaster headquarters	City Auditor
Prepare disaster headquarters for emergency operations to include maps and other display materials	City Auditor

RECOVERY TASKS	RESPONSIBILITY
Provide administrative support to disaster operations (record keeping, documentation, and fiscal)	City Auditor
Provide legal advise to support disaster operations	City Attorney

WARNING

PRIMARY RESPONSIBILITY: POLICE CHIEF / FIRE CHIEF

PURPOSE: To establish procedures and provide a network for dissemination of disaster emergency warnings in the City.

RESPONSE TASKS	RESPONSIBILITY
Receive and disseminate warning	Fire Chief / Police Chief

COMMUNICATIONS

PRIMARY RESPONSIBILITY: POLICE CHIEF

PURPOSE: To provide the City with a communications network for the transmission of disaster emergency information.

RESPONSE TASKS	RESPONSIBILITY
Provide a communications network for disaster emergency operations	Police Chief
Provide a message routing system within a disaster headquarters	City Auditor

PUBLIC WORKS AND ENGINEERING

PRIMARY RESPONSIBILITY: PUBLIC WORKS SUPERVISOR

PURPOSE: To provide for the preservation of life and property through engineering tasks in the City. To provide for snow and debris clearance from streets, highways, shelter, utilities, and essential facilities. To provide for the emergency repair of essential facilities in the City.

RESPONSE TASKS	RESPONSIBILITY
Maintain public utilities services	Public Works Supervisor
Provide emergency debris snow removal	Public Works Supervisor
Direct private support resources	Public Works Supervisor
Coordinate transportation resources	Supt. of Northwood Schools
Monitor public and private fuel utilization	Public Works Supervisor
Maintain roadways, culverts, and bridges	Public Works Supervisor
Take actions necessary to minimize damage to public and private property (diking, barricading, disconnect utilities, etc.)	Public Works Supervisor

DAMAGE ASSESSMENT

PRIMARY RESPONSIBILITY: CITY TAX ASSESSOR

PURPOSE: To provide a system for assessing property damage after a disaster emergency in the City.

RESPONSE TASKS		RESPONSIBILITY
Activate Damage Assessment Staff		Mayor / City Council
Conduct Damage Assessment of:		
a.	Private residences	City Tax Assessor
b.	Private business	City Tax Assessor
c.	Private non-profit facilities	City Tax Assessor
d.	Agriculture	County Agent
e.	Debris	Public Works Supervisor
f.	Public road systems	Public Works Supervisor
g.	Public utilities	Public Works Supervisor
h.	Public water control facilities	Public Works Supervisor
i	Public building & equipment	City Tax Assessor
j.	Other	City Tax Assessor

HEALTH AND MEDICAL

PRIMARY RESPONSIBILITY: CITY HEALTH OFFICER

PURPOSE: To provide for health and medical services in time of a disaster emergency in the City.

RESPONSE TASKS	RESPONSIBILITY
Provide emergency medical care	City Health Officer/ Ambulance Service
Control disease through necessary health measures	City Health Officer/ Ambulance Service
Provide emergency mortuary services as required	City Health Officer/ Mortician/County Coroner

PUBLIC SAFETY

PRIMARY RESPONSIBILITY: POLICE CHIEF / FIRE CHIEF

PURPOSE: To provide a means for the protection of life and property and maintenance of law and order during disaster emergency situations for the city.

RESPONSE TASKS	RESPONSIBILITY
Maintain law and order	Police Chief
Control and suppers fires	Fire Chief
Perform search and rescue	Fire Chief / Police Chief
Coordinate missing person service	Fire Chief / Police Chief / County Sheriff

RECOVERY TASKS	RESPONSIBILITY
Maintain law and order	Police Chief

INDIVIDUAL AND FAMILY ASSISTANCE

PRIMARY RESPONSIBILITY: MAYOR / CITY COUNCIL
PURPOSE: To provide disaster emergency victims of the City with services tailored to meet special and priority human needs.

RESPONSE TASKS	RESPONSIBILITY
Activate Individual and Family Assistance personnel	City government has no existing department to deal with these needs. Upon declaration of a disaster, the Mayor / City Council should request assistance through the County Disaster Emergency Services for response and recovery from Natural Disaster in the area of Individual and Family Assistance.
Provide support to shelter individuals and families left homeless as a result of a disaster emergency	
Provide support to mass feeding operations	
Provide support for the distribution and storage of clothing and essential items for individuals and families in need as a result of a disaster emergency	Contact: Grand Forks County DES Coordinator (701) 780-8213
Provide Support for crisis counseling	Grand Forks County Social Services Director (701) 772-8171
Provide storage sites for personal property during evacuation	

RECOVERY TASKS	RESPONSIBILITY
Provide support for crisis counseling	Alternate Contacts: Ministers residing in Northwood
Identify and support disaster centers	