Hospital Preparedness Plan for COVID-19/All Hazards

I. Structure for Planning and Decision Making

Item	Completed	In Progress	Not Started
A multidisciplinary planning committee with union appointed representatives has been created to specifically address reopening of elective services and preparedness planning for the next surge of COVID-19 infections. This can be an all hazards emergency preparedness planning committee, health and safety or other labor-management committee.			
Staff are assigned responsibility for coordinating preparedness planning, including a COVID-19 response coordinator (with back-up) and planning committee members. Insert name(s), title(s) and contact information: Primary (Name, Title, Contact Information): _____ Backup (Name, Title, Contact Information): _____			
A planning committee has been established and includes representation from the following: (Check categories below that apply for the facility and develop a list of committee members with the name, title, and contact information for each category checked below, and attach to this checklist.) • Hospital administration • Representatives from each of the facility bargaining units/unions • Legal counsel/risk management • Infection control/hospital epidemiology • Disaster coordinator • Public relations coordinator/public information officer • Medical staff (e.g., internal medicine, pediatrics, hospitalist, infectious disease) • Nursing administration • Human resources (personnel, including Equal Employment Opportunity office) • Occupational health • Intensive care • Emergency department • Engineering and maintenance • Environmental services • Security • Purchasing agent /materials management May also have representation from: • Physical therapy • Respiratory therapy • Diagnostic imaging (radiology) • Discharge planning • Staff development/education • Central (sterile) services • Dietary (food) services • Pharmacy services • Information technology • Laboratory services			

• Expert consultants (e.g., ethicist, mental/behavioral health professionals) • Other member(s) as appropriate (e.g., volunteer services, community representative, clergy, local coroner, medical examiner, morticians). The committee has a robust training and internal communication structure to assure effective coordination during a surge/response period.			
The hospital's COVID-19 response coordinator has contact with local or regional planning groups to obtain information on coordinating the hospital's plan with other COVID-19 and pandemic plans (insert names, titles, and contact information.) Local health department (Name, Title, Contact Information): _____ State health department (Name, Title, Contact Information): _____ Tribal health association (Name, Title, Contact Information): _____ Local, regional or state healthcare coalition (Name, Title, Contact Information): _____			

II. Development of a Written COVID-19 Plan

Item	Completed	In Progress	Not Started
A copy of the hospital COVID-19 preparedness plan/All Hazards plan developed and routinely updated by the committee is available at the facility and accessible by staff. *(Location)*: _____ *(Other locations):* _____			
The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used, including the delegation of authority to carry out the plan. *(Name, Title, Contact Information):* _____ *(Name, Title, Contact Information):* _____			
The plan stratifies implementation of specific actions on the basis of the CDC, state and local guidance. (See also https://www.cdc.gov/coronavirus/2019-ncov/community/index.html)			
Responsibilities of key personnel and departments within the facility related to executing the plan have been described.			
Personnel who will serve as back-up (e.g., B team) for key personnel roles have been identified and trained on response objectives, priorities, and policies.			

III. Elements of a COVID-19 Plan

A. General

Item	Completed	In Progress	Not Started
A plan is in place for protecting patients, healthcare personnel and visitors from COVID-19 that addresses the elements that follow.			
A person has been assigned responsibility for monitoring public health advisories (federal and state) and updating the COVID-19 response coordinator and members of the COVID-19 planning committee when COVID-19 is in the geographic area. This person should also monitor developments that might result in staff not being able to report to work, such as school closures. For more information, see https://www.cdc.gov/coronavirus/2019-ncov/index.html. (Insert name, title and contact information of person responsible.) **Primary** *(Name, Title, Contact Information):* _____ **Backup** *(Name, Title, Contact Information):* _____			
A written protocol has been developed for identifying, monitoring and reporting COVID-19 among hospitalized patients (e.g., weekly or daily number of patients with COVID-19).			
A written protocol has been developed for identifying, monitoring and reporting COVID-19 among staff, contractors and volunteers (e.g., weekly or daily number of staff, contractors and volunteers with COVID-19).			
A protocol has been developed for the evaluation and diagnosis of hospitalized patients with symptoms of COVID-19.			
A protocol has been developed for the evaluation and diagnosis of staff, contractors and volunteers of COVID-19.			
A plan to track staff absences has been developed for COVID-19 exposure and quarantine and COVID-19 infection.			
All COVID-19 infections among staff, contractors and volunteers will be recorded in the OSHA 300 log.			
A protocol has been developed for the management of persons with possible COVID-19 who are contacted and evaluated using telehealth or telemedicine methods, in the emergency department, hospital clinics, or are transferred from another facility or referred for hospitalization by an admitting physician. The protocol includes criteria for detecting a possible case, the diagnostic work-up to be performed, infection control measures to be implemented, supportive medical treatment, and directions for notifying public health and infection control.			
A system is in place to monitor for and internally review healthcare-associated transmission of COVID-19 among patients and staff in the facility. Information from this system will be used to implement prevention interventions.			

B. Communications

Item	Completed	In Progress	Not Started
INTERNAL COMMUNICATIONS			
A person has been assigned responsibility for communications with staff, patients, and their families regarding the status and impact of COVID-19 in the facility. Plans and responsibilities for communication with patients and their family members have been developed. **Primary** *(Name, Title, Contact Information):* _____ **Backup** *(Name, Title, Contact Information):* _____			
Communication plans include how signs, websites, email and other methods of communication will be used to inform staff, contractors, family members, visitors, and other persons coming into the facility (e.g., consultants, sales and delivery people) about the status of COVID-19 in the facility.			
Informational materials (e.g., brochures, posters) on COVID-19 and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for patients and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic.			
EXTERNAL COMMUNICATIONS			
A person has been assigned responsibility for communications with public health authorities (i.e., case reporting, status updates) during a COVID-19 outbreak. (Insert names, titles and contact information of primary and backup persons.) **Primary** *(Name, Title, Contact Information):* _____ **Backup** *(Name, Title, Contact Information):* _____			
Key public health points of contact for communication during a COVID-19 outbreak have been identified. (Insert name, title and contact information for each.) **Local health department communication contact** *(Name, Title, Contact Information):* _____ **State health department communication contact** *(Name, Title, Contact Information):* _____ **Tribal health department communication contact** *(Name, Title, Contact Information):* _____			

Item	Completed	In Progress	Not Started
Key preparedness (e.g., healthcare coalition) points of contact during a COVID-19 outbreak have been identified. *(Insert name, title, and contact information for each).* *(Name, Title, Contact Information):* _____ *(Name, Title, Contact Information):* _____			
A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals and hospital emergency medical services, relevant community organizations—including those involved with disaster preparedness) with whom it will be necessary to maintain communication during an outbreak. Attach a copy of contact list: *(Location of list):* _____			
A hospital representative(s) has been involved in the discussion of local plans for inter-facility communication during an outbreak and the hospital has been represented in discussions with healthcare coalitions and other hospitals regarding local plans for inter-facility situational awareness (and possible resource sharing and/or coordination) during a COVID-19 outbreak. *(Name, Title, Contact Information):* _____			

C. Supplies, PPE and Durable Medical Equipment

Item	Completed	In Progress	Not Started
The facility has assessed the current supply of personal protective equipment (facemasks, N95 respirators and equivalents, elastomeric respirators, PAPRs, face shields, goggles, gowns, gloves, fit testing supplies).			
The facility has estimated the number of these items needed for a minimum 8-week COVID-19 outbreak. See the NIOSH PPE burn rate calculator: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html. This estimate should be based on conventional provision of respirators and other PPE and not on contingency or crisis provision. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html The assumptions for the estimate must adhere to the requirements of OSHA's respiratory protection standard https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134 .			

Item	Completed	In Progress	Not Started
The facility will build a stockpile of the disposable PPE needed for a minimum 8-week outbreak and maintain the stockpile.This includes N95 respirators or stronger respirators, such as N100s, eye protection, gowns, gloves.			
The deadline for acquiring the minimum stockpile in preparation for a minimum 8-week outbreak is _____.(suggested date in Fall 2020)			
The facility will implement a protocol for regularly assessing the condition of N95 and other respirators in the stockpile. The facility will dispose of expired respirators from the facility stockpile when global supply chains are restored.			
The facility will develop a crisis respiratory protection program that will rely on emergency use of elastomeric respirators or powered air purifying respirators (PAPRs). This will include a stockpile of PAPRs, training and the supplies needed to disinfect them.			
The facility has established multiple channels for purchasing PPE and other supplies from multiple suppliers.			
The facility has developed a tiered plan to address shortages of N95 or equivalent respirators in which either • extended use • reuse • or decontamination of respirators may be used alone, but not in combination. For example, respirators that have been used for an entire shift may not be decontaminated and decontaminated respirators may not be used for an entire shift.			
The facility has assessed the current inventory of durable and consumable essential patient care materials and equipment (e.g. IV pumps, ventilators, pharmaceuticals).			
The facility has estimated the number of these items needed for a minimum 8-week COVID-19 outbreak.			
A strategy has been developed for how priorities would be made in the event there is a need to allocate limited patient care equipment, pharmaceuticals and other resources.			
A process is in place to ensure that the facility provides supplies and materials necessary to adhere to recommended infection prevention and control practices including: Alcohol-based hand sanitizer for hand hygiene is available in every patient room (ideally both inside and outside of the room) and other patient care and common areas. Sinks are well-stocked with soap and paper towels for hand washing. Signs are posted immediately outside of patient rooms indicating appropriate IPC precautions and required personal protective equipment (PPE). Tissues and facemasks for persons with respiratory symptoms to use near entrances and in common areas, with no-touch receptacles for disposal. PPE is available immediately outside of the patient room and in other areas where patient care is provided. Trash disposal bins are positioned near the exit inside each patient room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another patient in the same room. EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared patient care equipment. *Products with EPA-approved emerging viral*			

pathogens claims are recommended for use against COVID-19. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.			
Estimates have been shared with local, regional, and tribal planning groups to better plan stockpiling agreements.			
A process is in place to track and report available quantities of consumable medical supplies including the monitoring of supplies of facemasks, respirators, gowns, gloves, and eye protection (i.e., face shield or goggles).			
The facility has a contingency plan that includes engaging their health department and healthcare coalition when they experience (or anticipate experiencing) supply shortages. Contact information for healthcare coalitions is available here: https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx.			

D. Identification and Management of Ill Patients

Item	Completed	In Progress	Not Started
Specifically-trained healthcare personnel have been assigned responsibility for overseeing the triage process. (Insert name and contact information) *(Name, Title, Contact Information):* _____			
The hospital has a process for triage (e.g., initial patient evaluation) and admission of patients during an outbreak of COVID-19 that includes the following: Plans to post visual alerts (signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette that is language, format (i.e., prepared for individuals with visual, hearing or other disabilities) and reading-level appropriate. Supplies will be made available (tissues, no-touch waste receptacles, hand sanitizer). Facemasks will be available at triage for patients with respiratory symptoms. Training of personnel on appropriate processes (e.g., questions to ask and actions to take) to rapidly identify and isolate suspect COVID-19 cases.			
Plan to create an area to separate patients with respiratory symptoms. This can include temporary emergency department waiting, triage, assessment and admissions areas outside of the building. In absence of a designated space, a system is provided that allows patients to wait in a personal vehicle or outside the facility (if medically appropriate) and be notified by phone or other remote methods when it is their turn to be evaluated.			
An external site for COVID-19 testing has been established.			
Alternatives to face-to-face triage have been established. A telephone triage system for prioritizing patients who require a medical evaluation (i.e., those patients whose severity of symptoms or risk for complications necessitate being seen by a provider).			
Criteria for prioritizing admission of patients to those in most critical need have been established.			
A process is in place to ensure that, if the patient is being transported to the facility via emergency medical services, HCP in the receiving area are notified in advance.			

Item	Completed	In Progress	Not Started
A process is in place to ensure that, if the patient is being transported within the facility, HCP in the receiving area are notified in advance.			
A process is in place following identification of a suspect COVID-19 case to include: • Immediate notification of facility leadership/infection control. • Notification of local or state health department soon after arrival. • A method to specifically track admissions and discharges of patients with COVID-19.			

E. Visitor Access and Movement Within the Facility

Item	Completed	In Progress	Not Started
Plans for visitor access and movement within the facility have been reviewed and updated.			
The hospital has plans and materials developed to post signs at the entrances to the facility instructing visitors not to visit if they have fever or symptoms of a respiratory infection.			
The hospital has criteria and protocol for when visitors will be limited or restricted from the facility or into rooms of patients with suspected or confirmed COVID-19.			
Should visitor restrictions be implemented, the hospital has a process to allow for remote communication between the patient and visitor (e.g., video-call applications on cell phones or tablets) and has policies addressing when visitor restrictions will be lifted.			
If visitors are allowed to enter the room of a confirmed or suspected COVID-19 patient, the facility will: • Enact a policy defining what PPE should be used by visitors. • Provide instruction to visitors before they enter a patient room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. • Maintain a record (e.g., a log with contact information) of all visitors who enter and exit the room. • Ensure that visitors limit their movement within facility (e.g. avoid the cafeteria).			

F. Occupational Health

Item	Completed	In Progress	Not Started
The facility will obtain temporary alternative housing (e.g. hotel rooms, dormitory rooms) for any staff and contracted workers caring for COVID-19 patients or who have been exposed to COVID-19 patients to avoid potentially infecting household members.			
The facility has a system in place to notify staff, contracted workers, or volunteers immediately when they have been exposed to patients with suspected or confirmed COVID-19.			
Staff will be furloughed with no loss of sick leave or personal leave for 14 days of self-quarantine when exposed to patients with confirmed COVID-19.			

Item	Completed	In Progress	Not Started
The facility has employee sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill healthcare personnel (HCP) to stay home.			
Facility employees will not suffer a loss of pay, sick or annual leave if they are infected with COVID-19 or presumed to be COVID-19 positive.			
The facility will require subcontracting employers operating within the facility (e.g. food services, security services, etc.) to furlough exposed and/or infected contracted employees with no loss of pay or leave for time off during quarantine or illness. Sick leave policies must be non-punitive.			
Cases of COVID-19 infection among facility staff and contracted workers will be presumed to be occupationally acquired. The employee health department will record all cases in the OSHA 300 log.			
Employee health services will provide information on applying for workers compensation to infected staff and contracted employees.			
The facility follows the local/state public health authority's policies and procedures for monitoring and managing HCP with potential for exposure to COVID-19, including ensuring that HCP have ready access, including via telephone, to medical consultation.			
The facility instructs all staff including contractors, volunteers and students to regularly monitor themselves for fever and symptoms of COVID-19, as a part of routine practice.			
The facility has a process to conduct symptom and temperature checks prior to the start of any shift of asymptomatic, exposed HCP who are not work restricted.			
The hospital has a plan for monitoring and assigning work restrictions for ill and exposed HCP. (See: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).			
The facility will follow the requirements of the OSHA respiratory protection standard, including initial and annual fit testing and training for staff caring for suspected or confirmed COVID-19 patients. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134 In the event fit-testing supplies run low during a surge, the facility will temporarily discontinue annual fit testing. Personnel caring for patients with suspected or confirmed COVID-19 will be fit tested for any respirator that is new to them.			
The COVID-19/emergency preparedness committee, health and safety committee or labor-management committee will review and recommend improvements to the benefits under an existing Employee Assistance Program (EAP) or the facility will provide mental health counseling and support for employees and contracted workers. This may take the form of an EAP, peer-support network, support groups, or similar mental health services.			

G. Education and Training

Item	Completed	In Progress	Not Started
The hospital has plans to provide education and training to HCP, patients, and family members of patients to help them understand the implications of, and basic prevention and control measures for, COVID-19. All staff should be included in education and training activities.			
A person or team has been designated with responsibility for coordinating education and training on COVID-19 (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance). (Insert name(s), title(s), and contact information.) *(Name, Title, Contact Information):* _____ *(Name, Title, Contact Information):* _____			
Language and reading-level appropriate materials have been identified to supplement and support education and training programs to HCP, patients, and family members of patients (e.g., available through state and federal public health agencies such and through professional organizations), and a plan is in place for obtaining these materials.			
Facility has developed plans and materials for education and job-specific training of HCP which includes information on recommended infection control measures to prevent the spread of COVID-19, including: Signs and symptoms of COVID-19. How to monitor patients for signs and symptoms of COVID-19. How to keep patients, visitors, and HCP safe by using correct infection control practices including proper hand hygiene and selection and use of PPE, including "just in time" training on selection and proper use of (including donning and doffing) PPE, with a required demonstration of competency. How to properly clean and disinfect environmental surfaces and equipment Staying home when ill. • Recommended actions for unprotected exposures (e.g., not using recommended PPE, an unrecognized infectious patient contact.			
Facility has a process to provide ongoing training and support on infection control practices and PPE donning and doffing in order to improve adherence to best practices.			
The facility has a plan for providing training for staff who are willing to float to new areas to improve staffing for patient care.			
Facility has a plan for expediting the credentialing and training of non-facility HCP brought in from other locations to provide patient care when the facility reaches a staffing crisis.			

H. Healthcare Services/Surge Capacity

Item	Completed	In Progress	Not Started
INFECTION CONTROL, ENGINEERING CONTROLS AND CAPACITY BUILDING			
The facility has developed policies and protocols for maintaining separation of COVID-19 positive care areas and non-COVID-19 care to reduce infection spread within the facility.			
Surge capacity plans include strategies to use in emergency departments to mitigate surge and accommodate additional patients. Strategies such as alternate triage sites, use of telemedicine, and call centers may be considered to reduce surge on the facility.			
Surge capacity plans include strategies to help increase hospital bed capacity.			
The facility ventilation system - general dilution, AIIRS and local exhaust - has been assessed The ventilation system will run and be calibrated and maintained to meet all current ASHRAE standards. When possible, general dilution ventilation will be increased during high demand times.			
The facility has a plan and the capacity to add temporary negative pressure rooms/AIIRs and/or ventilated headboards during surge or periods of sustained demand.			
Surge capacity plans include temporary barriers to control movement and reduce infection spread into non-COVID-19 patient care areas.			
Plans include strategies for maintaining the hospital's core missions and continuing to care for patients with chronic diseases (e.g., hemodialysis and infusion services), women giving birth, emergency services, and other types of required non-COVID-19 care.			
Signed agreements have been established with area hospitals and long-term-care facilities to accept or receive appropriate non-COVID-19 patients who need continued inpatient care to optimize utilization of acute care resources for seriously ill patients.			
Facility space has been identified that could be adapted for use as expanded inpatient beds and this information has been provided to local, regional, and tribal planning contacts.			
Plans are in place to increase physical bed capacity (staffed beds), including the equipment, trained personnel and pharmaceuticals needed to treat a patient with COVID-19 (e.g., ventilators, oxygen).			
Logistical support has been discussed with local, state, tribal and regional planning contacts to determine the hospital's role in the set-up, staffing, and provision of supplies and in the operation of pre-designated alternate care facilities.			
Criteria have been developed for determining when to cancel elective admissions and surgeries.			
Plans for shifting healthcare services away from the hospital, e.g., to home care or pre-designated alternative care facilities, have been discussed with providers, healthcare coalitions, EMS and 9-1-1 services, and local, state, tribal, or regional planning contacts.			
Plans for initiating and expanding use of call centers and telemedicine to be able to serve patients without face to face contact. These plans include communicating with patients about how to access the call line or telemedicine services.			
Ethical issues concerning how decisions will be made in the event healthcare services must be prioritized and allocated (e.g., decisions based on probability of survival) have been discussed.			
A procedure has been developed for communicating changes in hospital status to health authorities and the public.			

STAFFING AND ADMINISTRATIVE CONTROLS	**Completed**	**In Progress**	**Not Started**
A cohort of staff who will only care for suspected and confirmed COVID-19 patients has been identified to reduce infection spread within the facility.			
Surge capacity plans include strategies for maximizing number of staff available for direct patient care.			
Staff in COVID-19 positive patient care areas who are at higher risk of severe disease have been temporarily re-assigned to other areas.			
A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on patients' health status, functional limitations, disabilities, and essential facility operations.			
A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during a COVID-19 outbreak. Insert name, title and contact information. *(Name, Title, Contact Information):*_____			
Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law.			
The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.			
POSTMORTEM CARE			
A contingency plan has been developed for managing an increased need for postmortem care and disposition of deceased patients.			
An area in the facility that could be used as a temporary morgue has been identified.			
Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.			

I. Resuming Non-Essential Care

Item	Completed	In Progress	Not Started
A plan for phased resumption of non-essential healthcare provision is based on • SYMPTOMS: Downward trajectory of reported COVID-like syndromic cases AND influenza-like illnesses over a 14-day period • CASES: Downward trajectory of documented cases OR downward trajectory of positive tests as a percentage of total tests within a 14-day period (flat or increasing number of tests) • HOSPITALS: Can treat *all cases without crisis care* AND a robust testing program is in place for healthcare workers See https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf and https://www.whitehouse.gov/openingamerica/#criteria.			
The supply of PPE must be sufficient to be provided in a conventional capacity. PPE supplies are not sufficient if respirators: • are being rationed and allowed only for high risk procedures • being used for extended periods or multiple days • being decontaminated and reused.			
The supply of patient care resources must be sufficient without jeopardizing surge capacity.			
Facilities must continue to evaluate the number of cases in their region to determine whether to prepare for more cases or surge conditions and discontinue nonessential care.			
Surgical and procedural care and high-complexity chronic disease management are prioritized.			
The facility must maintain separate COVID-19 care areas and non-COVID-19 care areas.			
Patients in non-COVID-19 care areas are screened for COVID-19 symptoms, including temperature checks. When adequate testing capability is established, patients should be screened by laboratory testing before care.			
Staff and contracted workers report on self-screening, including temperature checks.			
Laboratory testing of staff should be available on demand to staff and contracted workers. Personnel must be given their test results.			
A supply of N95 or similar respirators must be accessible to staff and contracted workers in non-COVID-19 care areas in the event patients in non-COVID-19 care areas develop symptoms or test positive.			
Staff and contracted workers wear facemasks at all times, except when respirator use for COVID-19 care is warranted.			
Staffing must be adequate so as not to jeopardize care in COVID-19 care areas and non-COVID-19 areas.			
Staffing cohorts for COVID-19 care and non-COVID-19 care are maintained.			
Visitors should be prohibited unless they are necessary for patient care. A system for screening visitors should be implemented.			