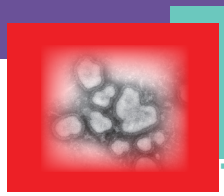

Technical Document 3

GENERAL RECOMMENDATIONS FOR THE ORGANIZATION OF HEALTH CARE FACILITIES FOR THE CARE OF A (H1N1) *INFLUENZA* CASES[1]

Following the declaration by WHO of phase 5 due to the progressive emergence of cases of H1N1 *Influenza*, which has triggered the response by health care facilities in 22 countries to date, it is necessary that health facilities implement new measures to strengthen their capacity to respond effectively to the demand that increasing reports of probable cases can generate and in case massive care is necessary. The following recommendations must be articulated alongside existing guidelines developed by the health authorities in each country concerning community matters, risk communication, public health surveillance and other aspects inherent to the situation.

TO WHOM THIS DOCUMENT IS ADDRESSED

This document is targeted at directors/managers of health care facilities, with emphasis on hospitals, and is aimed at supporting decision-making. This document complements the document "GENERAL RECOMMENDATIONS TO ADDRESS THE CLINICAL MANAGEMENT OF CASES OF INFECTION BY THE *INFLUENZA* A H1N1 VIRUS" which is targeted specifically at health care teams.

The following actions are basic recommendations and should be adapted according to the characteristics and conditions of the health facility.

Operational actions are presented below which should be implemented in every health facility and which are proposed in a three-stage sequence:

First-Line Actions:

For health facilities in countries or areas where cases of H1N1 *Influenza* have not been confirmed.

SECOND-LINE ACTIONS:

For health facilities in countries or areas where cases of H1N1 *Influenza* have been confirmed.

Third-Line Actions:

For health facilities in countries or areas where cases of H1N1 *Influenza* have been confirmed and excessive demand for health services, particularly at the hospital level, is observed.

1 This document **complements** technical document # 1 previously disseminated titled: "GENERAL RECOMMENDATIONS FOR THE ORGANISATION OF HEALTH CARE FACILITIES IN COUNTRIES WHERE CASES OF INFLUENZA A (H1N1) VIRUS HAVE NOT YET BEEN REPORTED."

1. Organization and Coordination

First-Line	Second-Line	Third-Line
1) Activate Hospital Emergency Committee: a) Review and update the Hospital Emergency Plan (health emergencies component). b) Update and activate call rosters and alert levels. 2) Ensure the preservation of basic services by obtaining agreements with service providers in other sectors whose support to the facility on anticipated contingency measures for the pandemic are essential. These services include electricity, communications, water supply, collection of ordinary and pathogenic waste, funerary, and others.	1) Assign available and on-site personnel in accordance with the level of alert defined. 2) Adopt staff management measures to ensure the greatest number of workers in the immediate and medium-term (at least for 4 months). 3) Suspend all contracted services which cannot be concluded in the immediate-term (2 weeks) and which imply restrictions in the delivery of services. 4) Appoint replacements for directors/ managers to guarantee the continuity of decision-making and resource management in case the incumbent is absent. 5) Designate a single communication channel for information dissemination and case reporting.	1) Activate administrative measures to restrict internal transit in the facility, reduce visiting hours, limit visitors, restrict accompanying persons to outpatient visits (only one accompanying person per patient if absolutely necessary). 2) Consider alternative sites for extramural care to ensure continuity of regular services of low complexity (hypertension, growth and development, prenatal care, vaccination, etc.).

2. Infection Control

First-Line	Second-Line	Third-Line
1) Activate Hospital Infection Control Committee. 2) Intensify compliance with standard and droplet precautions for infection control in health personnel. 3) Incorporate information mechanisms and orientation for users (patients and visitors) on infection control measures, respiratory hygiene, and cough and sneeze etiquette. 4) Disseminate criteria for use and distribution of personal protective equipment (PPE) to health care facility personnel.	1) Identify and mark isolation areas, routes and zones (rooms or buildings) where care is being provided to cases. 2) Strictly monitor the use of personal protective equipment by health care personnel (surgical-type mask, gloves, face masks or eye protection, N95 respirator) according to the infection control protocol. 3) Incorporate and implement measures to detect probable cases or contact with cases in the health protocols of other services (dental, blood donation, rehabilitation, etc.). 4) Direct referral cases arriving in the health facility straight to the hospital isolation area (rooms or buildings), avoiding unnecessary stops.	1) Limit procedures involving aerosols for probable or confirmed cases (respiratory nebulization, bronchoscopy, autopsies).

3. Enhanced Epidemiological Surveillance

First-Line	Second-Line	Third-Line
1) Implement and/or intensify measures for monitoring and notification in agreement with the directives of the health authority and in accordance with the case definition, emitted by the WHO and/or the case definition adopted by the national health authority. 2) Make available and disseminate among responsible personnel procedures for collection, packaging and transport of samples for clinical laboratory diagnosis, in accordance with protocols and directives of the health authority.	1) Maintain surveillance of persons who have been in contact with cases. 2) Intervene early in probable cases in clustered communities to contain institutional outbreaks. 3) Maintain reporting and notification actions.	1) Monitor the progression of case incidence and any changes in the mortality or morbidity profiles.

4. Triage

First-Line	Second-Line	Third-Line
1) Assign an exclusive area, with minimal transit, contiguous but not incorporated into the health care facility to implement triage for persons presenting respiratory symptoms. 2) Ensure availability of basic resources for the operation of such areas: personal protective equipment, hand hygiene supplies, registration inputs, medical equipment, furniture, etc. Appoint the medical, administrative and logistical staff to support the area. 3) Disseminate information to facility personnel on triage procedures for persons presenting respiratory symptoms, and clearly indicate defined triage routes and areas. 4) Implement the triage in emergency services, according to the protocol defined in the PAHO clinical guidelines.	1) Direct any persons presenting respiratory symptoms identified through outpatient consultations or emergency services to the triage area (excluding chronic respiratory patients under control).	1) Consider the implementation of triage for Intensive Care Unit admission, in facilities where these resources exist and where response capacity is overburdened.

5. Bed management

First-Line	Second-Line	Third-Line
1) Reinforce referral and counter-referral systems. 2) Implement/strengthen medical regulation systems (call-centers, 911 services, etc.). 3) Develop protocols for early hospital discharge. 4) Promote home care (see clinical management guidelines). 5) Promote hospitalization strategies that include day-care/short-term hospitalization, ARD rooms (management and stabilization of acute respiratory disease). 6) Anticipate protocols for reconversion of beds and for surge capacity.	1) Enable new individual or multiple isolation beds as cohorts emerge.	1) Defer care for patients with non-life threatening conditions, whenever deferment will not result in severe adverse effects. 2) Refer long-stay patients for placement in chronic care units as these become available. 3) Reconvert beds for elective procedures (outpatient surgery recovery, palliative care, etc.) into operational beds for priority services and H1N1 *Influenza* cases. 4) Refer acute inpatients (eg. low complexity post-operative) to home care (or lower levels of care) as long as care can be provided safely in those environments. 5) Enable additional and alternative inpatient units (hotels, schools, theaters, field hospitals, etc.) that can be used as a last resort, provided they meet the self-sufficiency criteria.

6. Resource management

First-Line	Second-Line	Third-Line
1) Activate human resource databases, including updating of telephones and home addresses. 2) Define and disseminate the internal guidelines for health personnel concerning alert levels to ensure availability and attendance during a probable emergency. 3) Identify, according to local or national guidelines, the second line of human resources (volunteers, universities, etc.). 4) Define the functions and protocols for potential additional health personnel. 5) Update agreements with providers of supplies, especially personal protective equipment; supplies for hand hygiene, cleaning, and disinfection; and medicines anticipated in the management guidelines. Agreement updates should redefine conditions to guarantee in stock supplies and timely delivery. 6) Define the supplies and medicine storage and distribution strategy ensuring immediate availability, security, rational use and efficient use of space. 7) Define a policy and a strategy to ensure an emergency stock of antivirals and supplies available for the initial days of the crisis. 8) Strengthen procedures for preventive maintenance and/or repair of medical equipment, and ensure that all electro-mechanical devices expected to be used are operational. 9) Maintain complete and routinely updated registries of consumption of supplies, drugs and other materials.	1) Allocate exclusive personnel and equipment (in a rational manner) for case care. 2) Increase stocks of personal protective equipment and critical supplies for case care (at least 20% more than usual). 3) Implement monitoring and alert mechanisms of stocks of personal protective equipment and critical supplies. 4) Train any extra human resources in procedures that have been defined as support functions they should perform. 5) Replace personal protective equipment and critical supplies when they have reached consumption levels of 40%, considering suppliers response time. 6) Prepare contingency actions with other health facilities (within the same network or catchment area) that allow temporary transactions of personal protective equipment and critical inputs in case of shortages.	1) Incorporate any extra human resources in actions predefined by the facility, starting with those involving less exposure to cases (regular care programs: immunization, hypertension, growth and development, among others). 2) Personal protective equipment (surgical mask) of visitors and guests must be purchased by them and not provided by the facility. 3) Optimize alternative forms of support such as: (a) Improve the capacity of caregivers, including providing rapid-training, to assist in inpatient care (particularly for pediatric patients) whenever staff is reduced. (b) If needed, promote family members' support in providing food for patients, following nutritional recommendations. 4) Activate contingency actions with other health facilities in regards to inputs.

7. Protecting the health and safety of health care workers (HCW)

First-Line	Second-Line	Third-Line
1) Conduct training in the use of personal protective equipment and bio-security measures. 2) Develop an epidemiological surveillance system for respiratory/febrile syndromes in health care facility workers. 3) Adopt protocols for prophylaxis (vaccine/ antivirals). 4) Assess personnel absence or sick leave due to *Influenza*-like illness (ILI). 5) Assess support networks and dependents of healthcare facility workers with the aim of anticipating support mechanisms in case of crisis. 6) Anticipate the domestic needs of staff when faced with measures of social impact (day care, etc.). 7) Anticipate the needs of health, administrative and logistical staff while in the facility (meals, rest, communication, hygiene, etc.).	1) Implement an epidemiological surveillance system for respiratory/febrile syndromes in health care facility workers. 2) Health care workers at higher risk of complications or death from *Influenza* (see clinical guidelines) should not in principle (following rational criteria) care for *Influenza* H1N1 cases. 3) Implement the prophylaxis protocol concerning vaccines and antivirals based on availability and policies.	1) Provide psychological support to health care and logistical personnel of the facility. 2) Implement support measures for facility workers in regards to domestic needs and for longer periods of service.