

LOUISIANA STATE UNIVERISTY HEALTH SCIENCE CENTER

BIOLOGICAL TERRORISM PLAN

Purpose: To provide guidelines for response to a real or suspected biological terrorism attack. The institutional response will be made in conjunction with local and state health departments.

Policy:

- I. Initiation of Plan
 - A. If a biological terrorism event is suspected, initiation of the emergency response will be the responsibility of the Emergency Department Physician.
 - B. Emergency Department Physician will notify the Hospital Administrator during normal hours and House Manager after hours who will notify Administrator on-call. The Hospital Administrator/Administrator on-call will make the decision to activate the Hospital Disaster Plan.
 - C. Hospital Administrator/Administrator on-call will ask the Switchboard to notify the following:
 1. All Hospital Administrators
 2. Medical Staff Directors
 3. Vice Chancellor for Business Affairs
 4. Director of Information Services
 5. Director of Safety
 6. Director of University Police
 7. Director of Physical Plant
 8. Infection Control Practitioner
 9. Section Chief, Infectious Diseases
- II. The Emergency Commander will have the Liaison Officer notify:
 - A. Public Health – 676-5222
 - B. Caddo Parish Office of Emergency Preparedness – 425-5351
 - C. State Regional Coordinator, Knox Andress – 681-4255 (work); 861-6080 (home) 863-6373 (pager) (318) 465-9500 (cell).
- III. Maintain an Index of Suspicion
 - A. Biological Terrorism may occur as a covert event in which people are unknowingly exposed and/or an outbreak is suspected. Biological terrorism may also occur overtly, the terrorists announcing an attack. The following epidemiological characteristics should alert health care providers of the possibility that a biological terrorism event has occurred:

1. A rapidly increasing disease incidence (e.g. within hours or days) in a normally healthy population.
2. An unusual increase in the number of people seeking care, especially with fever, respiratory or gastrointestinal complaints.
3. An endemic disease rapidly emerging at an uncharacteristic time or an unusual pattern.
4. Lower incident rates among people who had been indoors, especially in areas with filtered air or closed ventilation systems, compared with people who had been outdoors.
5. Clusters of patients arriving from a single location.
6. Large number of rapidly fatal cases.
7. Any patient presenting with a disease that is relatively uncommon and has biological terrorism potential (e.g., pulmonary anthrax, tularemia and pneumonic plague).

B. The health-care provider must first possess a high index of suspicion regarding the potential employment of biological weapons. This is due to the fact that, with many of the biological warfare (BW) diseases, very early treatment is mandatory if patients are to be salvaged. Anthrax, botulism, pneumonic plague, and smallpox are readily prevented if patients are provided proper antibiotics, antiserum, and/or immunization promptly following exposure. Conversely, all of these diseases may prove fatal if therapy or prophylaxis is delayed until classic symptoms develop. Unfortunately, symptoms in the early, or prodromal, phase of illness are non-specific, making diagnosis difficult. Moreover, many potential BW diseases, such as brucellosis, Q-fever, and Venezuelan equine Encephalitis (VEE), may never present as more than non-specific febrile illnesses.

IV. Assessment

Historical information of potential interest to the clinician might include information about illnesses in other family members, the presence of unusual situations, food and water procurement sources, vector exposure, immunization history, travel history and occupational duties. The Infection Control Department will develop a questionnaire to assess and identify the disease entity until such time as an outside agency takes over.

V. Potential Agents

Four diseases with the most recognized bioterrorism potential are: anthrax, botulism, pneumonic plague and smallpox. Because of the rapid progression to illness and potential for dissemination of

some of these agents, diagnostic laboratory confirmation may not be possible for sometime. A response based on the recognition of high-risk syndromes will be initiated. Other diseases may be Q-fever, ebola, brucellosis, hemorrhagic fever.

VI. Patient Management

- A. Precautions – agents of biological terrorism are generally not transmitted from person to person, re-aerosolization of these agents is highly unlikely. All patients, suspected or confirmed shall be managed utilizing Standard Precautions.

The following diseases or syndromes require Respiratory Precautions (see attached Appendix A) in addition to Standard Precautions.

1. smallpox
2. pneumonic plague

- B. Patient Placement – Depending on size of the outbreak and presenting symptoms, routine facility patient placement should be followed (use isolation rooms). However, if a number of patients present in which routine placement is not possible patient cohorting should be undertaken after consultation with the Infection Control Department.

1. In-patient and ICU beds
 - a. 9K, primary
 - b. 8K, spill over

*Each floor will accommodate 20 ICU patients and 26 acute care patient. The east side of 9K and 8K shall be used for ICU patients as it has the electrical capability to manage these patients. For placement and management of smallpox patients see Plan for Management of Smallpox Patients.

- C. Patient Transport – Transport and movement of patients with Bioterrorism – related infections should be limited. Patients with airborne transmitted diseases (pneumonic plague, smallpox) must wear a TB mask. Staff transporting patients shall wear gloves, gowns, and mask.
- 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 environmental control. The approved facility policies for cleaning, disinfecting and sterilization shall be followed unless otherwise indicated. Check with Environmental Services as to the disinfectant to use for smallpox, anthrax, botulism and plague.

- E. Discharge Management – Home care instructions concerning barrier precautions, hand washing, waste management and cleaning or disinfecting of the environment will be formulated based on the exposure and illness. Within the limitations imposed by the outbreak, education of care providers and patients regarding post discharge management will be provided as efficiently and effectively as possible.
- VII. Post Exposure Management
- A. Decontamination of Patients and Environment – Decisions regarding the need for decontamination of patients or patient clothing will be made based on the suspected or identified agent. Until a determination is made, patients must remain in the contaminated area.
 - B. Prophylaxis – Decisions regarding the prophylaxis of health care workers will be made based on the suspected or identified agent. The Occupational Health Physician will be responsible for determining treatment for employees.
- VIII. Termination of Bioterrorism Activity - Termination of bioterrorism response will be determined by appropriate individuals. The individuals making this decision will include, Hospital Administrator, Medical Director, Chancellor, Chief of Infectious Diseases, and State and Federal officials.

Appendix A