

Annex C: Bioterrorism Threats

Reporting Requirements and Contact Information

In the event a bioterrorism (BT) event is suspected, local emergency response systems should be activated. Notification should immediately include local infection control personnel and the LTC community's administration, and prompt communication with the local and state health departments, FBI field office, local police, CDC, and medical emergency services. **Each LTC community should include a list containing the following telephone notification numbers in its readiness plan:**

INTERNAL CONTACTS:

INFECTION CONTROL

ADMINISTRATION/PUBLIC AFFAIRS

EXTERNAL CONTACTS:

LOCAL HEALTH DEPARTMENT

REGIONAL EPIDEMIOLOGIST

STATE HEALTH DEPARTMENT

FBI FIELD OFFICE

BIOTERRORISM EMERGENCY NUMBER, CDC Emergency Response Office 770/488-7100

CDC HOSPITAL INFECTIONS PROGRAM 404/639-6413

Detection of Outbreaks Caused by Agents of Bioterrorism

BT occurs as covert events, in which persons are unknowingly exposed and an outbreak is suspected only upon recognition of unusual disease clusters or symptoms. BT may also occur as announced events, in which persons are warned that an exposure has occurred. A number of announced BT 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 BT agents. A healthcare facility's BT Readiness Plan should include details for management of both types of scenarios: suspicion of a BT outbreak potentially associated with a covert event and announced BT events or threats. The possibility of a BT event should be ruled out with the assistance of the FBI and state health officials.

Infection Control Practices for Patient Management

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

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, secretions, or items contaminated with such body fluids, whether or not gloves are worn. Hands are washed immediately after gloves are removed, between contacts, and as appropriate to avoid transfer of microorganisms to others and the environment. Either plain or antimicrobial-containing soaps may be used according to policy.

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 person if contact occurs with contaminated material. Hands are washed promptly after removing gloves.

Masks/Eye Protection or 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 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 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 others.

Post Exposure Management

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 BT agent is to reduce the extent of external contamination of the residents 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 residents and staff while providing care.

When developing BT Readiness Plans, facilities should consider available locations and procedures for patient decontamination.

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 residents 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.

Prophylaxis and post-exposure immunization

Recommendations for prophylaxis are subject to change. However, up-to-date recommendations should be obtained in consultation with local and state health departments and CDC. Communities should ensure that policies are in place to identify and manage health care workers exposed to infectious residents. In general, maintenance of accurate occupational health records will facilitate identification, contact, assessment, and delivery of post-exposure care to potentially exposed healthcare workers.