

***Standards of Care:
Providing Health Care During A
Prolonged Public Health Emergency***

***Draft for Public Comment
Standards of Care Workgroup
CT Department of Public Health
October 2009***

This information is for guidance only and is not intended as a substitute for professional legal or other advice. While every effort has been made to verify the accuracy of the information, legal authorities and requirements may depend on particular circumstances that may arise. Always seek the advice of your attorney with any questions you may have regarding a legal matter and the application of any statutes or regulations cited in this section.

A LETTER TO ALL CONCERNED PERSONS

Since February of 2008, representatives from the Department of Public Health have been meeting with representatives from other state agencies, hospitals, academic institutions, long-term care facilities, regional planning committees, and professional and trade associations to discuss how a prolonged public health emergency will affect the ability of health professionals and institutions to provide care. This draft Whitepaper is the product of those discussions, and is intended to provide a framework for a larger, statewide dialogue on these most important and timely issues. This document will be used as the basis of discussions in public forums throughout the state during the next year.

The link to this document is available on the Department of Public Health's webpage, along with the opportunity to provide electronic comments. The workgroup invites and welcomes your comments. All comments will be reviewed and revisions may be made to this Whitepaper based on the comments, as appropriate.

On behalf of the Standards of Care Workgroup, we thank you in advance for your participation in this process.

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This Whitepaper is dedicated to Dr. Richard Garibaldi who regrettably did not live to see the final product, but who contributed importantly to it.

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This document is a draft, and is only the beginning of our dialogue with providers and the public throughout the State. We anticipate that this dialogue will result in future contributions from countless citizens, and those contributions will be reflected in future drafts of this document. To those who will participate in this dialogue, we will also be most grateful.

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1 ***I. Introduction and Overview***

2 Since 9/11, states have struggled to prepare for the next emergency. Many
3 experts predict that the next emergency will be a prolonged public health emergency.
4 Indeed, most experts say that it is not a question of “if,” but “when.” During such an
5 event, health care facilities will face “the perfect storm” of an overwhelming demand for
6 services accompanied by a critical shortage of resources that will profoundly challenge
7 the underpinnings of our health care system and the individuals who comprise it. The
8 success with which health care facilities and providers meet these challenges will be
9 directly related to how well they plan and prepare for such an event.

10 While the term “altered standards of care” is often used to describe the change in
11 the standards that will apply during a prolonged public health emergency, this term is
12 misleading. The term “standard of care” is a legal term that refers to the treatment
13 provided by a similarly qualified, prudent practitioner *under the same or similar*
14 *circumstances*. Because standards of care, by definition, are dependent on the
15 circumstances, there is no absolute standard that is somehow “altered” during a
16 prolonged public health emergency. Instead, health care providers remain obligated, at
17 all times and under all circumstances, to provide the best possible care.

18 Regardless of the terminology, when resources are scarce, there is a change in the
19 underlying focus in providing care. Instead of seeking to provide the most
20 comprehensive care to every individual, providers will have to decide how to allocate
21 scarce resources to save the most lives possible. The scarcity of resources will force a
22 paradigm shift in the provision of care from being individual-based, to being population-
23 based, or as oft-said, “to do the greatest good for the greatest number.”

24 In order to address concerns raised by providers about standards of care during a
25 prolonged public health emergency, the Connecticut Department of Public Health
26 convened a multidisciplinary workgroup consisting of representatives from hospitals and
27 long term care facilities, nurses, physicians, ethicists, emergency preparedness
28 professionals, first responders, and health care attorneys to collaborate in creating a
29 framework for addressing these issues.

30 After first reviewing the literature, the workgroup identified three types of
31 “standards” to be addressed. The first type of standard the group identified is the

32 “standard of care” that is unique for every situation and is determined by clinicians based
33 on the totality of the circumstances. Because it is not possible to predict the many unique
34 circumstances that may arise when there are extreme scarcities of resources, the
35 workgroup determined that standard of care decisions under such circumstances must be
36 made by clinicians utilizing their best clinical judgment and applying widely held ethical
37 principles. The Department of Public Health has adopted the ethical guidelines set forth
38 in *Stand On Guard For Thee*, a report of the University of Toronto Joint Centre for
39 Bioethics Pandemic Influenza Working Group.¹ This document identifies ten substantive
40 ethical values and five procedural values to guide decision-making during prolonged
41 health emergencies when resources are scarce. Indeed, the formation of the Connecticut
42 workgroup and the development of this document are in compliance with two of the
43 substantive values identified in *Stand On Guard For Thee*: “Reciprocity” and “Trust.”

44 A second type of standard identified by the workgroup consists of standardized
45 practices that assume the availability of staff, space, medication, and equipment. These
46 standardized practices will become impossible to maintain during a prolonged public
47 health emergency. Under such circumstances, decisions will need to be made regarding
48 the allocation of scarce resources and “rationing” of care. This document does not
49 prescribe how scarce resources should be allocated and what specific changes should be
50 made to policies or practices. Instead, it identifies guiding principles and the types of
51 standardized practices facilities and emergency medical service providers may wish to
52 change based on the relevant literature. Because every provider community is unique, it
53 is critical that every organization form its own clinical workgroup to plan how it will
54 provide care during a prolonged public health emergency.

55 The third type of standard identified by the workgroup consists of standards that
56 are established by statute and regulation concerning, for example, scopes of professional
57 practice, documentation, physical plant specifications, staffing, and dietary requirements.
58 Because the Governor of the State of Connecticut is authorized by statute to modify or
59 suspend statutes and regulations, in whole or in part, after an emergency is declared,
60 these standards may be “altered” by executive orders. The challenge to the workgroup
61 was to create an expedited procedure for requesting such modifications and suspensions
62 during a public health emergency when efficiency is vital.

63 Inextricably related to standard of care issues are concerns about the difficulty of
64 maintaining a sufficient and functional workforce during a prolonged public health
65 emergency, and exposures to legal liability. Therefore, this document also suggests
66 some of the ways facilities may make the workplace as safe as possible under such
67 circumstances, and summarizes existing laws pertaining to liability during a declared
68 health emergency.

69 This document is not intended to reflect the policies of the Department of Public
70 Health; rather, it is intended as guidance for health care providers when planning their
71 response to prolonged emergency situations.

72 **II. *An Ethical Framework for Decision-Making During Prolonged Public Health***
73 ***Emergencies***

74
75 Connecticut General Statutes §52-184c defines “standard of care” as:

76 The prevailing professional standard of care for a given health care provider shall
77 be that level of care, skill and treatment which, *in light of all relevant surrounding*
78 *circumstances*, is recognized as acceptable and appropriate *by reasonably prudent*
79 *similar health care providers*. (Emphasis added.)

80
81 Because standards of care by definition depend on the circumstances, as
82 circumstances change, the care that is reasonably required and can be provided will also
83 change. What does not change, however, is the requirement that a provider always
84 exercise the skill and knowledge of a reasonably prudent similar health care provider
85 under the circumstances.

86 During a prolonged public health emergency, the circumstances within facilities
87 will change dramatically. There will be severe shortages of “staff, stuff and space,”
88 including saline, medication, blood, ventilators, oxygen, etc. At the same time, there
89 will be an overwhelming need for these scarce resources. Because the circumstances will
90 significantly change, the care that is provided will be different than under normal
91 circumstances. One “circumstance” that will change during a prolonged emergency or
92 mass casualty, will be the need to provide population-based care instead of individual-
93 based care.

94 The Agency for Healthcare Research and Quality (AHRQ) issued a report
95 entitled, “Altered Standards of Care in Mass Casualty Events”² in which they assume
96 “altered” standards involve “a shift to providing care and allocating scarce equipment,

97 supplies, and personnel in a way that saves the largest number of lives in contrast to the
98 traditional focus on saving individuals.” Similarly, the Homeland Security Council chose
99 not to define an “altered standard of care” in the National Strategy for Pandemic
100 Influenza Implementation Plan, concluding that “the standard of care will be met [during
101 a pandemic] if resources are fairly distributed and are utilized to achieve the greatest
102 benefit.”³

103 The California Department of Health incorporated this changed circumstance into
104 a definition of the “standard of care” during a prolonged emergency, as:

105 . . . the utilization of skills, diligence and reasonable exercise of judgment *in*
106 *furtherance of optimizing population outcomes* that a reasonably prudent person
107 or entity with comparable training, experience or capacity would have used under
108 the circumstances. (Emphasis added.)⁴

109
110 The addition of the phrase, “in furtherance of optimizing population outcomes”
111 reflects the changed circumstance that, during a prolonged public health emergency, the
112 goal will be to minimize morbidity and mortality within the population as a whole. This
113 goal is consistent with providing the best possible care under the circumstances when the
114 circumstances consist of a prolonged public health emergency.

115 Decision-making that focuses on optimizing population outcomes rather than
116 saving individual lives raises complex ethical issues. Such decisions will primarily
117 concern the need to allocate scarce resources that will necessarily require setting
118 priorities and rationing care. Such decisions will literally consist of life and death
119 decisions, and will impinge on closely held values. The public’s cooperation and
120 acceptance of such decisions requires that decision-makers be guided by and
121 communicate the ethical considerations that inform their decisions.

122 The ethical framework for decision-making that has been adopted by the
123 Department in its Pandemic Flu Plan, and that is equally applicable for any prolonged
124 public health emergency, consists of the guidelines set forth in *Stand On Guard For*
125 *Thee*. Decisions must: be based on trust and cooperation; respect personal liberty and
126 privacy; be non-discriminatory, proportional, and fair; and, protect those who bear the
127 greatest burdens in protecting the public good.

128 *Stand On Guard For Thee* identifies ten “substantive values” and five “procedural
129 values.” This framework will govern the Connecticut Department of Public Health’s

130 decision-making during a prolonged public health emergency, and is also recommended
131 as the framework for decision-making in the private sector. In applying this framework
132 to decision-making, the first task is to identify the relevant substantive values for the
133 particular decision. Once those values have been identified, the decision-making should
134 employ the five procedural values.

135 The ten “substantive values” identified in *Stand On Guard For Thee*, are:

- 136 1. *Individual liberty*: This value requires that restrictions be proportional, equitable,
137 and employ the least restrictive means.

138
139 Individual liberty (i.e., respect for autonomy) is a value enshrined in our laws and
140 in health care practice. During a prolonged public health emergency, it may be
141 necessary to restrict individual liberty in order to protect the public from serious
142 harm. Individual liberty can be preserved to the extent that the imposed limits and
143 the reasons for them are transparent. Restrictions to individual liberty will:

- 144
145 Be proportional to the risk of public harm.
146
147 Be necessary and relevant to protecting the public good.
148
149 Employ the least restrictive means necessary to achieve public health
150 goals.
151
152 Be applied in a non-discriminatory manner.

- 153
154 2. *Protect the public from harm*: In restricting the public, the reasons for a decision
155 must be explained, the need for compliance must be weighed, and decisions must
156 be reviewable.

157
158 To protect the public from serious harm and minimize serious illness, death, and
159 social disruption, public health authorities may determine that it is necessary to
160 implement containment strategies such as isolation, quarantine, and social
161 distancing, or to require health care facilities to restrict public access to some
162 areas or limit some services (e.g., elective surgeries). For these protective
163 measures to be effective, citizens must comply with them and enforcement actions
164 may become necessary. These decisions directly conflict with the value of
165 individual liberty, but are necessary to protect the public from harm. When
166 making such decisions, public health authorities will:

- 167
168 Weigh the benefits of protecting the public from harm against the loss of
169 liberty of the individuals who are impacted (e.g., isolation).
170

- 171 □ Ensure that all providers and the public are well aware of the medical and
172 moral reasons for the measures, the benefits of complying, and the
173 consequences of not complying.
174
- 175 □ Establish mechanisms to review decisions as the situation changes and to
176 address concerns or complaints.
177
- 178 3. *Proportionality:* Measures that are implemented should not exceed what is
179 needed to address the risk or needs of the population.
180
- 181 To ensure that restrictions on individual liberty and measures to protect the public
182 from harm do not exceed the minimum required to address the actual level of risk
183 or need in the community, decision makers will:
184
- 185 □ Use the least restrictive or coercive measure possible when limiting or
186 restricting liberties or entitlements.
187
- 188 □ Use more coercive measures only in circumstances where less restrictive
189 means have failed to achieve appropriate public health ends.
190
- 191 4. *Privacy:* Privacy may need to be compromised to protect the public
192
- 193 Individuals have a right to privacy, including the privacy of their health
194 information. During a prolonged public health emergency, it may be necessary to
195 override this right to protect the public from serious harm; however, to be
196 consistent with the ethical principle of proportionality, decision-makers will:
197
- 198 □ Determine whether the good intended is significant enough to justify the
199 potential harm of suspending privacy rights (e.g., potential stigmatization
200 of individuals and communities).
201
- 202 □ Take steps to prevent stigmatization (e.g., public education to correct
203 misperceptions about disease transmission).
204
- 205 □ Require private information only if there are no less intrusive means to
206 protect public health.
207
- 208 □ Limit any disclosure to only that information required to achieve
209 legitimate public health goals.
210
- 211 5. *Duty to provide care:* Health care professions will need to weigh their duty to
212 provide care against the competing need to take care of themselves and their
213 families and friends.
214
- 215 Health care workers have an ethical duty to provide care and respond to suffering.
216 During a prolonged health emergency, demands for care may overwhelm health

217 care workers and their institutions and create challenges related to resources,
218 practice, liability and workplace safety. Health care workers may have to weigh
219 their duty to provide care against competing obligations (i.e., to their own and
220 their family and friends' health).

221
222 When providers cannot provide appropriate care because of constraints caused by
223 the health emergency, they may be faced with moral dilemmas. To support
224 providers in their efforts to discharge their duty to provide care, government
225 agencies and providers are working collaboratively in Connecticut to:

- 226
227 Identify the barriers that will discourage health facilities' staff from
228 reporting to work during a prolonged public health emergency, and
229 make suggestions for minimizing those barriers.
- 230
231 Strive to ensure the appropriate supports are in place (e.g., resources,
232 supplies, equipment).
- 233
234 Provide accurate legal information to providers regarding such topics as
235 scopes of practice, liability, and modification and suspension of statutes
236 and regulations during a declared emergency.

237
238 6. *Reciprocity*: Society should support those who bear a disproportionate risk in
239 protecting the public, and minimize those burdens as much as possible.

240
241 Society has an ethical responsibility to support those who face a disproportionate
242 burden in protecting the public good. During a prolonged health emergency, the
243 greatest burden will fall on public health practitioners, other health care workers,
244 and patients and their families. Health care workers will be asked to assume
245 expanded duties. They may be exposed to greater risk in the workplace, suffer
246 physical and emotional stress, and be isolated from peers and family. Individuals
247 who are quarantined or isolated may experience significant social, economic and
248 emotional burdens. Decision-makers will:

- 249
250 Engage in pre-planning to identify risks to public health practitioners.
- 251
252 Take steps to ease the burdens of health care workers, and patients and
253 their families by creating and implementing policies and practices that
254 protect their safety.

255
256 7. *Equity*: Difficult decisions will need to be made about which health services
257 should be maintained and which ones to defer. Even emergency and necessary
258 services may be limited.

259
260 During a prolonged public health emergency, tough decisions may have to be
261 made about who will receive antiviral medication and vaccinations, and which

- 262 health services will be temporarily suspended. Depending on the extent of the
263 emergency, efforts to contain the spread of a disease may result in limiting access
264 to emergency or essential services. In these circumstances, decision-makers will:
265
- 266 □ Strive to preserve as much equity as possible between the needs of patients
267 suffering from the emergency, and patients who need urgent treatment for
268 other illnesses.
 - 269
 - 270 □ Establish fair decision-making processes and criteria, taking into
271 consideration the needs of vulnerable populations.
 - 272
- 273 8. *Trust*: Trust is enhanced when there is transparency in decision-making. Trust is
274 critical to maintain under challenging circumstances.
275
- 276 Trust is an essential part of the relationship between government and citizens,
277 between health care workers and patients, between organizations and their staff,
278 between the public and health care workers, and among organizations within a
279 health system. During a prolonged health emergency, some people may perceive
280 measures to protect the public from harm (e.g., limiting access to certain health
281 services) as a betrayal of trust. In order to maintain trust under such conditions,
282 decision-makers will:
283
- 284 □ Take steps to build trust with stakeholders before the emergency occurs
285 (i.e., to engage stakeholders early).
 - 286
 - 287 □ Ensure decision-making processes are ethical and transparent.
 - 288
- 289 9. *Solidarity*: A prolonged public health emergency will alter the concept of national
290 sovereignty and territoriality, and require collaboration across borders and
291 between institutions.
292
- 293 Responding successfully to a prolonged public health emergency will require
294 solidarity among communities, health care institutions, public health
295 organizations, and governmental entities at the state and federal levels. Solidarity
296 requires straightforward communication and open collaboration within and
297 between these stakeholders to share information and coordinate health care
298 delivery. By identifying that the health of the general public and service
299 providers is a goal that is worth promoting during a health emergency,
300 government decision-makers, public health workers, and other health care
301 professionals should model the value of solidarity while encouraging others to
302 think beyond traditional ethical values focused on the rights and interests of
303 individuals.
304
- 305 10. *Stewardship*: Inherent in stewardship are the concepts of trust, ethical conduct,
306 and responsible decision-making. Decisions about allocating resources must be

307 intended to achieve the best patient and public health outcomes under the
308 circumstances.

309
310 Both institutions and individuals will be entrusted with governance over scarce
311 resources such as vaccines, anti-virals and other therapeutics, ventilators, hospital
312 beds and even health care workers. Those entrusted with governance should be
313 guided by the notion of stewardship, which includes protecting and developing
314 one's resources and being accountable for the public's well-being. To ensure
315 good stewardship of scarce resources, decision-makers will consider both the
316 benefit to the public good and equity (i.e., fair distribution of both benefits and
317 burdens).

318
319 The five "procedural values" identified in *Stand On Guard For Thee* describe
320 what the decision-making process should look like, and are:

- 321
- 322 • *Reasonable*: Decisions should be evidence-based, relevant to the health needs of the
323 community, and made by credible decision-makers.
 - 324
 - 325 • *Open and transparent*: The process of decision-making must be open to scrutiny, and
326 the reasons for decisions must be made publicly available.
 - 327
 - 328 • *Inclusive*: There should be opportunities to include stakeholders in decision-making.
 - 329
 - 330 • *Responsive*: Decisions should be revisited and revised as new information becomes
331 available; there should be an ability to address disputes and respond to complaints.
 - 332
 - 333 • *Accountable*: Decision-makers should be accountable for their conduct.
 - 334

335 In applying these substantive and procedural values, the relevant substantive
336 values for the particular circumstances should first be identified, and then decision-
337 making should employ the five procedural values. For example, in deciding whether to
338 order a quarantine, the substantive values that apply are: Individual Liberty, Protection of
339 the Public From Harm, Proportionality, Privacy, and Reciprocity.

340 The substantive value of "Individual Liberty" is applicable since quarantines
341 restrict liberty of movement. Therefore, such orders should be the least restrictive,
342 proportional and necessary, and should be applied equitably.

343 The substantive value of "Protection of the Public from Harm" is applicable since
344 quarantines impinge on individual liberty in order to protect the public. Therefore, before
345 a quarantine is ordered, the necessity should be carefully considered, the reason should be
346 clearly articulated, and there should be a review mechanism.

347 The substantive value of “Proportionality” is also relevant and requires that the
348 restriction to individual liberty not exceed what is necessary to address the risk. The
349 value of “Privacy” is relevant since the individual’s right to privacy may be infringed
350 upon by a quarantine order.

351 Finally, the substantive value of “Reciprocity” is relevant and requires that
352 measures be taken to protect health care workers and law enforcement officers who will
353 disproportionately bear a burden and risk in protecting the public by caring for those who
354 are quarantined.

355 All five of the “Procedural Values” are applicable: the decision must be
356 “Reasonable,” “Open and Transparent,” “Inclusive,” “Responsive,” and “Accountable.”
357 For a full discussion of decision-making using these principles, please see *Stand On*
358 *Guard For Thee*.

359 Connecticut’s response to a prolonged public health emergency will be based on
360 these ten substantive ethical values and the five procedural values. It is likely that more
361 than one value will be relevant in any given situation, and some values will be in tension
362 with others. This tension is the cause of ethical dilemmas that may emerge during a
363 prolonged public health emergency, and reinforces the importance of shared ethical
364 language and decision-making processes.

365 ***III. Providing Care When There Are Scarce Resources: Allocating Scarce***
366 ***Resources and Modifying Standard Practices***

367 While much emergency disaster planning has focused on increasing the surge
368 capacity of the health care system, little planning has occurred for the probability that,
369 during a prolonged public health emergency, the system will be unable to respond
370 according to established standards of care for some period of time.⁵ Standards “are
371 authoritative statements by which a profession describes the responsibilities for which
372 practitioners are accountable.”⁶ These standards of care may need to be modified during
373 such public health emergencies. Such modification is morally justified when resources
374 and manpower needed to respond to altered conditions are in insufficient supply to meet
375 system demands. Instead of a health care delivery system that routinely responds to the
376 needs of particular individuals, the system will have to maximize benefits to society as a
377 whole. Guided by the utilitarian concept of maximizing societal “good,” planners will
378

379 need to formalize procedures related to the distribution of personnel, equipment, supplies,
380 and access to care. However, a utilitarian approach, often referred to as “the greatest
381 good (utility) for the greatest number,” requires that other ethical principles be tempered
382 but not forgotten such as equity (fairness and justice), protecting the public from harm,
383 respect for personal autonomy, and accountability.⁷ Each public health emergency
384 scenario and each health care delivery site is unique, making the establishment of “altered
385 standards” in advance of a prolonged emergency, difficult.⁸ However, planning for the
386 allocation of scarce critical resources in advance of the crisis is essential.⁹

387 The Department of Public Health recognizes that facilities typically have a core
388 set of values that support their missions, *e.g.*, respect for human dignity, stewardship of
389 the community, and equal access to care, which are consistent with the values described
390 in *Stand On Guard For Thee*. This section discusses the need to allocate scarce resources
391 and makes suggestions for modifying policies and procedures pertaining to standards of
392 care that are not mandated by statutes and regulations¹⁰ in a manner that is consistent
393 with these core values.

394 Facilities should consider the ethical values described in Section II when
395 developing policies or modified standards for the allocation and provision of scarce
396 resources and/or the realignment of patient care services from meeting individual needs
397 to meeting the needs of whole populations. All policies or altered standards should be
398 applied fairly and justly – without regard to factors such as race, gender, ability to pay or
399 payer source, social worth, perceived obstacles to treatment, or past use of resources.¹¹

400 **A. *Allocating Scarce Resources***

401 A number of approaches to the allocation of scarce resources from other
402 jurisdictions and in the literature were reviewed and discussed by the workgroup.¹² *See*
403 Appendix 1. There is an emerging consensus that national guidelines should be
404 developed to establish ethical principles for allocation decisions; and, prior to a public
405 health crisis, experts and the public should be involved in the development of such
406 guidelines.¹³

407 The workgroup decided that it would adopt a set of principles to provide guidance
408 for addressing the allocation of scarce resources. It also noted that while many of the
409 existing models address only the allocation of ventilators, this workgroup’s principles are

410 applicable to planning for any emergency involving scarcities of resources, as well as the
411 withdrawal of resources. These principles are also consistent with the substantive and
412 procedural values articulated in *Stand On Guard For Thee* and adopted by the
413 workgroup, including the substantive values of protecting the public from harm,
414 proportionality, equity and stewardship, and the procedural values of reasonableness,
415 transparency, inclusivity, responsiveness and accountability.

416 Allocation of those resources necessary to provide care to the most critically
417 injured or affected by a mass casualty event requires specific attention since the resources
418 necessary to provide such care (e.g., intensive care unit beds and access to life-sustaining
419 treatment such as artificial ventilators, hemodialysis and staffing), will be scarce. The
420 workgroup determined that the following principles, which are taken from an article
421 published in CHEST Journal, *Definitive Care for the Critically Ill During a Disaster: A*
422 *Framework for Allocation of Scarce Resources in Mass Critical Care: From a Task*
423 *Force for Mass Critical Care Summit Meeting* (January 26, 27, 2007, Chicago, IL),¹⁴
424 reflect its discussions and provide a sound foundation for Connecticut institutions
425 planning for allocation decisions during times of scarce resources:

- 426
- 427 1. critical care will be rationed only after all efforts at augmentation have been
428 exceeded;
 - 429 2. limitations on critical care will be proportional to the actual shortfall in
430 resources;
 - 431 3. rationing of critical care will occur uniformly, be transparent, and abide by
432 objective medical criteria;
 - 433 4. rationing should apply equally to withholding and withdrawing life-sustaining
434 treatments based on the principle that withholding and withdrawing care are
435 ethically equivalent; and
 - 436 5. patients not eligible for critical care will continue to receive supportive medical
437 or palliative care.

438

439 Facilities are also encouraged to consider adoption of care strategies to employ
440 during or in anticipation of a scarce resource situation similar to those developed by the
441 Minnesota Healthcare Preparedness Program:¹⁵

- 442
- 443 1. **Prepare:** pre-event actions taken to minimize resource scarcity
 - 444 2. **Substitute:** use an essentially equivalent device, drug, or personnel for one that
445 would usually be available (e.g., morphine or fentanyl)

- 446 3. **Adapt:** use a device, drug, or personnel that are not equivalent but that will
447 provide sufficient care (e.g., anesthesia machine for mechanical ventilation)
448 4. **Conserve:** use less of a resource by lowering dosage or changing utilization
449 practices (e.g., minimizing use of oxygen driven nebulizers to conserve oxygen)
450 5. **Re-use:** re-use (after appropriate disinfection/sterilization) items that would
451 normally be single-use items
452 6. **Re-allocate:** take a resource from one patient and give it to a patient with a better
453 prognosis or greater need.¹⁶
454

455 The workgroup anticipates that there will be significant public comment on the
456 process of determining how allocation decisions in a prolonged public health emergency
457 should be made in Connecticut. Refinements based on public review will be incorporated
458 to provide further guidance to facilities.

459 ***B. Modifying Standard Practices Within Facilities***

460 In planning for a prolonged public health emergency, facilities should develop
461 disaster management policies and modified standards to be implemented incrementally
462 based on the need and expected benefit. Disaster management policies or modified
463 standards should be clearly communicated during a public health emergency through a
464 designated command center at each facility. Officials staffing emergency command
465 center should decide when and for how long any particular policy or modified standard
466 needs to be in effect. Potential trigger points for the implementation of modified
467 standards will be unique to each facility. Educational initiatives such as disaster drills,
468 provider education, and public education should be planned and conducted at regular
469 intervals.

470 ***1. Elective or non-urgent care***

471 Consistent with the substantive values of protecting the public from harm and
472 stewardship, facilities may consider restricting access and/or limiting services by
473 suspending non-urgent surgery or elective procedures and routine out-patient clinics and
474 other out-patient specialty operations. By doing so, facilities may increase their surge
475 capacity. In determining which health services to maintain or defer, decision-makers
476 must employ fair decision-making processes and criteria, and be cognizant of their duty
477 to be good stewards of their resources. These processes and criteria should be stated in
478 the facility's disaster plan that is formulated prior to any public health emergency.

479

479 2. *Adjusting routine care*

480 For patients already admitted to facilities prior to the public health emergency,
481 adjustments may need to be made in the frequency of their assessments and routine care,
482 e.g., a diabetic patient having four glucometer measurements each day may have them
483 done twice a day. Specific treatments or interventions that are scheduled to be
484 administered on a regular basis may have the interval between them extended. For
485 example, if a patient is scheduled to have respiratory nebulizer treatments every six
486 hours, the treatments may be reduced to every eight hours. Some treatments or
487 interventions may be discontinued completely if the potential harm to the patient is
488 minimal, if there is an absolute lack of staff to perform the task, or if no equipment is
489 available. These policies, again, must be in keeping with the substantive and procedural
490 values set forth in *Stand On Guard For Thee*, including the substantive values of
491 protecting the public from harm, proportionality, the duty to provide care, equity, and
492 stewardship. Decision-makers should strive to preserve equity between needs of patients
493 suffering from the emergency and patients who need urgent treatment for other illnesses.

494 3. *General bed management*

495 During a public health emergency, additional beds may be added to traditional
496 private and semi-private rooms. Also non-treatment areas may be utilized for patient
497 beds or cots. Those rooms where procedures have been suspended, e.g., operating rooms
498 or out-patient specialty services, may need to be utilized for emergency patients.
499 Isolation rooms and negative pressure rooms may be designated for possible expanded
500 use during a crisis. It will most likely not be possible to fully honor the substantive value
501 of ensuring physical privacy.

502 4. *Streamlining documentation*

503 Routine documentation practices (especially redundant documentation in multiple
504 sites) may be minimized during the emergency. Checklists or a “short form” medical
505 record may be developed to speed the recording of critical information, including
506 pertinent assessment, diagnosis and treatment information, including medications
507 administered. Instead of performing and documenting routine assessments, consider only
508 those assessments that are essential to monitor a particular patient’s condition.

509

509 5. *Modification of consent/refusal process*

510 The typical informed consent/refusal process has four requirements: (1) the duty
511 to disclose information such as the nature and purpose of the intervention or treatment,
512 risks, benefits, and consequences, (2) an assessment of the patient's decisional capacity,
513 (3) ensuring the voluntariness of the consent, and (4) ensuring that the patient appreciates
514 the situation and its consequences. During a prolonged public health emergency, some of
515 these requirements may need to be modified according to the condition of the patient, or
516 if there is not sufficient time to obtain the informed consent/refusal from a person
517 authorized to make health care decisions for the patient, e.g. next-of-kin, health care
518 representative, or plenary guardian.

519 6. *Emergency modification and suspension of regulatory requirements*

520 While difficult, facilities must make every attempt to comply with regulatory
521 requirements during a prolonged public health emergency and to document such attempts
522 contemporaneously. When no longer able to comply, facilities should utilize the process
523 for requesting emergency modifications and suspensions of regulatory requirements from
524 both state and federal regulatory agencies (e.g., Health Insurance Portability and Privacy
525 Accountability (HIPAA),¹⁷ provisions of the Emergency Medical Treatment and Active
526 Labor Act (EMTALA),¹⁸ staffing ratios, scope of practice restrictions). *See* Section IV
527 of this document for a discussion of modifications and suspensions of state statutes and
528 regulations; *see* web pages of federal agencies for any guidance documents they may
529 have available.

530 7. *Implementation of expanded staff roles*

531 In the clinical setting, staff may also become scarce; shortages of particular types
532 of practitioners may require expanding the roles of others. Expanded staff roles also
533 should occur incrementally and only for as long as necessary. Those performing
534 expanded roles should be under the supervision of an experienced, licensed MD or DO,
535 APRN, RN, or other person of appropriate discipline for the specific types of care, who
536 delegates and directs a team of health care workers and oversees a patient caseload.
537 Planning should incorporate volunteers who are part of the Connecticut Emergency
538 Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP)
539 system and other volunteers involved in organized efforts in the State.¹⁹ All staff should

540 receive training and drill their expanded roles, if possible. Staff and volunteers should
541 also receive just-in-time training as needed. It is not recommended that unlicensed
542 assistive personnel (e.g., medical technicians or patient care technicians) perform an
543 expanded role by working beyond the scope of their training.

544 8. *Intensive care unit utilization*

545 When resources become insufficient for the number of patients in need, a
546 standardized triage tool should be used for decision-making about which patients will be
547 admitted or discharged from the ICU based on the probability of their survival and the
548 increased demand for intensive/critical care. Use of a standardized triage tool will
549 effectuate the substantive value of equity. For example, the Sequential-related Organ
550 Failure Assessment (SOFA) is one such tool that ranks function in six body systems
551 (respiratory, hepatic, neurological, renal, cardiac, and coagulation); the score ranges from
552 1 to 24. It has been suggested that during surge capacity events, those patients with
553 SOFA scores >11 have a high probability of death and ought to be discharged from
554 critical care units and receive palliative care, those with SOFA scores between 8 and 11
555 have *intermediate* priority for critical care, and those with scores <7 have *highest* priority
556 for critical care.²⁰ The workgroup recommends the use of such a standardized triage tool
557 across hospitals in order to provide a consistent response for the public and to minimize
558 “hospital shopping.” Facilities should also consider assigning separate staff to the
559 “triage” and “treatment” functions to ensure the equity of the process and minimize the
560 burden on individual staff.²¹

561 *Summary*

562 Guided by the substantive and procedural values articulated in *Stand On Guard*
563 *For Thee*, facilities should engage in advanced planning for the allocation of scarce
564 resources and modification of standards of care during a prolonged public health
565 emergency. All policies or altered standards should be applied fairly and justly and
566 implemented incrementally according to the severity and duration of the event.
567 Educational initiatives such as disaster drills and public and provider education should be
568 included in planning. The following areas should be considered by facilities in planning:

- 569 ■ Increasing surge capacity
- 570 ■ Adjusting routine care
- 571 ■ Expanding bed capacity

- 572 ▪ Streamlining documentation
- 573 ▪ Modifying consent process
- 574 ▪ Requesting emergency modification and/or suspension of regulatory requirements
- 575 ▪ Implementing expanded staff roles
- 576 ▪ Utilizing a standardized triage tool to allocate ICU beds

577 ***C. Modifying Standard Practices within the Emergency Medical Services System***

578 During a prolonged public health emergency, the ability of the Emergency
579 Medical Services (EMS) system to continue operations “as usual” will be severely
580 hampered. Not only will the EMS system receive its usual call volume for “routine”
581 medical emergencies (e.g., heart attacks, strokes, diabetic emergencies, trauma events),
582 but it will also experience a surge in calls related to the prolonged public health
583 emergency. Consistent with the substantive values cited above, including protecting the
584 public from harm, duty to provide care, equity, and stewardship, EMS planning for
585 prolonged public health emergencies must take into consideration the need to prioritize
586 all of the demands for emergency services, and strive to preserve equity between the
587 needs of patients suffering from the public health emergency and patients who need
588 urgent treatment for other illnesses. To accomplish this task, the relationship between
589 Public Safety Answering Points (PSAPs) and Coordinated Medical Emergency Direction
590 (CMED) Centers (communication operators) and EMS providers should be
591 strengthened.²² It will be essential for communication operators to work in cooperative
592 partnerships with EMS providers to ensure that 9-1-1 calls are answered in a timely
593 manner, and that telephone triage can be accomplished safely. Hospitals and EMS
594 organizations should plan to train certified and licensed staff to perform triage for patient
595 management including transport decision-making.

596 Hospital planning for prolonged public health emergencies must include planning
597 for the provision of medical direction to EMS personnel with regard to both dispatch and
598 treatment protocols. This planning must be consistent with the substantive value of
599 stewardship, and include:

- 600 ▪ effective and equitable triage
- 601 ▪ restricting access and limiting services, as necessary, to protect both the public at
602 large and EMS providers
- 603 ▪ making decisions that accomplish the maximum good for the maximum number of
604 people

605 ▪ determining who to transport, to what location and by what means, considering the
606 nature of the emergency, available treatment, and potentially severe resource
607 shortages.

608
609 Pursuant to Title 28 of the General Statutes, the Governor may take direct operational
610 control over civil preparedness forces, including EMS once a civil preparedness
611 emergency is declared. However, the Governor may also choose not to exercise that
612 authority. In either event, EMS medical directors will likely continue to be responsible
613 for determining when and what treatment and dispatch protocols are utilized since, if the
614 Governor asserts authority over EMS, he or she will likely look to the existing system of
615 EMS medical direction for guidance.

616 In the event of a prolonged public health emergency, EMS medical directors will
617 receive guidance regarding appropriate treatment protocols from various sources
618 including the Department, the Office of Statewide Emergency Telecommunications
619 (OSET), the Connecticut EMS Medical Advisory Committee (CEMSMAC), and others.
620 Upon receipt of such guidance, medical directors should work with the Department, their
621 facilities, and regional and statewide organizations to review and revise those protocols to
622 fit the local needs. As much as possible, EMS medical directors should engage in pre-
623 planning for such protocols in conjunction with their facilities and regional and statewide
624 organizations, by identifying criteria and factors that may contribute to a decision to
625 implement altered protocols, *e.g.*, the nature of the public health emergency, hospital and
626 alternative care facility capacities, resource availability, and other hospital policies and
627 procedures. The altered protocols will provide the most good at that time for the
628 population in the affected areas.

629 1. *Expanded scopes of practice*

630 a. *Licensed providers.* Paramedics are the only providers in Connecticut who are
631 specifically licensed to provide pre-hospital care. Sponsor hospitals provide paramedics
632 with medical oversight, either directly “on-line” by radio or cell phone, or indirectly or
633 “off line” by written protocol. Paramedics’ scope of practice permits them to supervise
634 other paramedics as well as all certified EMS care providers in Connecticut. Given
635 paramedics’ enhanced education and training, and their licensed status, paramedics may
636 be utilized during a prolonged public health emergency in an expanded role. In order to

637 function in an expanded role, however, medical direction must also be enhanced. For
638 example, additional written protocols should be developed for the specific type of health
639 emergency (e.g., pandemic influenza). Such protocols should also assume shortages of
640 physicians who provide direct medical oversight and most likely would be designed as
641 “standing” orders that would not require direct medical oversight to carry them out.

642 *b. Certified providers.* Medical Response Technicians (MRTs), Emergency Medical
643 Technicians-Basic (EMT-Bs), and Emergency Medical Technicians-Intermediate (EMT-
644 Is) are all certified in Connecticut, rather than licensed. Because of the training of
645 certified EMS care providers, it is not recommended that they perform in an expanded
646 role by working beyond the scope of their certification.

647 *2. Alteration in destination.* Under normal circumstances, destination facilities for
648 9-1-1 patients are either general hospitals having a fully staffed and functional emergency
649 department or satellite emergency clinics associated with emergency departments.
650 During a prolonged public health emergency, alternative care sites may be established,
651 and planning should include the potential for patients to be transported to these sites
652 pursuant to protocols, following proper triage or medical direction from a sponsor
653 hospital. The communication operators will comply with dispatch protocols that are
654 developed by medical directors based on information they receive from various sources
655 including OSET and vendors. Planning for the transport of patients to alternative care
656 sites will be guided by the “forward movement of patients” (FMOP) plan. Under the
657 FMOP plan, communication operators will provide oversight, coordination, and
658 communication to ensure that no single hospital or region becomes overwhelmed with
659 patients from an event or on-going public health emergency. Communication operators
660 will identify and coordinate bed counts via the State Emergency Operations Center
661 (EOC) to facilitate the amendment of destination protocols at the time of the public health
662 emergency. These policies and procedures may result in restricted access or limited
663 services in order to effectuate the substantive values of protecting the public from harm,
664 the duty to provide care, equity, and stewardship. Any such policies and procedures must
665 be consistent with the procedural values of reasonableness, transparency, inclusivity,
666 responsiveness, and accountability.

667 3. *Resource utilization.* In planning for a prolonged public health emergency, the
668 EMS system, including medical direction as necessary, should plan to maximize
669 personnel use and may consider employing options such as extended shifts, non-medical
670 drivers, one-person response vehicles for patient evaluation per established protocols, and
671 use of non-traditional transport vehicles (vans, buses) to maximize transport capability.
672 Such plans could be deployed on a local or regional level by EMS medical oversight, or
673 on a statewide level by gubernatorial declaration.

674 Shortages of emergency response vehicles and staffing during a prolonged public
675 health emergency, will likely result in the temporary inability of the EMS system to serve
676 some portions of the state. Increased demands for service in any Primary Service Area
677 (PSA) will initially be managed through cooperative agreements and established mutual
678 aid agreements. As the demand becomes too great to be controlled through such
679 agreements, providers should consider combining staff from services in close proximity,
680 placing them all on the same roster, and then staffing emergency vehicles as the available
681 staffing allows.

682 Emergency care and transportation resources should be made as fluid as possible
683 within the state system to allow for the deployment of sufficient resources to meet the
684 increased needs of any service area during a public health emergency. PSA designations
685 may be suspended and reassigned, as necessary, by order of the Commissioner of Public
686 Health, upon request from the chief administrative official of a town, pursuant to §19a-
687 179-4(e) of the Regulations of Connecticut State Agencies.

688 ***IV. Modifying and Suspending Statutes and Regulations***

689 During a prolonged public health emergency, individuals providing health care
690 services in regulated facilities may be unable to adhere to the multitude of statutes and
691 regulations that apply to the delivery of such health care services. Under normal
692 circumstances, a failure to comply with these requirements could potentially result in
693 administrative, civil, and/or criminal liabilities. However, during the course of a
694 prolonged public health emergency, some of these regulatory requirements may both
695 impede the providers' ability or willingness to deliver care and also present obstacles to
696 necessary emergency response efforts.

697 Section 28-9(a) of the General Statutes provides that upon the Governor's
698 declaration of a state of civil preparedness emergency, the Governor is authorized to:

699 . . . modify or suspend in whole or in part, by order as hereinafter provided, any
700 statute, regulation or requirement or part thereof whenever in his opinion it is in
701 conflict with the efficient and expeditious execution of civil preparedness
702 functions. The governor shall specify in such order the reason or reasons
703 therefore and any statute, regulation or requirement or part thereof to be modified
704 or suspended and the period, not exceeding six months unless sooner revoked,
705 during which such order, modification or suspension shall be enforced. Any such
706 order shall have the full force and effect of law upon the filing of the full text
707 thereof in the office of the Secretary of the State. . . .
708

709 Thus, upon the declaration of a civil preparedness emergency, the Governor may
710 modify or suspend any statute or regulation, in whole or in part, if the provision conflicts
711 with the efficient and expeditious execution of civil preparedness functions. This
712 authority is critical to the efficient functioning of facilities and health care systems
713 during a prolonged public health emergency. In order to effectively implement this
714 provision, the workgroup has identified statutes and regulations for many types of
715 facilities, which may require modification or suspension. *See* Appendix 2. Requests for
716 modifications or suspensions of statutes and regulations from health care facilities will be
717 submitted to the Department of Public Health for its review and recommendation to the
718 Governor. If a request is recommended for approval by the Department, the Department
719 will submit a proposed Executive Order to the Governor for her signature. The
720 Department may also request that the Governor preemptively issue executive orders
721 before a request is received, to protect the public health and safety.

722 **A. *Identifying Provisions that May Require Modification or Suspension***

723
724 Every health care facility that anticipates experiencing a significant impact as a
725 result of a prolonged public health emergency is expected to prepare a Continuity of
726 Operations Plan (COOP). Every COOP plan should include a listing of all statutes and
727 regulations applicable to the facility that may require a modification or suspension in the
728 event of a prolonged emergency.

729 To facilitate this process, the Standards of Care workgroup has identified such
730 statutes and regulations for the following types of health care facilities:

- 731
- general and special hospitals

- 732 ▪ children's general hospitals
- 733 ▪ hospice facilities
- 734 ▪ chronic disease hospitals
- 735 ▪ residential care homes (homes for the aged and rest homes)
- 736 ▪ chronic and convalescent nursing homes and rest homes with nursing supervision
- 737 ▪ pharmaceutical services in chronic and convalescent nursing homes and rest
- 738 homes with nursing supervision

739
740 See Appendix 2.

741 The workgroup recognizes that there are additional provisions governing
742 numerous other types of health care facilities (e.g., home health and assisted living
743 service agencies, dialysis and ambulatory surgical centers) that may require modification
744 or suspension in the event of a prolonged public health emergency. The workgroup will
745 continue to develop similar lists for other types of facilities to the extent it is able.
746 However, the ultimate responsibility for identifying such statutes and regulations rests
747 with the facilities. As facilities complete such listings, they should provide them to the
748 Department of Public Health in a format similar to that utilized in this Whitepaper.

749 For each of the listings that have been compiled to date, the statutes and
750 regulations fall into the following four general subject areas: (1) staffing requirements;
751 (2) physical plant requirements; (3) documentation requirements; and, (4) reporting
752 requirements. These listings were provided to representatives of each type of facility for
753 their review and revision and are included in Appendix 2.

754 The workgroup requests that health care facilities review the listings and provide
755 the Department with any amendments they may identify. These listings should then be
756 used by facilities, to the extent they may be applicable, in the development of their COOP
757 plans.

758 ***B. Procedures for Obtaining Modifications or Suspensions of Statutes and***
759 ***Regulations***

760
761 The declaration of a civil preparedness emergency alone is not sufficient to
762 effectuate a modification or suspension of regulatory requirements. Before a statute or
763 regulation is modified or suspended, the Governor must issue an executive order.

764 With respect to certain regulatory requirements, such as those pertaining to the
765 transfer or discharge of patients or documentation of patient deaths, executive orders may
766 be drafted and issued relatively early in the course of a declared civil preparedness

767 emergency as facility resources risk becoming overwhelmed by a significant health care
768 surge, and emergency response measures rapidly require altered facility protocols.

769 Other regulatory provisions, such as those pertaining to staffing ratios or the
770 number of allowable patients per facility unit, may be communicated to the Department,
771 which will assess the request on a “real time” basis during the course of the emergency.
772 In such cases, a protocol will be established by the Department in conjunction with the
773 provider community to process facilities’ requests for modifications and suspensions of
774 statutes and regulations. The protocol will address the need to compile, assess, and
775 forward requests and recommendations to the Governor’s office, including a draft
776 Executive Order, when appropriate, and in a timely manner. Once a request has been
777 granted and filed with the Secretary of State, the Executive Order will be rapidly
778 publicized and disseminated statewide on the Governor’s and the Department’s websites
779 and through the emergency Health Alert Network (HAN). It is important to note that
780 until an executive order is issued and filed with the Secretary of State, no statutory or
781 regulatory requirement is modified or suspended.

782 ***V. Ethical Obligations To Make the Workplace As Safe As Possible and***
783 ***To Report to Work***

784
785 *Stand On Guard For Thee* identifies the substantive ethical values of “Duty to
786 Provide Care” as requiring workers to report to work during a prolonged public health
787 emergency, and “Trust” and “Reciprocity” as requiring that facilities ease the
788 disproportionate burden on those who are providing care by pre-planning to protect their
789 safety as much as possible. Regardless of any ethical duty to work, in reality, many staff
790 will *not* report to work for a variety of reasons, including the need to care for themselves
791 or sick family members; to mourn lost loved ones; to keep themselves safe; to provide
792 care for children, their elders and pets; and due to liability and other legal concerns.²³

793 The literature reflects differing opinions as to whether licensed health care
794 professionals have an absolute duty to report to work during a health emergency. States
795 that view a licensee’s duty as “absolute”²⁴ authorize government officials to *order* health
796 care professionals to work during an emergency regardless of whether they are employed
797 in clinical, non-clinical, or even non-health care settings. Connecticut has no such laws.
798 If the Department receives a complaint that a licensed health care professional has failed

799 to report to work, the Department will act consistently and will consider the totality of the
800 circumstances in each individual case and the principles and values set forth in this
801 document, in determining whether to pursue disciplinary action.

802 The willingness of all staff, regardless of whether they hold a license, to report to
803 work is critical to a successful public health response to a prolonged emergency, and
804 employers must plan to care for their workers in order to encourage them to work. By
805 engaging staff in pre-planning to address their concerns, not only will facilities satisfy
806 their ethical obligation to keep staff as safe as possible, but staff will be more likely to
807 resolve their ethical dilemma by choosing to work.²⁵

808 **A. *The physical safety of staff and their families***

809 The environment of each facility should be made as safe as possible by instituting
810 infection prevention and control measures as dictated by the circumstances, by working
811 with staff to create policies that promote staff safety, and by educating staff as to these
812 protections and policies in advance of an emergency.

813 Staff safety begins with the staff planning for their families. Facilities should
814 work with their staff to ensure that their families are prepared for a prolonged public
815 health emergency, and all staff should be assisted in developing family emergency plans.

816 Facilities should develop and implement policies to protect their staff. For
817 example, facilities may stockpile personal protective equipment (PPE) and other infection
818 control modalities, and fit and train staff to use the equipment when performing aerosol-
819 generating procedures, cardiopulmonary resuscitation, *etc.* Facilities may also have a
820 supply of anti-viral medication for staff who have inadvertent exposure to patients with
821 latent or active disease, and staff should understand the limitations of such medications.
822 Staff should understand the likelihood and timeframe for securing vaccines, anti-virals
823 and other therapeutics, their limitations, and the established priorities for their
824 administration. Other protective policies may limit the nosocomial spread of a virus by,
825 e.g., limiting access to the facility or requiring that everyone who enters wear a surgical
826 mask.

827 Policies should be developed that address workplace absences during prolonged
828 public health emergencies to care for sick family members, including leave policies and
829 policies for payment of salaries. Facilities may consider providing care for both well and

830 sick family members at the facility or at alternative care sites, and may plan for
831 transportation, housing, and dietary issues that will emerge as supporting infrastructures
832 break down.

833 Facilities may wish to implement a screening process (e.g., “fever stations”) in
834 order to screen and exclude symptomatic employees from on-site work. Sick employees
835 should stay home, and well employees who are not physically needed at the facility may
836 telecommute. All employees should have advance knowledge of the options that will be
837 available to them.

838 ***B. Legal Concerns***

839 Health care providers may have unique legal concerns about liabilities, changing
840 standards of care, and practice outside the scope of licensure during a lengthy public
841 health emergency. To alleviate these concerns, facilities may provide training *in advance*
842 of an emergency, on the legal consequences of the Governor’s declaration of an
843 emergency, as well as laws relating to liability as described in this document.

844 Liability concerns may also be lessened by the creation and implementation of
845 policies that modify standard practices for providing care during a prolonged emergency.
846 For example, facilities may identify a threshold that, when reached, will trigger a change
847 in procedures, *e.g.*, reducing the frequency of taking vital signs for non-critical patients.
848 Other suggested options are discussed in Section III of this paper.

849 Finally, staff responsible for state and federally mandated activities, should be
850 assured that state mandates concerning standards of care, scopes of practice, physical
851 plant requirements, and documentation, may and will be modified or suspended during a
852 declared emergency, and that federal mandates have been waived for previous health
853 emergencies.

854 ***Summary***

855 A facility’s success in addressing its ethical obligations to its staff will impact on
856 each employee’s decision to work during a prolonged health emergency. To minimize
857 the danger to staff, facilities may wish to consider the following measures:

- 858 • Institute uniform infection prevention and control precautions
- 859 • Require that each staff develop a family emergency plan
- 860 • Institute infection control procedures including PPE
- 861 • Train staff on hygienic measures (hand hygiene, respiratory etiquette)

- 862 • Make vaccines, anti-virals and other therapeutics available to staff on a prioritized
863 basis when they become available
- 864 • Limit the nosocomial spread of viruses by, *e.g.*, limiting access to the facility,
865 requiring that persons who enter wear surgical masks
- 866 • Create a telecommuting policy
- 867 • Create policies that balance the need to be present in the workplace with the needs
868 of staff to care for sick family members without adverse consequences
- 869 • Inform staff of steps the facility will take to support and protect its workers, and
870 of the facility's expectations during a prolonged public health emergency
- 871 • Consider the consequences of absences and incentives for working during
872 prolonged health emergencies
- 873 • Utilize a screening process to evaluate symptomatic employees (*e.g.*, fever
874 stations)
- 875 • Make staff aware of all emergency-related policies in advance, and encourage
876 them to save their sick leave to the extent they are able
- 877 • Organize child and elder care for well and sick family members of staff
- 878 • Plan for pet care
- 879 • Increase the length of work shifts; cancel vacations
- 880 • Be prepared to prioritize and shift staffing to maintain essential services
- 881 • Cross-train staff
- 882 • Create policies that address transportation, housing and dietary needs of staff
- 883 • Consider recruiting staff from non-traditional sources, *e.g.*, health science
884 students
- 885 • Discuss other staff concerns and competing obligations
- 886

887 **VI. *Liability Issues***

888 Concerns about standards of care are inextricably tied to questions of liability.
889 Additionally, it is essential that health care workers understand how liability laws as well
890 as standards of care are impacted by a declared emergency, since such standards will be
891 used to determine liability in regulatory and judicial venues.

892 The following table provides a summary of the liability protections currently in
893 place in Connecticut for individuals responding to a public health emergency.

Statute/Regulation	Description of Statute/Regulation and Waiver Requirements	Applicability
<i>Protections Under State Law</i>		
<p>Title 28: Connecticut General Statutes §28-13(a)</p>	<p>Provides immunity from liability for “death of or injury to persons or for damage to property as a result of any civil preparedness activity” except in cases of willful misconduct.</p> <p>Connecticut’s “civil preparedness” definition includes “measures to be taken after an attack, major disaster or emergency, including activities for rescue, emergency medical, health and sanitation services...” CGS §28-1(4).</p> <p>The definition of “civil preparedness forces” includes emergency medical service personnel licensed or certified under CGS §19a-179 and certain medical responders as follows: The Connecticut Disaster Medical Assistance Team (DMAT) and the Medical Reserve Corps, (MRCs) under the auspices of the Department of Public Health, the Connecticut Urban Search and Rescue team, under the auspices of the Department of Emergency Management and Homeland Security, and the Connecticut behavioral health regional crisis response teams, under the auspices of the Department of Mental Health and Addiction Services and the Department of Children and Families. CGS § 28-1(5).²⁶ Citizen Emergency Response Teams (CERTs) are civil preparedness forces according to a formal opinion from the Connecticut Attorney General’s Office.²⁷</p>	<p>This exemption from liability is applicable to the state, political subdivisions of the state, agents or representatives of the state or any political subdivision of the state and for civil preparedness forces. It also applies to anyone employed by or authorized to assist any agency of the federal government in the prevention or mitigation of any major disaster or emergency.</p> <p>Generally, the immunity from liability would be triggered by a declaration by the Governor. The Governor is authorized to take control of civil preparedness forces and functions after declaring a civil preparedness emergency. CGS §28-9. However, the civil preparedness forces definition specifically states that immunity from liability is available for certain personnel for training activities, which would occur in the absence of a declaration. CGS §28-1(5).</p> <p>While these definitions do include certain specified medical health providers, including emergency medical service personnel, in the liability exemptions under Title 28, health care providers caring for patients in institutions or alternate care facilities in a prolonged health care emergency do not appear to be within the definition of civil preparedness forces performing civil preparedness activities.</p>

<p>Public Health Emergency Preparedness Authority (PHERA) CGS §19a-131 et seq.</p>	<p>Under a declared public health emergency, CGS §19a-131i provides immunity from personal liability to persons acting on behalf of the state within the scope of such person’s practice or profession and pursuant to sections 19a-131 to 19a-131h, inclusive as long as their actions are not wanton, reckless or malicious, and written consent has been obtained for vaccinations.</p>	<p>Governor declares a public health emergency under CGS §19a-131a. This provision does not encompass health care facilities and providers within such facilities providing health care to patients unless they are acting on behalf of the state to implement an order issued pursuant to the public health emergency response plan developed under PHERA. Public health response does not encompass the provision of individual patient care within the private medical system.</p>
<p>Connecticut Good Samaritan Law: CGS §52-557b</p>	<p>CGS §52-557b(a) states that certain persons including but not limited to licensed doctors and dentists, registered nurses and licensed practical nurses, or medical technicians or persons “operating a cardiopulmonary resuscitator or an automatic external defibrillator” under American Red Cross or American Heart Association standards, who provide emergency medical or professional assistance voluntarily and without compensation and “other than in the ordinary course of such person’s employment or practice” shall not be held civilly liable for injuries caused by negligence. Gross, willful or wanton negligent acts or omissions causing injury are not protected.</p>	<p>Does not require an emergency declaration to be triggered. The Good Samaritan Law only protects practitioners or other trained persons who provide emergency assistance other than in the ordinary course of their employment, i.e., in a volunteer and unpaid capacity. It does not apply to health care facilities or to health care practitioners who are providing services for which they are employed, even though the services may be provided in circumstances such as a declared civil preparedness or public health emergency.</p>
<p>Protections Under Federal Law</p>		
<p>Public Readiness and Emergency Preparedness Act (PREP Act): 42 U.S.C. 247d-6d</p>	<p>The PREP Act provides immunity from liability, except for acts of willful misconduct, for the manufacture, testing, development, distribution, or use of a “covered countermeasure.” Pandemic countermeasure influenza A (H5N1) vaccine was declared a covered countermeasure by the Secretary of the Department of Health and Human Services, effective on December 1, 2006 and extending through February 28, 2010. In addition to manufacturers and distributors of the countermeasure, “a licensed individual who is</p>	<p>Provides limited immunity from suit under Federal and State law</p> <ul style="list-style-type: none"> • to persons involved in among other things, dispensing, prescribing (doctors), administration and use (first responders and healthcare professionals) • of countermeasures (FDA-regulated products: vaccines, drugs, medical devices) and • to persons who are program planners – city officials, Governors

	<p>authorized to prescribe, administer, or dispense the countermeasure under the law of the state in which such Covered Countermeasure was prescribed, administered or dispensed” is a “qualified person” for purposes of the PREP Act liability exemption. Under the PREP Act, liability immunity is provided to licensed providers administering the H1N1 vaccine.</p>	<p>– for claims arising out of, related to, or resulting from the administration or the use of the countermeasure – if a declaration has been issued for the countermeasure.</p>
<p>Volunteer Protection Act: 42 U.S.C. §14501</p>	<p>The Volunteer Protection Act of 1997 is a federal law, which extends immunity to volunteers for nonprofit organizations and governmental entities. It protects volunteers (defined as uncompensated except for reimbursement for costs) from economic damages and limits losses for noneconomic and punitive damages provided the volunteer was acting within scope of responsibilities; if appropriate, is properly licensed, certified or authorized by state authorities; and the harm was not caused through willful, reckless or criminal conduct, gross negligence or gross indifference.</p>	<p>Does not require an emergency declaration to apply. Does not provide protection to the organization. Does not provide protection for personnel who are compensated for their services.</p>
<p>Federal Tort Claims Act (FTCA): 28 U.S.C. §§ 1346(b), 2401(b), 2671-80.</p>	<p>Since 2002, federal law has extended the Federal Tort Claims Act (FTCA), which assures that health care professionals who volunteer during a federally declared Homeland Security disaster are covered under the Act so long as the individual is, or can be considered, a Federal employee. In extending the definition of a federal employee, the FTCA covers health care professionals who register with Emergency Management Assistance Compacts (EMAC) or Federal initiatives (e.g., National Disaster Medical System) for services rendered under these authorities. 28 U.S.C. §§ 1346(b), 2401(b), 2671-80. (2006).</p>	<p>This immunity is only applicable to health professionals who volunteer to assist during a federally declared Homeland Security disaster.</p>

894 In planning for prolonged public health emergencies characterized by scarcities of
895 resources and increasing demands for services, facilities must, nevertheless, plan to
896 provide the “level of care, skill and treatment which, *in light of all relevant surrounding*
897 *circumstances*, is recognized as acceptable and appropriate by reasonably prudent similar
898 health care providers.” Emphasis added, § 52-184c of the General Statutes. This
899 whitepaper is intended to provide guidance for planning to provide an acceptable
900 standard of care under the circumstances of a prolonged public health emergency. In its
901 capacity as a regulatory agency, the Department will consider the whitepaper guidance
902 and a provider’s adherence to it when it investigates any complaint related to care
903 provided under such circumstances. However, there is no guarantee that a court will
904 accept adherence to the whitepaper guidance as a defense against liability in any lawsuit
905 arising from emergency care.
906

Glossary

Aerosol-generating procedures - Procedures that stimulate coughing and promote the generation of aerosols. <http://www.cdc.gov/ncidod/sars/guidance/i/pdf/healthcare.pdf>

Anti-virals – An agent that suppresses the ability of a virus to replicate and, hence, inhibits its capacity to multiply and reproduce. Lehne, R.A., *Pharmacology* (6th Ed.), St. Louis, Missouri: Saunders/Elsevier (2007).

Critical care - Constant complex health care as provided for various acute life-threatening conditions such as multiple trauma, severe burns, myocardial infarction or after certain kinds of surgery. Care is most frequently provided by specially trained personnel in a unit equipped with technologically sophisticated devices for treating and monitoring the condition of the patient. Also called *intensive care*. Mosby's Medical Dictionary, 8th edition. 2009, Elsevier.

Emergency Health Alert Network (HAN)– A nationwide information and communications system that links together local, state and federal health agencies to protect communities from bio-terrorism and other health threats.
https://www.han.ct.gov/local_health/han.asp?bar=5

Executive order - An order issued by or on behalf of the executive of the State, usually intended to direct or instruct the actions of executive agencies or government officials, or to set policies for the executive branch to follow. Black's Law Dictionary (8th ed. 2004).

Fever stations – A screening checkpoint that healthcare facilities may employ in order to exclude symptomatic employees from entering the premises.

Isolation/negative pressure rooms – Treatment rooms that are specifically designed to prevent the flow of air from the room into the corridors and common areas where susceptible persons may be exposed, through the use of fans and vents that direct the airflow outside of the building and/or through HEPA filters.
<http://www.med.yale.edu/ynhh/infection/airborne/airborne.html>

Oxygen driven nebulizers - A device used to reduce liquid to an extremely fine cloud, especially for delivering medication to the deep part of the respiratory tract. The American Heritage Medical Dictionary 2007 Houghton Mifflin Company.

Personal Protective Equipment (PPEs)– Equipment designed to protect the wearer from exposure to hazards. Examples include gloves, gown, respiratory protection, and eye protection.
<http://www.cdc.gov/ncidod/sars/guidance/i/pdf/healthcare.pdf>

Sequential Organ Failure Assessment (SOFA) - A tool used to score an individual's organ dysfunction in six categories (respiratory, coagulation, liver, cardiovascular, central nervous system, and renal). Each category has a score range from 0 – 4; the higher the score, the more severe the organ dysfunction. Ferreira, F.L., Daliana, P.B., Bross, A.,

Melot, C., Vincent, J.L. “Serial evaluation of the SOFA score to predict outcome in critically ill patients,” *JAMA*, 286(14), 1754-1758 (2001).

Standardized triage tool – A method of ranking sick or injured people according to the severity of their sickness or injury in order to ensure that medical and nursing staff facilities are used most efficiently; assessment of injury intensity and the immediacy or urgency for medical attention. McGraw-Hill Concise Dictionary of Modern Medicine. 2002, The McGraw-Hill Companies, Inc.

Surge Capacity – The ability of a health care system to expand rapidly to meet an increased demand for qualified personnel, medical care, and public health services in response to sudden or prolonged demands resulting from bioterrorism or other large-scale public health emergencies or disasters.

<http://www.ahrq.gov/news/ulp/btsurgemass/masscastr.htm>

Draft

Appendix 1
Literature Re: The Allocation of Scarce Resources

1. *NYS Workgroup on Ventilator Allocation in an Influenza Pandemic: Draft for Public Comment: March 15, 2007:*
http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator_guidance.pdf

Presents a framework, including exclusion criteria, for the allocation of ventilators.

2. *Ontario Health Plan for an Influenza Pandemic, August 2008:*
www.health.gov.on.ca/english/providers/program/emu/pan_flu/ohpip2/ch_17a.pdf

Describes a triage tool based, in part, on Sepsis-related Organ Failure Assessment (SOFA); provides inclusion and exclusion criteria based on Minimum Qualifications for Survival (MQS); relies upon a central triage committee.

3. *Minnesota Department of Health*

Describes strategies for allocating scarce resource including oxygen, medication administration, hemodynamic support and IV, nutrition, staffing and mechanical ventilation. www.health.state.mn.us/oep/healthcare

4. *CHEST Article: Definitive Care for the Critically Ill During a Disaster: A Framework for Allocation of Scarce Resources in Mass Critical Care: From a Task Force for Mass Critical Care Summit Meeting, January 26, 27, 2007, Chicago, IL:*
http://chestjournal.org/cgi/content/abstract/133/5_suppl/51S

Focuses on tertiary triage based on objective and quantitative criteria. The triage algorithm is composed of three components: the inclusion criteria, the exclusion criteria, and prioritization of care. No appeal process but suggests a review committee

5. *California Department of Public Health: Scarce Resource Allocation, pp. 73- 81.*
http://bepreparedcalifornia.ca.gov/NR/rdonlyres/52B36F50-E74A-441E-9638-AE1FDD19124F/0/FoundationalKnowledge_FINAL.pdf

Extracts guidelines from a number of sources, including the 1993 American Medical Association publication of *Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients Allocation of Ventilators for Pandemic Influenza*, issued in draft by the New York State (NYS) Task Force on Life and the Law in March 2007; *Concept of Operations for Triage of Mechanical Ventilation in an Epidemic*, Hick et al., *Academy of Emergency Medicine* (2006), 13:223-229; the Ontario Health Plan for an Influenza Pandemic (OHPIP) protocol, which utilizes SOFA for ethical guidance for both acceptable and the inappropriate criteria for making resource allocation decisions during a healthcare surge emergency.

*Appendix 2 –
Statutes and Regulations That May Require
A Waiver or Modification by Executive Order*

SHORT-TERM HOSPITALS

The following statutes and regulations may require a waiver or modification from the Governor in the event of a declared emergency under Title 28 of Connecticut's General Statutes. These waivers may be required if facilities experience a reduction in staffing due to absences, if hospital-based health professionals are required to work at other locations and/or if health facilities experience a significant health care surge during a public health emergency.

1. GENERAL & SPECIAL HOSPITALS

A. STAFFING REQUIREMENTS

1. **P.H.C. §19-13-D3(c)**: Minimum medical staffing requirements and ratios of staff to patients.
2. **P.H.C. §19-13-D3(e)**: Requirements and staffing ratios for nursing services.
3. **P.H.C. §19-13-D3(g)**: Requirements for pharmaceutical services.
4. **P.H.C. §19-13-D3(l)**: Requirements for the surveillance, prevention, control and investigation of infections and communicable diseases.
5. **P.H.C. §19-13-D3(d)**: Requirements for contents of medical records and medical records department.
6. **P.H.C. §19-13-D3(h)**: Requirements for appropriate dietary services.
7. **P.H.C. §19-13-D3(j)**: Requires that essential services be maintained during a disaster and similar emergency situation and that there be adequate care for persons with acute emergencies at all hours.
8. **P.H.C. §19-13-D3(k)**: Requirements for procedures to be carried out for each case **admitted to a maternity service**.
9. **C.G.S. § 19a-490l**: Mandatory limits on overtime for nurses working in hospitals.

B. PHYSICAL PLANT REQUIREMENTS

1. **P.H.C. §19-13-D3(a)(1)-(4)**: Physical plant requirements; fire safety requirements; requirements for explosive gas and radioactive materials; good repair and cleanliness of facilities.
2. **P.H.C. §19-13-D3(a)(5)**: Requirements for structure, rooms and beds for in-patient maternity service and labor and delivery units.
3. **P.H.C. §19-13-D3(f)**: Requires a clinical laboratory, blood bank, pathological services, radiology department and on-site operating room in diagnostic and therapeutic facilities.

4. **P.H.C. §19-13-D3(g):** Requires clean, adequately lighted, and ventilated pharmacy facilities and that all pharmacy drugs, disinfecting solutions and preparation be distinctly and correctly labeled and readily available for inspection.
5. **P.H.C. §19-13-D3(i):** Requirements for adequate laundry, housekeeping and maintenance services, proper heat, hot water, lighting and ventilation, sufficient communication system; maintenance of hospital shall be such as reasonably to ensure the health, comfort and safety of patients at all times; prompt removal of a deceased patient to an unoccupied room, and available room to provide for dignified holding of the body.
6. **C.G.S. § 19a-30:** Clinical laboratories. Regulation and licensure. Proficiency standards for tests not performed in laboratories.

C. REPORTING REQUIREMENTS

1. **P.H.C. §19-13-D3(k)(5):** Requires indication of postpartum maternity infection to be reported immediately to the physicians responsible for the care of the maternity patient and her newborn infant. Requires isolation of contagious, infected obstetrical patients and infants.
2. **C.G.S. §19a-510a:** Reporting requirements for treatment of burn injuries or injuries from fireworks.
3. **C.G.S. §19a-127n:** Adverse event reporting requirements.

D. DOCUMENTATION REQUIREMENTS

1. **P.H.C. §19-13-D3(d):** Requirements for medical records and medical records department.
2. **P.H.C. §19-13-D3(k):** Documentation and reporting requirement for maternity service.
3. **P.H.C. §19-13-D3(1)(I)(B):** Requirements for infection incident log.
4. **P.H.C. §§7-62-2 & 7-62-3:** Documentation requirements for anticipation of death and/or pronouncement of death by physician or registered nurse.
5. **C.G.S. §7-48:** Filing requirements for birth certificates.
6. **C.G.S. §7-49:** Penalties for failure to timely file birth certificates.
7. **C.G.S. §7-60:** Registration of fetal death certificates.
8. **C.G.S. §7-62b(c):** Requirements for the completion and signing of death certificates within 24 hours after death.
9. **C.G.S. § 19a-509e:** Protocol required to address patients showing symptoms of substance abuse.
10. **C.G.S. § 19a-509d:** Transcription, execution and countersigning of verbal medication orders.

2. *CHILDREN'S GENERAL*

A. *STAFFING REQUIREMENTS*

1. **P.H.C. §19-13-D4a(b):** requires minimum governing board duties/requirements, and hospital administrator's duties; Personnel shall be employed in sufficient numbers and of adequate qualifications to efficiently perform hospital functions.
2. **P.H.C. §19-13-D4a(c):** Medical staffing requirements and ratios of staff to patients.
3. **P.H.C. §19-13-D4a(d):** Requirement for medical records department and contents of medical record.
4. **P.H.C. §19-13-D4a(e):** Requirements and staffing ratios for nursing services.
5. **P.H.C. §19-13-D4a(f):** Requires facilities, equipment and qualified personnel for necessary diagnostic and therapeutic procedures, including a clinical laboratory, pathology services, a radiology department and an operating room for diagnostic and therapeutic facilities.
6. **P.H.C. §19-13-D4a(g):** Requirements for hospital pharmaceutical services.
7. **P.H.C. §19-13-D4a(h):** Requirements for appropriate dietary services.
8. **P.H.C. §19-13-D4a(j):** Requires provisions to be made to maintain essential services during disaster and emergency situations.
9. **P.H.C. §19-13-D3(l):** Requirements for the surveillance, prevention, control and investigation of infections and communicable diseases.
10. **C.G.S. § 19a-490l:** Mandatory limits on overtime for nurses working in hospitals.

B. *PHYSICAL PLANT REQUIREMENTS*

1. **P.H.C. §19-13-D4a(a)(1):** Requires hospital buildings to have adequate space and proper equipment for patient accommodations and service.
2. **P.H.C. §19-13-D4a(a)(2):** Requires buildings and equipment to meet state fire safety code requirements.
3. **P.H.C. §19-13-D4a(a)(3):** Requires hospitals to meet DPH requirements for explosive gas and radioactive materials areas.
4. **P.H.C. §19-13-D4a(a)(4):** Requires buildings and equipment be in good repair and kept clean.
5. **P.H.C. §19-13-D4a(g)(3):** Requires hospital pharmacy to be clean, adequately lighted and ventilated, and the equipment and facilities maintained in good order.
6. **P.H.C. §19-13-D4a(i):** Requirements for adequate laundry, housekeeping and maintenance services, proper heat, hot water, lighting and ventilation, sufficient communication system; maintenance of hospital shall be such as reasonably to ensure the health, comfort and safety of patients at all times.

C. *REPORTING REQUIREMENTS*

1. **P.H.C. §19-13-D4a(i)(7):** Requires reports of suicides, accidents, or injuries which may result in permanent defect, scar, or handicap be made to DPH within twenty-four hours.
2. **C.G.S. §19a-510a:** Reporting requirements for treatment of burn injuries or injuries from fireworks.
3. **C.G.S. §19a-127n:** Adverse event reporting requirements.

D. *DOCUMENTATION REQUIREMENTS*

1. **P.H.C. §19-13-D4a(c)(4)(D):** Requires medical records for psychiatric patients to include a psychiatric examination recorded within seven days of admission.
2. **P.H.C. §19-13-D4a(d):** Requirements for medical records and medical records department.
3. **P.H.C. §§7-62-2 & 7-62-3:** Documentation requirements for anticipation of death and/or pronouncement of death by physician or registered nurse.
4. **C.G.S. §7-48:** Filing requirements for birth certificates.
5. **C.G.S. §7-49:** Penalties for failure to timely file birth certificates.
6. **C.G.S. §7-60:** Registration of fetal death certificates.
7. **C.G.S. §7-62b(c):** Requirements for the completion and signing of death certificates within 24 hours after death.
8. **C.G.S. § 19a-509e:** Protocol required to address patients showing symptoms of substance abuse.
9. **C.G.S. §19a-509d:** Transcription, execution and countersigning of verbal medication orders.

3. *SPECIAL, HOSPICE*

A. *STAFFING REQUIREMENTS*

1. **P.H.C. §19-13-D4b(b):** Requirements for structure of hospice administration.
2. **P.H.C. §19-13-D4b(c):** Medical staff requirements.
3. **P.H.C. §19-13-D4b(d):** Requirement for medical records department and contents of medical record.
4. **P.H.C. §19-13-D4b(e):** Requirements for nursing services and nursing service staff ratios.
5. **P.H.C. §19-13-D4b(f)(4):** Requires an organized pharmaceutical service with licensed pharmacist, an active medical staff committee to serve in advisory capacity for matters of drugs and drug practices.
6. **P.H.C. §19-13-D4b(g):** Requirements for social work department and staff; continuing education programs.
7. **P.H.C. §19-13-D4b(h)(1):** Requires pastoral service with twenty-four hour on-call availability.
8. **P.H.C. §19-13-D4b(i):** Requires designated staff to provide patients and families with experiences in the arts.

9. **P.H.C. §19-13-D4b(j):** Requires director of volunteer service to be employed full time to plan, organize and direct comprehensive volunteer services.
10. **P.H.C. §19-13-D4b(k):** Requires diagnostic and palliative services including a clinical laboratory, radiological services, and potentially blood bank and pathological services, with twenty-four hour on-call availability.
11. **P.H.C. §19-13-D4b(n):** Requirements for dietary services.
12. **P.H.C. §19-13-D4b(o):** Requirements for hospice-based home care programs.
13. **P.H.C. §19-13-D4b(p):** Requirements for the surveillance, prevention, control and investigation of infections and communicable diseases.
14. **P.H.C. §19-13-D4b(q)(1):** Requires adequate laundry service, housekeeping and maintenance services.
15. **P.H.C. §19-13-D3(l):** Requirements for the surveillance, prevention, control and investigation of infections and communicable diseases.
16. **C.G.S. § 19a-490l:** Mandatory limits on overtime for nurses working in hospitals.

B. PHYSICAL PLANT REQUIREMENTS

1. **P.H.C. §19-13-D4b(a)(1)-(5):** Physical plant requirements; fire protection association standards; requires buildings and equipment be of good repair, with adequate maintenance to ensure cleanliness and order; requires that hospice facilities avoid an institutional atmosphere and be as homelike as practicable; handicapped accessibility; requires waivers from DPH for deviation from service requirements.
2. **P.H.C. §19-13-D4b(a)(6):** Nursing unit and patient room requirements
3. **P.H.C. §19-13-D4b(a)(7):** Requires nursing units to satisfy specific requirements regarding service areas; *e.g.*, single patient isolation rooms, public telephones and drinking fountains.
4. **P.H.C. §19-13-D4b(a)(8):** Requires certain construction requirements be met.
5. **P.H.C. §19-13-D4b(a)(9):** Requires certain mechanical system requirements be met.
6. **P.H.C. §19-13-D4b(a)(10):** Requires certain electrical system requirements be met (*e.g.*, subsection (D)(2) (patient room lighting); subsection (E)(1) (number of grounding type receptacles per bed)).
7. **P.H.C. §19-13-D4b(q)** Requires proper heat, hot water, lighting and ventilation; requires that hospice ensure the health, comfort and safety of patients at all times; Upon patient's death, body shall be moved to bereavement room in the same institution pending pronouncement of death by a physician. A room must be available where only family and friends may view the body.

C. REPORTING REQUIREMENTS

1. **C.G.S. Sec. 19a-127n:** Adverse event reporting requirements.

D. DOCUMENTATION REQUIREMENTS

1. **P.H.C. §19-13-D4b(d)**: Requirements for medical records and medical records department.
2. **P.H.C. §19-13-D4b(f)(5)**: Requires an organized pharmaceutical service with written policy and procedures manual.
3. **P.H.C. §19-13-D4b(l) and (m)**: Requires written plans for respiratory care services and rehabilitative services, including a procedure for reporting problem areas to the administrator, recommendations, solutions, and identify action taken.
4. **P.H.C. §19-13-D4b(n)(2) and (3)**: Requires written policies/procedures for all dietetic activities; dietitian shall record nutritional histories, food habits, dietary counseling of patients.
5. **P.H.C. §19-13-D4b(t)**: Requires that all records, memos, and reports be maintained on the hospice premises as a condition for the initial issuance of or retention/renewal of a license to any person to operate and maintain a hospice.
6. **P.H.C. §§7-62-2 & 7-62-3**: Documentation requirements for anticipation of death and/or pronouncement of death by physician or registered nurse.
7. **C.G.S. §7-62b(c)**: Requirements for the completion and signing of death certificates within 24 hours after death.
8. **C.G.S. § 19a-509e**: Protocol required for patients with symptoms of substance abuse.
9. **C.G.S. §19a-509d**: Transcription and execution, countersigning of verbal medication orders.

LONG-TERM HOSPITALS

The following statutes and regulations may require a waiver or modification from the Governor in the event of a declared emergency under Title 28 of Connecticut's General Statutes. These waivers may be required if facilities experience a reduction in staffing due to absences, if facility health professionals are required to work at other locations and/or if health facilities experience a significant health care surge during a public health emergency.

1. CHRONIC DISEASE HOSPITALS

A. STAFFING REQUIREMENTS

1. **P.H.C. § 19-13-D5(b)**: Requires the hospital to be managed by a governing Board and administrator and sets forth its minimum duties; personnel shall be employed in sufficient numbers and of adequate qualifications that the functions of the hospital may be performed effectively.

2. **P.H.C. § 19-13-D5(c):** Requirements for medical staff organization; rules and regulations; requires monthly medical staff conferences to be attended by at least seventy-five percent of active staff members.
3. **P.H.C. §19-13-D5(e):** Requirements for nursing services and nursing service staff ratios.
4. **P.H.C. §19-13-D5(g):** Requirements for pharmaceutical services.
5. **P.H.C. §19-13-D5(h):** Requirements for appropriate dietary services.
6. **P.H.C. §19-13-D5(d):** Requirements for medical records department and medical records.
7. **P.H.C. §19-13-D5(l):** Requirements for the surveillance, prevention, control and investigation of infections and communicable diseases.
8. **C.G.S. § 19a-490l:** Mandatory limits on overtime for nurses working in hospitals.

B. PHYSICAL PLANT REQUIREMENTS

1. **P.H.C. § 19-13-D5(a):** Requires that hospital buildings have adequate space and equipment, and buildings meet the requirements of the state fire safety code; hospitals to meet DPH requirements for explosive gas and radioactive materials areas, and requires that buildings and equipment be in good repair and kept clean at all times.
2. **P.H.C. §19-13-D5(f):** Requires that facilities, equipment and qualified personnel be provided for diagnostic and therapeutic procedures, including a clinical laboratory and radiological services and provision for surgical and pathological services.
3. **P.H.C. §19-13-D5(g)(2)-(4):** Requires that the hospital pharmacy comply with state and federal drug laws, be maintained in good order, adequately lighted and ventilated.
4. **P.H.C. §19-13-D5(i):** Requires adequate laundry, housekeeping and maintenance services, proper heat, hot water, lighting and ventilation, and a sufficient communication system; when a patient dies, the body shall be moved promptly to an unoccupied room in the same institution, and the facility shall make a room available for so that the body is not exposed to the view of patients or visitors.
5. **P.H.C. §19-13-D5(k)(2):** Requires that provision be made for physical and occupational therapy and supervised recreational activities.

C. REPORTING REQUIREMENTS

1. **C.G.S. §19a-127n:** Adverse event reporting requirements.
2. **C.G.S. §19a-535b(b):** Requires that in the case of an involuntary transfer or discharge, the patient and, if known, the patient's legally liable relative, guardian or conservator and the patient's personal physician, if the discharge plan is prepared by the medical director of the chronic disease hospital, shall be given at least thirty days written notice of the proposed action to ensure orderly transfer or discharge.

D. DOCUMENTATION REQUIREMENTS

1. **P.H.C. § 19-13-D5(c)(2):** Requires that medical staff adopt written rules and regulations to govern its activities.
2. **P.H.C. §19-13-D5(d):** Requirements for medical records and medical records department.
3. **P.H.C. §19-13-D5(l)(9):** Requires that the minutes of the hospital infection control committee shall document the review and evaluation of data and development and revision of measures for infection control.
4. **P.H.C. §§7-62-2 & 7-62-3:** Documentation requirements for anticipation of death and/or pronouncement of death by physician or registered nurse.
5. **C.G.S. §7-62b(c):** Requirements for the completion and signing of death certificates within 24 hours after death.
6. **C.G.S. § 19a-509d:** Transcription, execution and countersigning of verbal medication orders.
7. **C.G.S. § 19a-509e:** Protocol for patients with symptoms of substance abuse.
8. **C.G.S. § 19a-535b(b):** Requires that a facility shall not transfer/discharge a patient from the facility except for medical reasons, patient welfare or welfare of other patients, as documented in the patient's medical record.

2. RESIDENTIAL CARE HOMES (HOMES FOR THE AGED AND REST HOMES)

A. STAFFING REQUIREMENTS

1. **P.H.C. § 19-13-D6(e):**Requirements for appropriate dietary services.
2. **P.H.C. § 19-13-D6(j):** Requires no less than 1 attendant per 25 residents, or fraction thereof, from 7 a.m. to 10 p.m. and from 10 p.m. to 7 a.m.
3. **P.H.C. § 19-13-D6(m):** Requirements for medication administration.
4. **C.G.S. § 19a-535:** Restrictions on the transfer or discharge of patients; notice and plan requirements; appeal rights.

B. PHYSICAL PLANT REQUIREMENTS

1. **P.H.C. § 19-13-D6(b)(A):** Requirements for a safe, sanitary, and comfortable environment; that site be away from nuisances; other site specifications; articulates minimum services required per physical plant (lobby, dining areas, lounges, laundry facilities, etc.)
2. **P.H.C. § 19-13-D6(b)(B):** Stipulates minimum residential room requirement (clear floor area, beds, dimensions, furnishings, etc.).
3. **P.H.C. § 19-13-D6(b)(C):** Requirements for resident baths.
4. **P.H.C. § 19-13-D6(b)(D):** Requirements for resident toilet rooms.
5. **P.H.C. § 19-13-D6(b)(E):** Requires each resident wing/floor contain at least one lounge area of 225 square feet or 9 square feet per resident, whichever is greater.

6. **P.H.C. § 19-13-D6(b)(F):** Requires dining and recreation rooms be no less than 30 square feet per resident bed (subsect.1), have storage space to conveniently store equipment and supplies (subsect. 2(c)), and have accessible toilet and hand washing facilities (subsect. 2(d)).
7. **P.H.C. § 19-13-D6(b)(G):** Requires a resident recreation area which, if separated from dining area, contains 15 square feet per resident, and 10 square feet per resident for outdoor porches or paved patios.
8. **P.H.C. § 19-13-D6(b)(H):** Requirements for dietary facilities.
9. **P.H.C. § 19-13-D6(b)(I):** Requirements for central storage rooms.
10. **P.H.C. § 19-13-D6(b)(J):** Requirements for laundry services.
11. **P.H.C. § 19-13-D6(b)(K):** Requirements for separate employee facilities.
12. **P.H.C. § 19-13-D6(b)(L):** Requires details of building/room construction.
13. **P.H.C. § 19-13-D6(b)(M):** Requirements for mechanical systems; HVAC specifications.
14. **P.H.C. § 19-13-D6(b)(N):** Electrical system/calling station requirements.
15. **P.H.C. § 19-13-D6(b)(O):** Requirements for emergency electrical service.
16. **P.H.C. § 19-13-D6(b)(Q):** Requires that each resident room be numbered; number and licensed room capacity posted by each door, census not to exceed the number for which the license is issued, nor shall the number of residents in any room exceed licensed capacity.
17. **P.H.C. § 19-13-D6(b)(S):** Requires the site be kept clean and in good repair at all times.
18. **P.H.C. § 19-13-D6(f):** Requirements for available recreational activities.
19. **P.H.C. § 19-13-D6(g):** Requires certain general conditions be met; e.g., relating to heat, hot water, lighting, ventilation, communication systems, housekeeping, laundry and maintenance, and protocol upon death of a patient.
20. **P.H.C. § 19-13-D6(i):** Requires that in combustible buildings the third floor above the basement shall not be converted to resident use unless a passenger elevator is installed to serve each floor.

C. REPORTING REQUIREMENTS

1. **P.H.C. §19-13-D6(g)(3):** Requires that any accident, disaster or other unusual occurrence in the institution be reported within seventy-two hours to the state department of health.
2. **P.H.C. § 19-13-D6(g)(7):** Requires that the facility immediately notify the department if the licensee plans structural changes, plans to sell, or discontinue operation.
3. **P.H.C. § 19-13-D6(m)(2)(E)(iii):** Requires that significant medication errors shall be reported in writing within seventy-two hours to the department.

D. DOCUMENTATION REQUIREMENTS

1. **P.H.C. § 19-13-D6(c):** Administration specifications and requirements; e.g., employee orientation and continuing education records.

2. **P.H.C. §19-13-D6(d):** Requires there be a record of each resident, to include the name, residence, age, sex, nearest relative, religion, etc. kept on forms approved by the state department of health.
3. **P.H.C. § 19-13-D6(m):** Requirements in documentation and administration of medications; medication recordkeeping requirements.
4. **P.H.C. §§7-62-2 & 7-62-3:** Documentation requirements for anticipation of death and/or pronouncement of death by physician or registered nurse.
5. **C.G.S. §7-62b(c):** Requirements for the completion and signing of death certificates within 24 hours after death.
6. **C.G.S. § 19a-509d:** Transcription, execution and countersigning of verbal medication orders.

3. ***CHRONIC AND CONVALESCENT NURSING HOMES AND REST HOMES WITH NURSING SUPERVISION***

A. ***STAFFING REQUIREMENTS***

1. **P.H.C. §19-13-D8t(d):** General condition requirements, including requirements for patient admissions, visiting hours, pronouncement of death and medication administration.
2. **P.H.C. § 19-13-D8t(f):** Requirements for facility administrator, including requirements that administrator serve full time and be on 24 hour call in a chronic and convalescent nursing home with 45 or more licensed beds, and a rest home with nursing supervision with 60 or more licensed beds and that the administrator may not serve as director of nurses, except for a facility with 29 beds or less.
3. **P.H.C. § 19-13-D8t(h):** Specifies eligibility and duties for medical director position.
4. **P.H.C. § 19-13-D8t(i):** Medical staff requirements, including that there be no less than 3 physicians at the facility and requirements for active organized medical staff members.
5. **P.H.C. § 19-13-D8t(j):** Sets forth the qualifications and responsibilities of the director of nurses and requires there be an assistant director of nurses in any facility of 120 beds or more.
6. **P.H.C. § 19-13-D8t(l):** Requirements for nurses aide training and responsibilities.
7. **P.H.C. § 19-13-D8t(m):** Requirements for nursing services and nursing service staff ratios.
8. **P.H.C. § 19-13-D8t(n):** Requirements for the provision of medical and professional services.
9. **P.H.C. § 19-13-D8t(q):** Requirements for the provision of adequate dietary services.
10. **P.H.C. § 19-13-D8t(r)(3):** Requires each facility to employ therapeutic recreation director to meet specified ratio of hours of recreation per week to number of licensed beds in the facility.
11. **P.H.C. § 19-13-D8t(s):** Requirements and ratios for social work service staff.

12. **P.H.C. § 19-13-D8t(t):** Infection control committee and surveillance program.
13. **P.H.C. § 19-13-D8u:** Requirements for intravenous therapy programs in chronic and convalescent nursing homes and rest homes with nursing supervision.
14. **P.H.C. § 19-13-D8v:** Requirements for pharmaceutical services in chronic and convalescent nursing homes and rest homes with nursing supervision.
15. **C.G.S. § 19a-535:** Restrictions on the transfer or discharge of patients; notice and plan requirements; appeal rights.

B. *PHYSICAL PLANT REQUIREMENTS*

1. **P.H.C. § 19-13-D8t(d)(4):** Requires that all areas used by patients shall have temperatures of no less than 75° F and all other occupied areas shall have temperatures of no less than 70° F.
2. **P.H.C. § 19-13-D8t(v)(2):** Requirements for compliance with fire safety standards.
3. **P.H.C. § 19-13-D8t(v)(5):** Requires that all facilities licensed for more than 120 beds be connected to public water and sanitary sewer systems and an open outdoor area with a minimum of 100 square feet per patient.
4. **P.H.C. § 19-13-D8t(v)(6):** Requires sufficient space for all business and administrative functions.
5. **P.H.C. § 19-13-D8t(v)(7):** Patient room requirements.
6. **P.H.C. § 19-13-D8t(v)(8):** Patient toilet and bathing facility requirements and specifications.
7. **P.H.C. § 19-13-D8t(v)(9):** Requirements and specifications for nursing service areas.
8. **P.H.C. § 19-13-D8t(v)(10):** Requirements and specifications for medical and therapeutic treatment facilities.
9. **P.H.C. § 19-13-D8t(v)(11):** Requirements and specifications for common patient areas.
10. **P.H.C. § 19-13-D8t(v)(12):** Requirements and specifications for dietary facilities.
11. **P.H.C. § 19-13-D8t(v)(13):** Requirements for provision of grooming equipment and holding room for deceased persons.
12. **P.H.C. § 19-13-D8t(v)(14):** Requires there be general storage space of at least 10 square feet per bed, and at least 2 feet by 4 feet per bed if not kept in the patient room.
13. **P.H.C. § 19-13-D8t(v)(15):** Requirements and specifications for laundry services.
14. **P.H.C. § 19-13-D8t(v)(16):** Requirements for mechanical systems, including ratio of elevators to beds, air conditioning, heating and plumbing systems.
15. **P.H.C. § 19-13-D8t(v)(17):** Requirements for electrical systems, lighting, grounding receptacles and that a nurses' calling station be installed at each patient bed.

16. **P.H.C. § 19-13-D8t(v)(18):** Requirements for emergency sources of fuel and electricity.
17. **P.H.C. § 19-13-D8t(v)(19):** Details of construction regarding patient rooms, doors, corridors, grab bars, walls and floors.
18. **P.H.C. § 19-13-D8t(b)(3)(C):** Requires that no facility shall have more patients than the number of beds for which it is licensed.
19. **P.H.C. § 19-13-D8t(b)(5):** Requires that a new license be issued if there is a change of ownership, level of care, number of beds or location.

C. REPORTING REQUIREMENTS

1. **P.H.C. § 19-13-D8t(b)(5):** Requires the licensee to notify the department in writing no later than 90 days prior to any proposed change in status.
2. **P.H.C. § 19-13-D8t(b)(6):** Requires the licensee to notify the department immediately, to be confirmed in writing within five days, of both the resignation or removal and the subsequent appointment of the facility's administrator, medical director, or director of nurses.
3. **P.H.C. § 19-13-D8t(b)(8):** Requires the facility to directly notify each patient concerned, the next of kin and/or guardian, the patient's personal physician, and any third party payors concerned at least 30 days prior to the voluntary surrender of the facility's license or surrender of license upon the department's order of revocation, refusal to renew or suspension of license.
4. **P.H.C. § 19-13-D8t(d)(1)(c):** Requires that in the event of an emergency, a patient may be admitted to a facility without compliance with admission requirements so long as the facility notifies the Department within 72 hours after such admission
5. **P.H.C. § 19-13-D8t(g):** Requirements for reportable events to the Department.

D. DOCUMENTATION REQUIREMENTS

1. **P.H.C. § 19-13-D8t(g):** Requirements for reportable events, and facility documentation of said events.
2. **P.H.C. § 19-13-D8t(h)(3):** Requires that a record be kept by the facility of the medical director's visits and statements for review by the department.
3. **P.H.C. § 19-13-D8t(i)(3)&(5):** Requirements for documentation of staff appointments.
4. **P.H.C. § 19-13-D8t(m)(3):** Requires the facility to maintain monthly written and signed summaries of actions taken with respect to nursing staff assessments.
5. **P.H.C. § 19-13-D8t(n):** Requirements for the provision of medical and professional services, including intake examination and history within 48 hours of admission, patient assessments by attending physician, transfer of patients, problems and diagnoses and procedures that must be timely recorded in patient's medical record.

6. **P.H.C. §19-13-D8t(o):** Specifies requirements for contents, legibility and review of patient medical records.
7. **P.H.C. §19-13-D8t(p):** Requirements for documentation of discharge planning.
8. **P.H.C. § 19-13-D8t(r)(4):** Requires records of patient participation in recreational activities be maintained on a daily basis.
9. **P.H.C. § 19-13-D8u(c)(5):** Requirement for documentation and log of each IV therapy initiated with certain minimum information.
10. **P.H.C. §§7-62-2 & 7-62-3:** Documentation requirements for anticipation of death and/or pronouncement of death by physician or registered nurse.
11. **C.G.S. §7-62b(c):** Requirements for the completion and signing of death certificates within 24 hours after death.
12. **C.G.S. § 19a-509d:** Transcription and execution, countersigning of verbal medication orders.

4. PHARMACEUTICAL SERVICES IN CHRONIC AND CONVALESCENT NURSING HOMES AND REST HOMES WITH NURSING SUPERVISION

A. STAFFING REQUIREMENTS

1. **P.H.C. § 19-13-D8v(b)(2):** Requirements, responsibilities and working hours for pharmacists' services.
2. **P.H.C. § 19-13-D8v(b)(6):** Requires the composition of a pharmacy and therapeutics committee, sets forth its functions and meeting schedule, to be held at least quarterly.

B. PHYSICAL PLANT REQUIREMENTS

1. **P.H.C. § 19-13-D8v(b)(3):** Requires there be proper space and equipment for the storage, safeguarding, preparation, dispensing and administration of drugs.

C. REPORTING REQUIREMENTS

1. **P.H.C. §19-13-D8v(b)(5)(C):** Requires that medication errors and apparent adverse drug reactions be recorded in the patient's medical record, reported to the attending physician, director of nursing, and consultant pharmacist, and described in a full incident report.

D. DOCUMENTATION REQUIREMENTS

1. **P.H.C. § 19-13-D8v(b)(4):** Requires the development, implementation and enforcement of policies and procedures for control, accountability, distribution, and assurance of quality of all drugs and biologicals, pharmaceutical records.
2. **P.H.C. §19-13-D8v(b)(5):** Requires each facility to develop written policies and procedures for the safe prescribing and administration of drugs; specifications for medication orders.

3. **P.H.C. § 19-13-D8v(b)(6)(B):** Requires the pharmacy and therapeutics committee to document its activities, findings, and recommendations.

5. ***CHRONIC AND CONVALESCENT NURSING HOMES AND REST HOMES WITH NURSING SUPERVISION WITH AUTHORIZATION TO CARE FOR PERSONS WITH MANAGEABLE PSYCHIATRIC CONDITIONS AS DETERMINED BY A BOARD QUALIFIED OR CERTIFIED PSYCHIATRIST***
 - A. ***STAFFING REQUIREMENTS***
 1. **P.H.C. § 19-13-D13(a):** Requires that in all chronic and convalescent nursing homes of any size and rest homes with nursing supervision of 61 beds or more there shall be a registered nurse, or a nurse with special training or experience in the care of mental patients on duty at all times. In rest homes with nursing supervision of 60 beds or less the registered nurse or a nurse with special training or experience in the care of mental patients may be a consultant. Consultation shall be at least eight hours per week.
 2. **P.H.C. § 19-13-D13(c):** Requirements for care, restraint and transfer of patients.

 - B. ***DOCUMENTATION REQUIREMENTS***
 1. **P.H.C. § 19-13-D13(b):** Requirements for written certificate of admission.
 2. **P.H.C. § 19-13-D13(c)(2):** Requirements for written order of patient restraint.
 3. **P.H.C. §§7-62-2 & 7-62-3:** Documentation requirements for anticipation of death and/or pronouncement of death by physician or registered nurse.
 4. **C.G.S. §46a-152(d):** Requires that any use of physical restraint/seclusion shall be documented in the person's medical or educational record.

Notes

1. University of Toronto Joint Center for Bioethics – Pandemic Influenza Work Group, *Stand On Guard For Thee, Ethical Considerations in Preparedness Planning for Pandemic Influenza*, Nov. 2005.
2. *Altered Standards of Care in Mass Casualty Events*, prepared by Health Systems Research Inc. under Contract No. 290-04-0010, AHRQ Publication No. 05-0043. Rockville, MD: Agency for Healthcare Research and Quality, April 2005, pp. 7-8.
3. Homeland Security Council, *National Strategy for Pandemic Influenza Implementation Plan*, ISBN 0-16-076075-5, May 2006, p. 110.
4. California Department of Public Health, *Standards and Guidelines for Health Care Surge During Emergencies, Volume 1: Hospitals*, p. 8.
5. *Altered Standards of Care in Mass Casualty Events*, Prepared by Health Systems Research Inc. under Contract No. 290-04-0010, AHRQ Publication No. 05-0043. Rockville, MD: Agency for Health care Research and Quality. April 2005, p. 7. <http://www.ahrq.gov/research/altstand/altstand.pdf>
6. American Nurses Association, *Adapting Standards of Care under Altered Conditions*, Center for Health Policy, Columbia University of School of Nursing: New York, 2007, p. 4.
7. Kinlaw, K., Levine, R., Centers for Disease Control & Prevention, *Ethical Guidelines in Pandemic Influenza, Recommendations of the Ethics Subcommittee of the Advisory Committee to the Director*, 2007.
8. Virginia Department of Public Health, Virginia Hospital and Health Care Association, *Critical Resource Shortages: A Planning Guide*, p. 2, prepared by Troutman Sanders, LLP.
9. CHEST 2008, American College of Chest Physicians, *Definitive Care for the Critically Ill During a Disaster: A framework for Allocation of Scarce Resources in Mass Critical Care*, p. 64S.
10. Statutory and regulatory standards will require a waiver from the Governor and are addressed in Section IV of this whitepaper.
11. Phillips SJ, Knebel A, Eds. *Mass Medical Care with Scarce Resources: A Community Planning Guide*, p. 71, prepared by Health Systems Research, Inc., an Altarum company, under contract No. 290-04-0010, AHRQ Publication No.07-001. Rockville, MD: Agency for Health Care Research and Quality, 2007.
12. A list of the resources and a brief summary is provided in Appendix 1.

13. See, e.g., *Emergency Preparedness: States Are Planning for Medical Surge, but Could Benefit from Shared Guidance for Allocating Scarce Medical Resources*, GAO-08-668 (June 2008), p. 27; Committee on Homeland Security, *Getting Beyond Getting Ready for Pandemic Influenza* (Jan. 2009), p. 14; White, Katz, Luce and Lo: *Who Should Receive Life Support During a Public Health Emergency? Using Ethical Principles to Improve Allocation Decisions*. *Ann Intern Med* (2009), vol. 150, pp. 132-138; *NYS Workgroup on Ventilator Allocation in an Influenza Pandemic*, pp. 2 and 43.
http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator_guidance.pdf
14. http://chestjournal.org/cgi/content/abstract/133/5_suppl/51S at p. 53S.
15. Minnesota Healthcare Preparedness Program
<http://www.health.state.mn.us/oep/healthcare/standards.pdf>.
16. *Id.*
17. <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/>
18. <http://www.cms.hhs.gov/emtala/>
19. The ESAR-VHP system is a statewide mechanism for recruiting, registering and verifying credential information about potential health volunteers in the state. See information on Connecticut's program at <http://www.ct-esar-vhp.org/>.
20. *Supra*, n. 13.
21. *Id.* at pp.33-34.
22. PSAPs answer 9-1-1 calls and manage emergency care requests, while CMEDs coordinate and operate the Statewide UHF Radio System and provide various services in support of the EMS system, including coordinating responses and enabling medical control communications. Some CMEDs are also PSAPs and perform those responsibilities as well. The U.S. Department of Transportation has published a guide, *Preparing for Pandemic Influenza: recommendations for Protocol Development for 9-1-1 Personnel and Public Safety Answering Points*, May 2007. This guide serves to address PSAP Communications during a pandemic, specifically, yet it could be adapted to meet the needs during any prolonged public health emergency.
<http://www.nhtsa.gov/people/injury/ems/pandemicinfluenza>
23. See, Qureshi, K., Gershon, R.R.M., Sherman, M. F., et al., *Health Care Workers' Ability and Willingness to Report to Duty During Catastrophic Disasters*. *Journal*

- of Urban Health: Bulletin of the New York Academy of Medicine (2005), vol. 82(3), pp. 378-388; Qureshi, K. Merrill, J., Calero-Breckheimer, A. *Emergency Preparedness Training for Public Health Nurses: A Pilot Study*. Journal of Urban Health: Bulletin of the New York Academy of Medicine (2002), vol. 79, pp. 413-416; *see also Potential Penalties for Health Care Professionals Who Refuse to Work During a Pandemic*, JAMA, March 26, 2008, 299:12, pp. 1471 – 2; *Emergency health care workers' willingness to work during major emergencies and disasters*, The Australian Journal of Emergency Management (May 2007), 22:2; Hewlett, B.L. and Hewlett, B.S., *Providing care and facing death: nursing during Ebola outbreaks in Central Africa*. Journal of Transcultural Nursing (2005), vol. 16, pp. 289-297; Upshur, R., *The role and obligations of health-care workers during an outbreak of pandemic influenza*, Project on Addressing Ethical Issues in Pandemic Influenza Planning (draft), WHO (2006), pp. 4-8.
24. Some commentators have compared the ethical obligation to that of firefighters and police officers. Harris J., Holm, S: *Risk-taking and professional responsibility*, J.R. Soc. Med. (1997), vol. 90, pp. 625-629.
25. Multiple studies have found that health professionals' decisions to provide care during a natural disaster are directly influenced by, among other things, their perception of the risks and their perceived ability to provide the type of care required. Lanzilotte S., Galanais, D., & Leoni, N., *et al.*, *Hawaii Medical Professionals Assessment*, Hawaii Medical Journal (2002), vol. 61, pp. 162-173; Irvin, C., Cindrich, L., Patterson, W., *et al.*, *Survey of Hospital Healthcare Personnel Response During a Potential Avian Influenza Pandemic: Will They Come to Work?* Prehospital and Disaster Medicine, 23:4, pp. 330-32; Iserson, K., Heine, C., Larkin, G., *et al.*, *Fight or Flight: The Ethics of Emergency Physician Disaster Response*, Annals of Emergency Medicine (April 2008), 51:4, pp. 345-53.