THE FRIENDLY HOME

PANDEMIC EMERGENCY PLAN
EMERGING INFECTIOUS DISEASE (EID) RESPONSE PLAN

BACKGROUND

Definitions:
Emerging Infectious diseases (EIDs)
Infectious diseases, whose incidence in humans has increased in the past two decades or threatens to increase in the near future, have been defined as "emerging." These diseases, which respect no national boundaries, include:

- New infections resulting from changes or evolution of existing organisms;
- Known infections spreading to new geographic areas or populations;
- Previously unrecognized infections appearing in areas undergoing ecologic transformation;
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.

For an emerging disease to become established at least two events must occur –

- (1) the infectious agent has to be introduced into a vulnerable population and
- (2) the agent has to be able to spread readily from person-to-person and cause disease. The infection also has to be able to sustain itself within the population; that is, more and more people continue to become infected.

Definitions:
Pandemic
A sudden infectious disease outbreak that becomes very widespread and affects a whole region, continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

Isolation
Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease.

Quarantine
Separation and restriction of the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.

Cohorting
Imposed grouping of two or more residents exposed to, or infected with, the same infectious disease that are separated physically from other residents who have not been exposed to, or infected with, that infectious disease.

Cohort Staffing
The practice of assigning specific staff to care only for residents known to be exposed to or infected with the same infectious disease. Such staff "does not" participate in the care of residents who have not been exposed or infected with that infectious disease.

PURPOSE

The purpose of this Pandemic Emergency/Emerging Infectious Disease Response Plan is to contain an outbreak of disease caused by an infectious agent or biological toxin or respond to other infectious disease emergencies as defined above. This is consistent with the facility's mission to protect the residents and staff from illness and/or death.

Activities that may be implemented during an Infectious Disease Response include:

- Coordination with other healthcare facilities, local, regional, state and federal agencies and other organizations responding to a public health emergency.
- Development and dissemination of information and guidance for the residents, families and staff within the community.
- Containment measures such as infection control, mass prophylaxis, isolation and quarantine, or restriction and clearance.
- Activities such as surveillance, investigation, and lab testing.

POLICY

This plan will be posted on the facility website and will be updated and submitted for review, by the Commissioner of Health, on an annual basis. The facility will make a copy of this plan available immediately upon request.

During periods of quarantine and/or restricted visitation the facility will implement a method for residents to keep in touch with families or responsible parties, such as providing no-cost access to teleconferencing services, or other means as preferred and identified by residents and their families.

When visitation is restricted the facility will update resident families or responsible parties on a weekly or more regular basis on how they can remotely keep in touch with residents. The facility will assign staff to ensure all residents and families are updated at least weekly on the number of pandemic related infections and deaths at the facility, including residents with pandemic related infection who pass away for reasons other than infection. This responsibility will be assigned at the time of the event.

The facility will assign staff to update families and responsible parties as to the condition of infected residents on a daily basis or upon a change in a resident's condition. This responsibility will be assigned at the time of the event.

Hospitalized residents will be admitted or readmitted in accordance with all applicable laws and regulations, including but not limited to 10 NYCRR 415.3(i)(3)(iii), 415.19 and 415.26(i); and 42 CFR 483.15.
Any current resident hospitalized, in accordance with all applicable laws and regulations including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15(e), shall have their place at the facility preserved.

As required by regulation the facility will maintain, or have access to, a two (2) month supply of Personal Protective Equipment (PPE), or any superseding requirements under New York State Executive Orders and/or NYS DOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic. This supply of PPE with either be stored onsite or will be readily accessible by the facility.

The facility will evaluate their vendor supply plan for re-supply of food, water, medications, environmental cleaning agents, and sanitizing agents as part of their event assessment.

The facility will ensure it meets all reporting requirements for suspected or confirmed communicable diseases as mandated under the New York State Sanitary Code (10 NYCRR 2.10 Part 2), as well as by 10 NYCRR 415.19, and reporting requirements of the Health Commerce System, e.g., HERDS survey reporting. This responsibility will be assigned at the time of the event.

SCOPE

An infectious disease emergency occurs when urgent and possibly extensive public health and medical interventions are needed to respond to and contain an infectious disease outbreak that has the potential for significant morbidity and mortality in a given area.

This plan is a functional response guide for the facility Leadership Team and Department Managers.

This plan is to be used in conjunction with the facility's Emergency Operations Plan, Infection Control Plan, and Respiratory Protection Program.

ASSUMPTIONS

The Pandemic Emergency / Emerging Infectious Disease Response Plan integrates the key elements of communicable disease control and prevention with emergency management concepts. The Incident Command System (ICS) organizational structure will be used to scale the response as needed to effectively manage and meet the incident objectives of the infectious disease emergency response.

The Pandemic Emergency / Emerging Infectious Disease Response Plan assumes that individuals occupying leadership positions have completed ICS training. The Pandemic Emergency / Emerging Infectious Disease Response Plan further acknowledges that there could be a limited

number of personnel within the facility with the knowledge and training in infectious diseases, epidemiology, public health, and emergency preparedness.

The Plan assumes each incident will require tailored activation and use of the Pandemic Emergency / Emerging Infectious Disease Response Plan. This plan can be adjusted to address scenarios varying by infectious diseases, size and/or overall severity.

This Pandemic Emergency/Emerging Infectious Disease Response Plan assumes that all confidential data regarding individual cases will not be shared outside of those who need to know, or in order to fulfill legally mandated public health reporting and information sharing.

The facility will form an Emerging Infectious Disease Support Team during pandemic or infectious disease events to include administrative, clinical and support team members to ensure proper response to the infectious disease.

GENERAL ACTIONS APPLICABLE TO ALL STAFF

Healthcare must always be prepared to protect people within our buildings and to protect our residents, families, and staff from harm resulting from exposure to an emerging infectious disease while they are in the facility.

Every disease is different. The local, state, and federal health authorities (NYS DOH, CDC, CMS, OSHA, etc.) will be the source of the latest information and most up-to-date guidance on prevention, case definition, surveillance, treatment, and clinical response related to a specific disease threat.

Incidents involving an emerging infectious disease, or a suspected case, require the consultation of the facility Medical Director and/or other physicians and Infection Control Practitioners as well as referring to the facility Medical Director and/or other physicians in addition to referring to the facility Infection Control Plan and Respiratory Protection Program.

GENERAL PREPAREDNESS FOR EMERGING INFECTIOUS DISEASES (EIDS)

- The facility's Infection Control Plan will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza and should be referenced.
- This plan will:
    - Include administrative controls (screening, isolation, visitor policies, including restrictions as necessary, and employee absentee plans).
    - Address environmental controls (isolation areas/rooms, plastic barriers, sanitation stations, and special areas for contaminated waste).
    - Address human resource issues such as employee leave, staffing, and emergency credentialing.
- Assigned clinical leadership will be vigilant and stay informed about EIDs around the world. They will keep administrative leadership briefed on potential risks of new infections in their community and region.

- As part of the Emergency Preparedness Program (EPP), the facility will maintain, or have readily accessible, a two (2) month supply of personal protective equipment (PPE), or any superseding requirements under New York State Executive Orders and/or NYS DOH regulations governing PPE supply requirements executed during a specific disease outbreak or pandemic, including gowns/isolation gowns, face shields/eye protection, masks, assorted sizes of disposable N95 respirators or other appropriate respiratory barrier devices, and gloves, sanitizer, and disinfectants (meeting EPA guidance current at the time of the event).
- The facility will develop plans with their vendors for resupply of food, medications, medical supplies, sanitizing agents, and PPE in the event of a disruption to the normal supply chain including an EID outbreak. See *EOP Section 5 – Emergency Lists.*
- The facility will provide orientation and in-service training to all staff on the Infection Control Plan and Respiratory Protection Program, including the Pandemic Emergency Plan - Emerging Infectious Diseases response plan (including Reporting Requirements), exposure risks, symptoms, prevention and the use of Personal Protective Equipment, regulations, including 10 NYCRR 415.3(i)(3)(iii), 415.19 and 415.26(i); 42 CFR 483.15€ and 42 CFR § 483.80), and Federal and State guidance/requirements on an annual or as needed basis.
- The facility will follow applicable OSHA requirements, including OSHA's Bloodborne Pathogens (29 CFR 1910.1030), Personal Protective Equipment (29 CFR 1910.132), and Respiratory Protection (29 CFR 1910.134) standards.
- The facility will ensure there is adequate staff access to communicable disease reporting tools, and other outbreak-specific reporting requirements on the Health Commerce System (e.g., Nosocomial Outbreak Reporting Application (NORA) and HERDS surveys).
- The facility will provide initial fit testing for staff that provide resident care prior to the use of N95 respirators, and then annually thereafter.
- The facility will provide education and training on the proper donning and doffing of PPE.
- Department and Clinical managers will monitor staff usage of PPE to ensure it is being properly used (appropriate fit, donning/doffing, appropriate choice of PPE per established procedures, etc.).

PLAN ACTIVATION

Only authorized staff may direct the activation / deactivation of the Pandemic Emergency / Emerging Infectious Disease Response Plan. The activation and notification process should be used in accordance with the Emergency Operations Plan. Staff authorized to initiate activation / deactivation include the:

- Administrator / Executive Director
- Director of Health Services
- Medical Director and/or Infection Control Practitioner
- Other Leadership Team member (as defined by Emergency Operations Plan)

The need to notify department managers / supervisors and external partners of the activation of the Pandemic Emergency / Emerging Infectious Disease Response Plan will be determined by the circumstances of the event including: the suspected disease, the anticipated scope of the response, and the size of the impacted populations.

The Pandemic Emergency / Emerging Infectious Disease Response Plan assumes that all incident communications and requests will follow Incident Command System guidelines. Any communications that changes the scope of the operations, the objectives, or strategies must be approved by the Incident Commander.

ADMINISTRATION / CLINICAL LEADERSHIP CONSIDERATIONS

The leadership team will consider recommendations and requirements from the CDC, OSHA, Center for Medicare and Medicaid (CMS), NYS DOH, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA), and other state or federal laws in determining the disease-specific response actions and precautions it will take to protect its residents, visitors, and staff members.

Once notified by public health authorities at either the federal, state, and/or local level that the EID is likely to, or already has spread to the facility's community, the facility will activate specific surveillance and screening as instructed by the NYS DOH, the Centers for Disease Control, and Prevention (CDC), or the local public health authorities.

The facility will consider posting signage for cough etiquette, handwashing, and other hygiene measures in high traffic areas and will provide Alcohol Based Hand Rub and facemasks, if indicated and practical.

Protecting the residents and staff shall be of paramount concern.

The facility may temporarily limit or restrict visitors, subject to superseding NYS Executive Orders and/or NYS DOH guidance in order to reduce exposure risk to residents and staff.

If necessary, and in accordance with applicable NYS Executive Orders and/or NYS DOH guidance, the facility may implement procedures to close the facility to new admissions, limit or restrict visitors when there are confirmed cases in the community, and/or screen all permitted visitors for signs of infection.

The leadership team shall consider:

- The degree of frailty of the residents in the facility.
- The likelihood of the infectious disease being transmitted to the residents and employees.
- The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces).
- The precautions which can be taken to prevent the spread of the infectious disease and other relevant factors.
- The formation and activation of an Emerging Infectious Disease Support Team to include administrative, clinical and support team members.

Once these factors are considered, the leadership team will weigh its options and determine the extent to which exposed staff, or those showing signs of the infectious disease, must be precluded from contact with residents or other employees.

- Apply whatever action is taken uniformly to all staff in like circumstances.
- Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.
- Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.
- Use accepted scientific procedures and guidance from local public health, NYS DOH and/or CDC, whenever available, to determine the level of risk posed by an employee.
- Permit employees to return to work when cleared by a licensed physician; however, additional precautions may be taken to protect the residents as recommended by the local public health, NYS DOH, and/or CDC.

VP/ADMINISTRATOR / INCIDENT COMMANDER

- Assemble key leadership team members. Take into consideration all the following guidance, as applicable to the Infectious Disease the facility or community is managing.
- Consider activating the Command Center (follow *Activation of Plan* in *Section A*) to ensure procedures are in place.
- Reference the following EOP Sections to address the below listed considerations.
    - *EOP Section 3: Incident Command System* and associated Job Action Sheets
- Assess impact on facility operations and resident care.
- Assign a person the responsibility to monitor local, state and federal health websites for updates to existing guidance for long-term care facilities and report to the Command Center team on those updates.
- Director of Health Services will be responsible for meeting the reporting requirements for suspected or confirmed communicable diseases as mandated under the New York State Sanitary Code (10 NYCRR 2.10 Part 2), as well as by 10 NYCRR 415.19 and reporting requirements of the Health Commerce System, e.g., HERDS survey reporting.
- Develop an action plan with the Command Center team and brief department managers and supervisors.
- Work with Director of Health Services and/or Medical Director to review incident considerations, determine level of service, and need to reschedule or cancel activities.
- During periods of quarantine and/or restricted visitation implement a method for residents to keep in touch with families or responsible parties, such as providing no-cost access to teleconferencing services, or other means as preferred and identified by residents and their families.
- When visitation is restricted assign appropriate staff to update resident families or responsible parties on a weekly or more regular basis on how they can remotely keep in touch with residents. Ensure all residents and families are updated at least weekly on the number of pandemic related infections and deaths at the facility, including residents with pandemic-related infection who pass away for reasons other than infection.
- Assign appropriate staff to update families and responsible parties on the condition of infected residents on a daily basis, or upon a change in a resident's condition

- Approve requests for additional resources (e.g., supplies, equipment, staff, etc.).
- The Incident Commander / Administrator will direct a review and revision, as needed, of internal policies and procedures, stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.
- The Incident Command team will determine a location for the staging and distribution of supplies, equipment, and pharmaceuticals as needed for the incident.
- To ensure that staff and/or new residents are not at risk of spreading the EID into the facility, screening for exposure risk and signs and symptoms may be done PRIOR to admission of a new resident and/or allowing new staff persons to report to work.
- Ensure that appropriate physical and social distancing measures are put into place where indicated. This may include, but is not limited to, cancellation of certain activities and services, changes in resident and staff dining, and other physical space requirements, etc.

Communications

- Reference the following EOP Sections to address the below listed considerations.
  - *EOP Section 7 – Policies and Planning / Communications Plan*
  - *EOP Section 2 – Procedures Applicable to All Hazards*
  - *EOP Section 3 – Incident Command System / Public Information Officer*
- Provide staff with incident updates on a regular basis, as necessary.
- Appoint a Public Information Officer to prepare media statements, approve as necessary.
- Appoint a Liaison Officer when the incident is multi-jurisdictional or involves several agencies or other healthcare facilities. The Liaison Officer is the main point of contact for other community-based partners involved in response operations (e.g., Red Cross, Fire Department, Emergency Medical Services, Office of Emergency Management, etc.). The Liaison Officer will provide and receive updates and ensure the prompt response to questions, resource requests, and other needs.
- Determine need for the Liaison Officer to contact the following:
  - Local/State Department of Health
  - NYS Department of Health
  - CDC
  - Department of Health and Human Services
  - Healthcare Coalition and/or Mutual Aid partners
- Conduct internal (support team only) conference calls to discuss any new developments, such as state or local policy changes, or ongoing challenges that are arising within long-term care industry and to share any innovative solutions or best practices.
- Develop a communications plan and assign responsibility for communicating to residents and their families. Consider usage of signage and/or resident letters, based on CDC/CMS or health department guidance specific to the EID.
  - Residents and their families will be provided education about the disease and the facility's response strategy at a level appropriate to their interests and need for information by the clinical and social work staff.
- During times when visitation is limited or restricted, implement a method for residents to stay in touch with loved ones (families or responsible parties) such as providing access to teleconferencing services at no cost to the resident.

- Establish a dedicated telephone hotline and continue with established email inbox for facility staff. The hotline should provide updated, evidence-based guidance on outbreak-related topics (e.g., infection control, resident isolation, resident and staff testing). This hotline and inbox should be staffed 24/7 by members of the EID support team if indicated.
- Convene weekly (or as frequently as needed) conference calls with facility staff to discuss newly released guidance, and to discuss potential strategies for addressing their challenges and concerns.
    - Review federal, state, and local Infection Prevention & Control guidance with facility staff during the regular conference calls.
- Ensure that all documents, messaging, and information developed during the incident are reviewed and approved by the Incident Commander and/or Public Information Officer prior to dissemination.

Assessment

- Reference the following EOP Sections to address the below listed considerations.
    - *EOP Section 2 – Procedures Applicable to All Hazards / Managing Security and Safety during a Disaster*
    - *EOP Section 5 – Emergency Lists*
    - *EOP Section 2 – Procedures Applicable to All Hazards / Managing Resources and Assets during a Disaster*
    - *EOP Appendix – Vendor Agreements*
- Develop a system to monitor for, and internally review, development of symptoms among residents and healthcare personnel (HCP) in the facility. Information from this monitoring system should be used to implement prevention interventions (e.g., isolation, cohorting).
    - Example: CDC guidance on respiratory surveillance: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf.
- Assign a team member(s) to conduct the following assessments and report back to the Incident Commander:
    - Current resident census and number of open beds
    - Number of affected residents and staff
    - Inventory of PPE types and quantities
        - Input PPE inventory into the PPE Burn Rate Calculator at the onset of the event
- Request an assessment of critical supplies throughout the facility using the *Department Rapid Assessment Form*. Direct departments to conduct assessments of food, water, medical and other supplies.
- Assign a team member to identify resource shortages (medical supplies / equipment, PPE, staffing, etc.).
    - Develop a plan to mitigate resource shortages (e.g.: vendor support, EOC support, staffing agencies, etc.)
    - Determine ability to obtain or borrow resource shortages from other healthcare facilities. Collaborate with the healthcare coalition, mutual aid plan members and/or local / state EOC as necessary.

- Review agreements with vendors and other healthcare facilities. Request vendor support to ensure enough supplies are on hand including:
    - PPE and related supplies for fit testing, if applicable
    - Medications
    - Medical Supplies/Equipment
    - Food/Water
    - Sanitation and Disinfectants
- Ensure vendor support is available for medical waste disposal.
- Assess the need to order a Building Lockdown via Security. *EOP Section 2 – Procedures Applicable to All Hazards / Managing Security and Safety during a Disaster*.
- Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the facility along with the instruction that anyone who is sick must not enter the building.
- Consider the following extra security precautions:
    - Professional Visitors: No one allowed in facility without Command Center clearance.
    - Resident Visitors: No one allowed in facility. Relatives and responsible parties will be given appropriate information and location to wait as directed by the Command Center.

Staffing

- Reference the following EOP Sections to address the below listed considerations:
    - *EOP Section 2 – Procedures Applicable to All Hazards / Management of Staff during a Disaster.*
- Self-screening: Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
    - Reporting any suspected exposure to the EID while off duty to their supervisor and public health.
    - Precautionary removal of employees who report an actual or suspected exposure to the EID.
    - Self-screening for symptoms prior to reporting to work.
    - Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.
- Whenever possible, well and unexposed staff should work in non-infected resident care units.
- Determine need for further staff education efforts, as necessary, relative to the current threat or infectious disease.
- Review staffing levels and scheduling. Ensure enough staffing resources for sustaining operations for the duration of the event. (i.e. 12-hour shifts versus 8-hour). Develop a plan to address potential staff shortages such as cross training of staff to be feeding assistants, etc.
- Consider contracting staff to supplement current staffing.

- Review and implement disaster credentialing and privileging policies and processes as needed.

Suspected Case within the Facility

- Ensure infected residents are isolated/cohorted and or transferred based on their infection status in accordance with applicable guidance from the CDC, local/state health departments.
    - Follow the guidance of local public and/or state health authorities regarding the transfer of the suspected infectious resident to the appropriate acute facility via emergency medical services if necessary. Residents that are hospitalized will be readmitted to the facility after treatment.
- Place a resident who exhibits symptoms of the EID in an isolation room (single room preferred unless cohorting residents with similar symptoms) and notify local and/or county/state public health authorities.
- As necessary, consider cohorting multiple infected residents using part of a unit (e.g., end of a wing), a dedicated floor or wing, and discontinuing any sharing of bathrooms with residents outside of the cohorting area.
    - Consider posting signage or other means of identifying the area(s) being used for infected residents.
    - At the time of the event determine an effective means to prevent non-infected residents from entering into the cohorting area (e.g., assigned staff members, closure of cross corridor doors, etc.).
- If the suspected infectious resident requires care while awaiting or instead of transfer, follow facility policies for isolation procedures, including all recommended PPE for staff at risk of exposure.
- Keep the number of staff assigned to enter the room of the isolated resident to a minimum.
    - Ideally, only specially trained and prepared staff (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room.
    - Provide all assigned staff additional “just in time” training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.
- If feasible, ask the isolated resident to wear a facemask while staff is in the room.
- Provide care at the level necessary to address essential needs of the isolated resident unless it is advised otherwise by public health authorities.
- Conduct control activities such as the management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposed individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.
- Implement the isolation protocol in the facility (isolation rooms, cohorting, cancelation of group activities and social dining) as described in the facility’s infection control plan and/or recommended by local, state, or federal public health authorities.
- Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities and in keeping with guidance from the CDC.

DEPARTMENT-SPECIFIC ACTIONS

NURSING STAFF

- Work with Incident Commander and assigned Public Information Officer to prepare messaging for families of residents and staff.
- Consider the following to address staff concerns:
    - Provide incident specific education, including frank discussions about potential risks and plans for protecting healthcare providers.
- Participate in lockdown of facility to control people coming into the facility. See *Building Lockdown Procedure*. See *EOP Section 2 – Managing Safety and Security During a Disaster*.
- Cancel communal dining and all group activities, such as internal and external group activities, as necessary.
- Explore alternatives to face-to-face visits if visitors are restricted from entering the facility such as teleconferencing services, or other means as preferred and identified by residents and their families. Ensure families and/or responsible parties are updated on a weekly basis how they can remotely keep in touch with residents when visitation is limited or restricted.
- Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes.
- If residents leave their room, determine the need for residents to wear a facemask, perform hand hygiene, limit their movement in the facility, while maintaining physical distancing (staying at least 6 feet away from others), when necessary.
- As assigned provide updates to families and responsible parties on the condition of infected residents on a daily basis or upon a change in a resident's condition.

<u>General Guidelines for Infection Control Practices for Resident Management</u>

- Contact state and local Health Departments, CDC and/or the Department of Health and Human Services for updated information and protocols to follow.
- Any symptomatic staff or residents with suspected or confirmed illnesses should, at a minimum, be managed using Standard Precautions. Additional precautions may be needed to reduce the likelihood for transmission.

Standard and transmission-based precautions to be followed to prevent spread of infections.

A facility's infection control practices are important for preventing the transmission of infections. Infection control precautions used by the facility include two primary tiers: "Standard Precautions" and "Transmission-Based Precautions."

Hand Hygiene

Hand hygiene is the single most important practice to reduce the transmission of infectious agents in healthcare settings. This includes hand washing with either plain or antiseptic-containing soap and water for at least 20 seconds, and/or the use of alcohol-based products (gels, rinses, and foams) that do not require the use of water.

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The CDC continues to recommend the use of alcohol-based hand rub (ABHR) as the primary method for hand hygiene in most clinical situations. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare personnel after brief interactions with residents or the care environment.

Standard Precautions
Standard precautions represent the infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered.

These evidence-based practices are designed to protect healthcare staff and residents by preventing the spread of infections among residents and ensuring staff does not carry infectious pathogens on their hands or via equipment during resident care.

Standard precautions include hand hygiene, use of PPE (e.g., gloves, gowns, facemasks), respiratory hygiene and cough etiquette, safe injection practices, and safe handling of equipment or items that are likely contaminated with infectious body fluids, as well as cleaning and disinfecting or sterilizing potentially contaminated equipment.

In order to perform hand hygiene appropriately, soap, water, Alcohol Base Hand Rub (ABHR), and a sink should be readily accessible in appropriate locations, including but not limited to, resident care areas, and food and medication preparation areas. Staff must perform hand hygiene (even if gloves are used):

- Before and after contact with the resident.
- Before performing an aseptic task.
- After contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident's room.
- After removing personal protective equipment (e.g., gloves, gown, facemask).
- After using the restroom.
- Before meals.

If residents need assistance with hand hygiene, staff should assist with washing hands after toileting, before meals, and use of ABHR or soap and water at other times when indicated.

The use of PPE during resident care is determined by the nature of staff interaction and the extent of anticipated blood, body fluid, or pathogen exposure to include contamination of environmental surfaces. Furthermore, appropriate use of PPE includes but is not limited to the following:

- Gloves worn before and removed after contact with blood or body fluid, mucous membranes, or non-intact skin.
- Gloves changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care.
- Gown worn for direct resident contact if the resident has uncontained secretions or excretions or with contaminated or potentially contaminated items.

- Appropriate mouth, nose, and eye protection (e.g., facemasks, face shield) is worn for procedures that are likely to generate splashes or sprays of blood or body fluids.
- PPE appropriately discarded after resident care prior to leaving room followed by hand hygiene.
- Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms) although, equipment supply carts should not be brought into the resident's room.

Transmission-based Precautions

Transmission-based precautions are used for residents who are known to be, or suspected of being, infected or colonized with infectious agents, including pathogens that require additional control measures to prevent transmission.

In Long Term Care Facilities, it is appropriate to individualize decisions regarding resident placement (shared or private), balancing infection risks with the need for more than one occupant in a room, the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident.

It is essential to communicate transmission-based precautions to all healthcare personnel, and for personnel to comply with requirements. Pertinent signage (i.e., isolation precautions) and verbal reporting between staff can enhance compliance with transmission-based precautions to help minimize the transmission of infections within the facility.

It is important to use the standard approaches, as defined by the CDC, for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precaution determines the type of PPE to be used.

Communication (e.g., verbal reports, signage) regarding the type of precaution to be used is important. When transmission-based precautions are in place, PPE should be readily available. Proper hand washing remains a key preventive measure, regardless of the type of transmission-based precaution employed.

Transmission-based precautions are maintained for as long as necessary to prevent the transmission of infection. It is appropriate to use the least restrictive approach possible that adequately protects the resident and others. Maintaining isolation longer than necessary may adversely affect psychosocial well-being. The facility should document in the medical record the rationale for the selected transmission-based precautions.

Contact Precautions

Contact precautions are intended to prevent transmission of infections that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves upon entering (i.e., before making contact with the resident or resident's environment) the room or cubicle. Prior to leaving the resident's room, the PPE is removed, and hand hygiene is performed. Depending on the situation, options for residents on contact precautions may include the following: a private room, cohorting, or sharing a room with a roommate with limited risk factors (e.g., without indwelling devices, without pressure ulcers and not immunocompromised).

Droplet Precautions

The use of droplet precautions applies when respiratory droplets contain viruses or bacteria particles which may be spread to another susceptible individual. Respiratory viruses can enter the body via the nasal mucosa, conjunctivae, and less frequently, the mouth. Examples of droplet-borne organisms that may cause infections include, but are not limited to, Mycoplasma pneumoniae, influenza, and other respiratory viruses.

Respiratory droplets are generated when an infected person coughs, sneezes, or talks, or during aerosol generating procedures such as nebulizer treatments, suctioning, endotracheal intubation/extubation, cough induction by chest physiotherapy, and cardiopulmonary resuscitation.

The maximum distance for droplet transmission is currently unresolved, but the area of defined risk based on epidemiological findings is approximately 3-10 feet. In contrast to airborne pathogens, droplet-borne pathogens are generally not transmitted through the air over long distances.

Facemasks are to be used upon entry (i.e., within three feet of a resident) into a resident's room with respiratory droplet precautions. If substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield in place of goggles) should be worn. The preference for a resident on droplet precautions would be to place the resident in a private room. If a private room is not available, the resident could be cohorted with a resident with the same infectious agent or share a room with a roommate with limited risk factors. Spatial separation of at least 3 feet and drawing the curtain between resident beds is especially important for residents in multi-bedrooms with infections transmitted by the droplet routes.

Airborne Precautions

Airborne transmission occurs when pathogens are so small that they can be easily dispersed in the air, and because of this, there is a risk of transmitting the disease through inhalation. These small particles containing infectious agents may be dispersed over long distances by air currents and may be inhaled by individuals who have not had face-to-face contact with (or been in the same room with) the infectious individual. Staff caring for residents on airborne precautions should wear a fit-tested N95 or higher-level respirator that is donned prior to room entry.

Precautions to Prevent Transmission of Infectious Agents

It is important that facility staff clearly identify the type of precautions and the appropriate PPE to be used in the care of the resident. The PPE should be readily available near the entrance to the resident's room. Signage can be posted on the resident's door instructing visitors to see the nurse before entering.

It is not always possible to prospectively identify residents needing transmission-based precautions (presumptive precautions). The diagnosis of many infections is based on clinical signs and symptoms but often requires laboratory confirmation. However, since laboratory tests (especially those that depend on culture techniques) may require two or more days to complete, transmission-based precautions may need to be implemented while test results are pending, based on the clinical presentation and the likely category of pathogens.

The use of appropriate transmission-based precautions when a resident develops signs or symptoms of a transmissible infection or arrives at the facility with symptoms of an infection, (pending laboratory confirmation) reduces transmission opportunities. However, once it is confirmed that the resident is no longer a risk for transmitting the infection, removing transmission-based precautions avoids unnecessary social isolation.

Personal Protective Equipment (PPE)

Using personal protective equipment provides a physical barrier between micro-organisms and the wearer. It offers protection by helping to prevent micro-organisms from:

- contaminating hands, eyes, clothing, hair, and shoes
- being transmitted to other residents and staff

Healthcare workers evaluating and interacting with a suspected infectious disease resident must properly wear PPE for standard, contact and droplet precautions. The appropriate PPE must be readily available so that it may be donned immediately when a suspected resident is identified.

It is important to use personal protective equipment effectively, correctly, and always where contact with resident's blood, body fluids, excretions, and secretions may occur.

PPE description, at a minimum:

- Gown (fluid resistant or impermeable)
- Facemask, or necessary respiratory protection (N95)
- Eye protection (goggles or face shield)
- Gloves

Refer to the facility Infection Control Plan for further guidance.

Resident Placement and the Use of Private Rooms for Infection Prevention and Control

The physician and person(s) responsible for infection control should assess individual residents as to the potential for transmitting infectious organisms.

- Room assignments and restriction of activities are determined by this assessment. Although there are many reasons for using private rooms, the major reasons are diseases transmitted in whole or in part by the airborne route or by the resident who extensively soils the environment with body substances.
- Private rooms are generally indicated for residents with uncontrollable excretions (diarrhea), secretions, excessive coughing, heavy wound drainage or widespread skin disease. Residents should be confined to their rooms while the above conditions exist.
- If the situation is small-scale, follow routine resident placement and established infection control practices.
- If many residents are presenting with similar syndromes, group affected individuals into a designated wing or area of the facility. Before grouping, consult with the local / state Health Department and the facility Infection Control personnel regarding adequate isolation (i.e. ventilation).

Resident Care

Only direct care providers should enter the resident room:

- No person enters room without mandatory training and demonstrated competency.
- Autonomous practice (supported by experts).
- Physical and Occupational Therapy, as necessary.
- Environmental decontamination, as necessary.

The care providers will need to be trained and able to demonstrate competency in the following areas:

- Donning and doffing of PPE.
- Use of the “Buddy System.”
- Waste management protocols.
- Decontamination and containment protocols.
- Specimen handling for diagnostic testing.

General Guidelines for Resident Transport within or outside the facility

- Limit movement to that which is to provide proper resident care.
- Mask resident if airborne or droplet organism is suspected, or resident is coughing.

When transporting a resident out of the facility (e.g.: dialysis appointment, evacuation, etc.) When transporting a known confirmed infectious resident, it is recommended that drivers wear an N95 respirator or facemask and eye protection such as a face shield or goggles as dictated by the contagion transmission type (as long as they do not create a driving hazard).

The resident(s) should wear a facemask or cloth face covering. Occupants of the vehicle should avoid or limit close contact (within 6 feet) with others. The use of larger vehicles such as vans or facility buses is recommended when feasible to allow greater social (physical) distance between vehicle occupants.

Additionally, drivers should practice regular hand hygiene, avoid touching their nose, mouth, or eyes.

The Infection Control Plan provides guidance for cleaning and disinfecting after transport of an infectious resident(s).

General Guidelines for Handling Deceased Residents

- Keep tracking records of all residents.
- Attach a form of identification to the body if there is not an identification wrist band (e.g. toe-tag).
- The decedent should be placed in a body bag if requested for transport to funeral home, Coroner, Medical Examiner.
- Personal effects such as eyeglasses, dentures, and hearing aids should be bagged and labeled and placed next to the body.
- Any necessary paperwork for release of the remains should be completed prior to contacting the funeral firm or medical examiner.
- If the facility has a morgue or holding area, the personal effects should remain at the location where the decedent will be signed out and a property form or receipt prepared for either the family or the funeral home.
- Once the decedent is prepared for transport, (i.e. pouched and labeled) the body may be released to the county or other authority as appropriate.

DINING SERVICES

- Assess emergency food, liquids, and supplies and provide information to the Command Center.
- Coordinate meal service with Nursing. Modify menu if deliveries will not be possible. Use disposable plates, cups and utensils as necessary.
- As necessary ensure staff uses necessary PPE if delivering meals or interacting with any residents who may be infectious.
- Establish plan for feeding staff if shift change will not be possible.

THE FRIENDLY HOME

LAUNDRY

Ensure that Environmental Services and Laundry personnel are aware of current guidelines, internal procedures and contacts.

- Review policies and ensure sufficient supplies in the event deliveries cannot be made.
- Environmental cleaning: The facility will follow current CDC and NYS DOH guidelines for environmental cleaning and decontamination specific to the EID in addition to routine cleaning for the duration of the threat.
- Wear appropriate personal protective equipment if cleaning up any contaminate.
- Cleaning, disinfecting and sterilization of equipment and environment:
    - Use principles of Standard Precautions.
    - Germicidal cleaning agents should be available in contaminated and/or isolated resident care areas for cleaning spills of contaminated materials and disinfecting non-critical equipment.
    - Discard single-use resident items appropriately.
    - Contaminated waste should be sorted and discarded in accordance with federal, state, and local regulations.
    - Used resident care equipment soiled or potentially contaminated with blood, body fluids, secretions, or excretions should be handled in a manner that prevents exposure to skin and mucous membranes, avoids contamination of clothing, and minimizes the likelihood of transfer of microbes to other residents and environments.
    - Rooms and bedside equipment should be cleaned using Standard Precautions, unless the infecting microorganism and the amount of environmental contamination indicates special cleaning.
    - Resident linen should be handled in accordance with Standard Precautions. Although linen may be contaminated, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms to other residents, personnel and environments. Facility policy and local/state regulations should determine the methods for handling, transporting and laundering soiled linen.
- Coordinate a linen reduction program, as necessary, with nursing and other appropriate departments.
- Implement environment controls to safely handle, and locate areas, for contaminated waste. Ensure contaminated waste is stored in a safe and secure manner. Use appropriate signage on storage areas. For Example:

MAINTENANCE

- Determine ability to isolate sections of the building for contagious residents.
- Assist with implementing the facility's emergency Building Lockdown Plan. See *EOP Section 2 – Managing Safety and Security During a Disaster*.
- Assess HVAC capabilities and determine if increased air changes are necessary, as per the CDC recommendations issued at the time of the event.

SECURITY (or staff assigned security responsibilities)

Elevated Threat Alert Procedures

- Facility isolation: In the event there are confirmed cases of the EID in the local community, the facility may consider closing the facility to new admissions and limiting visitors based on the advice of local public health authorities.
- Implement the facility emergency Building Lockdown Plan as directed by the Command Center.
- Determine the need for additional staff to provide security or assist with the building lockdown. See *EOP Section 2 – Managing Safety and Security During a Disaster*.
- Control entrances and exits to the building for staff and visitors. Designate an entrance that visitors can use to access the healthcare facility. Reinforce any visitor restrictions.
- Enact special security precautions to safeguard the facility, residents, and staff. Ensure the security of stored emergency supplies such as food, water, PPE, and medical supplies.

SOCIAL SERVICES

- Fear and panic can be expected from both residents and healthcare providers. Psychological responses may include anger, panic, unrealistic concerns about infection, or fear of contagion.
- As assigned by the Command Center, work with families and other responsible parties on behalf of residents.
- Minimize panic by clearly explaining risks to residents.
- Treat anxiety in unexposed persons who are experiencing somatic symptoms with reassurance.
- Fearful or anxious healthcare workers may benefit from their usual sources of social support or by being asked to fulfill a useful role.
- Work with Incident Commander to ensure regular information updates are available to the public.

CENTRAL SUPPLY

- Assess supplies to determine how long you can continue operations. Take results to Command Center.
- Ensure supplies (medical, PPE, etc.) are securely stored.
- Establish receiving area for additional equipment and supplies. Plan storage and tracking.
- Ensure that there is a sufficient supply of PPE and protocols for obtaining additional PPE supplies.

- Be cognizant of expiration dates of certain PPE, including respirators.
- Collaborate with local/state public health, local/state emergency management, sending and receiving facilities, and other healthcare organizations or systems to address any potential supply chain issues through the Liaison Officer.
- Determine the role of local / state / federal public health authorities in assisting the healthcare sector in prioritizing orders with manufacturers / suppliers.

HUMAN RESOURCES

- Track hours worked by staff during the response for potential reimbursement during declared public health emergencies.
- Facilitate purchasing of supplies necessary for the emergency response.
- Track and report to the Incident Commander the financial cost of the response including all workmen's comp, property damage, and other claims resulting from the event.

RETURN TO NORMAL OPERATIONS / RECOVERY

Recovery from the spread of an infectious disease will begin when facility officials receive notice from the local Public Health Department or NYS Department of Health based on CDC guidance, that facilities may resume normal operations.

The Incident Commander or designee will determine if staffing, supplies, resources and systems are adequate to manage ongoing activities.

In consultation with Public and/or State Health Department Authorities the facility will recommend specific actions to be taken to return the facility to pre-event status.

The facility will:

- Assess facility, staff, and department operations to determine ability to return back to normal operations.
- Implement sanitization and disinfection procedures.
- Deploy solid waste disposal plans.
- Maintain review of and implement procedures provided in NYS DOH and CDC recovery guidance that is issued at the time of each specific infectious disease or pandemic event, regarding how, when, which activities/procedures/restrictions may be eliminated, restored, and the timing of when those changes may be executed.
- Reconsider physical and social distancing restrictions that had been implemented.
- Communicate to residents, families, and other relevant stakeholders any relevant recovery activities regarding a return to normal operations.
- Conduct an After-Action Review to evaluate the response actions taken by the facility as a result of the infectious disease.
- Determine effectiveness of existing plan to respond to similar events in the future.
- Revise existing plan as necessary to address any deficiencies.
- Review processes and incident communication protocols.

- Document / Archive all information of the response
- Assess the economic impact on the facility. Have Finance Section collect cost for reimbursement.
- Have department heads restock supplies.
- Close down Incident Command.

THE FRIENDLY HOME

Online Resources

IDSA Practice Guidelines

Practice guidelines are systematically developed statements to assist practitioners and patients in making decisions about appropriate health care for specific clinical circumstances.

https://www.idsociety.org/practice-guideline/practice-guidelines

WILL UTILIZE DAILY HERDS REPORT for burn rate calculations.

FRIENDLY HOME SCREENING TOOL has been attached at the end of this document.

THE FRIENDLY HOME

COVID Specific Template Letter to Employees

To Our Employees:

We know some of you are concerned about the spread of COVID-19 (the new coronavirus) and how it may impact us here at **[FACILITY NAME]**. Ensuring our staff and residents are in a safe and healthy environment is our first priority. At this time, we don't have any cases in our **[CENTER/COMMUNITY]**. The Centers for Disease Control and Prevention (CDC) have recommended a variety of steps that we are implementing to help reduce the potential for the virus to enter our building. However, we need your help in battling COVID-19. Below are some examples of how you can help protect yourselves and our residents, as well as prevent the spread throughout the community.

1. **Sick employees should stay home.** At this time, we request that you stay home if you have any symptoms of respiratory illness. Those symptoms include: cough, fever, sore throat, runny nose, and/or shortness of breath.
2. **Notify us if you develop respiratory symptoms while at work.** These include: cough, fever, sore throat, runny nose, and/or shortness of breath.
3. **Practice proper hand washing hygiene.** All employees should wash their hands for at least 20 seconds or use alcohol-based hand sanitizer that contains at least 60-95% alcohol upon entering the building and before and after interaction with residents. Soap and water should be used preferentially if hands are visibly dirty.
4. **Cover your mouth and nose with a tissue when coughing or sneezing.** Please review the CDC's information on coughing and sneezing etiquette.
5. **Perform routine environmental cleaning.** Routinely clean all frequently touched surfaces in the workplace, such as workstations, countertops, and doorknobs. Use the cleaning agents that are usually used in these areas and follow the directions on the label. No special cleaning is necessary for COVID-19.

Our **[CENTER/COMMUNITY]** is following the recommendations of the CDC on using basic contact precautions to prevent the spread, which includes wearing gowns and gloves when interacting with residents who present symptoms—as we always do. We also are staying up to date with the CDC recommendations as they may continue to change. In addition, our **[CENTER/COMMUNITY]** is in close contact with the local and state health department and are following their guidance.

We are asking all non-essential visitors to avoid coming to the building unless absolutely necessary, and actively screening individuals—including staff—who enter. We are posting signs on our entryway doors to notify visitors of this policy and request that they not enter the building.

We will notify you if any residents or staff are diagnosed with COVID-19. Should you have any questions, please feel free to contact **[POINT OF CONTACT AND CONTACT INFO]**.

For additional information, please visit the CDC's coronavirus disease information page.

Sincerely,

[FILL IN YOUR CENTER INFORMATION]

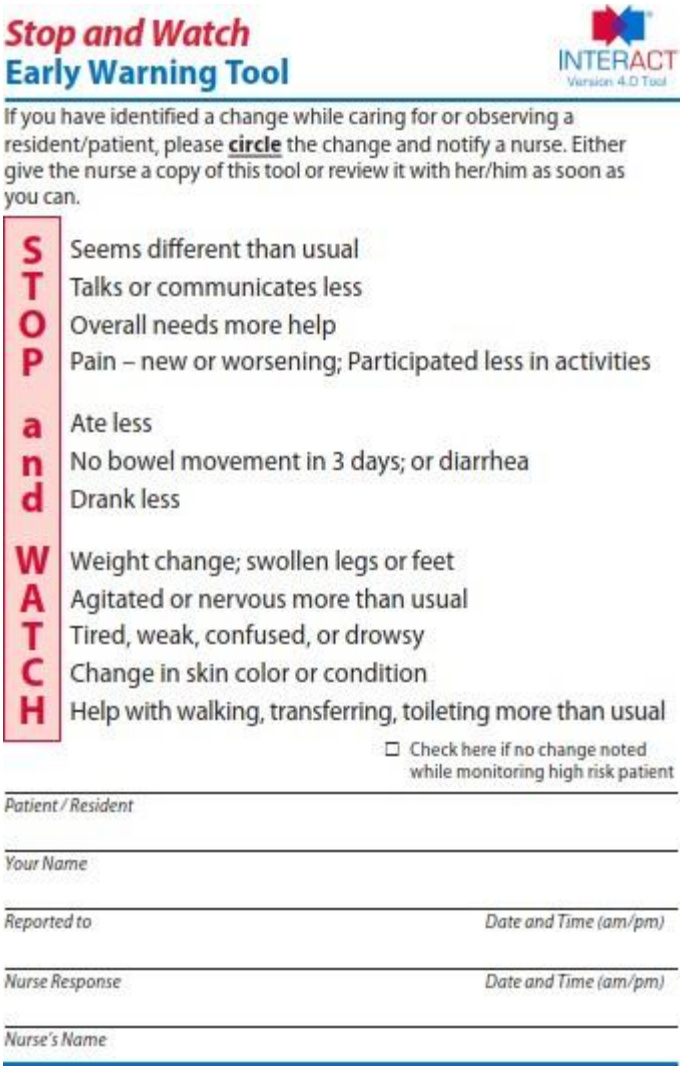
COVID-19

ROCHESTER REGIONAL HEALTH

COVID-19 Clinical Workflows for Nursing Homes

A. All Staff:

In the elderly, initial symptoms of acute infections are often non-specific. All staff should continue to use the Stop and Watch tool and notify the nurse of any changes in a resident. Additionally, all staff observing a resident with specific symptoms of respiratory infection (runny nose, sneeze, cough, sore throat, trouble breathing, fever) will notify the nurse immediately. The nurse should also be notified of any residents who do not have symptoms but report being in contact with someone who has developed a respiratory illness or fever.



Stop and Watch
Early Warning Tool

INTERACT Version 4.0 Tool

If you have identified a change while caring for or observing a resident/patient, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

STOP
- Seems different than usual
- Talks or communicates less
- Overall needs more help
- Pain – new or worsening; Participated less in activities

and
- Ate less
- No bowel movement in 3 days; or diarrhea
- Drank less

WATCH
- Weight change; swollen legs or feet
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

COVID-19 Clinical Workflows for Nursing

B. Clinical Staff:

A nurse will observe all residents for respiratory symptoms and obtain each resident's body temperature every shift and as needed. If possible, measurement of oxygen saturation should also be obtained.
Observations & Considerations for patients with a change in condition:

- If the resident is exhibiting respiratory signs or symptoms, keep the door to the room closed, implement **Contact** & **Droplet** precautions, and place a **medical mask on the resident** unless the resident is unable to tolerate the mask
- Obtain vital signs
- Fingerstick glucose (residents with diabetes)
- Alcohol intoxication or drug use (if a narcotic overdose is suspected, administer naloxone (Narcan) immediately)
- General: Chills, fatigue, loss of appetite, muscle aches
- Head: Runny nose, sore throat, headache, changes in the sense of smell or taste
- Respiratory: **New cough**, **abnormal lung sounds, Accessory muscle breathing, pursed-lip breathing, Respiratory distress**
- GI: **Nausea, vomiting, diarrhea, abdominal pain**, constipation, heartburn, abdominal distention or tenderness, rebound tenderness, bowel sounds
- Injuries (bruising, laceration, fractures), head trauma
- Assess all joints for change in the normal range of motion, weight-bearing, etc
- **Acute mental status change**
- Not eating or drinking as much as usual
- If pain: exact locations, pain scale, description (sharp, dull, burning), persistent or intermittent
- Fainting, dizziness or lightheadedness when standing up
- Acute decline in ADL abilities
- Thirst, signs of dehydration
- Jaundice
- Bleeding, hemorrhage
- Cardiovascular: Chest pain, new irregular pulse, cyanosis, mottling, edema
- GU: New or worsened incontinence, pain with urination, blood in urine, urinary retention/bladder scan
- Neurologic changes: consciousness/alertness, orientation, weakness, gait changes (unsteadiness, loss of coordination or balance)
- Very low urinary output (<30cc/hr)
- Skin: sweats (diaphoresis), cold/clammy/pale skin; any new skin condition, i.e., bruising (including potential head trauma), **rash, red fingers or toes**, infection/cellulitis

Nurse to notify provider immediately if the resident is exhibiting the bolded potential COVID-19 symptoms; for other changes in condition, follow the guidance at www.ssesbar.org.

Provider is to determine if findings potentially represent COVID-19 Disease.

- Assess for symptoms and signs of viral illness as outlined in *UpToDate* or similar reference
- **Notify nursing immediately of any resident suspected to have COVID-19 or diagnosed with COVID-19**
- Order COVID-19 testing.
    - If the resident is an "Index Case," that is, the first potential case of COVID on a nursing unit, contact Scott Schabel at 585-563-4312 regarding expedited testing options.
    - False-negative results are common. If, based on exposure and symptoms, the provider

diagnoses COVID-19 disease despite a negative result, the case should be considered a "presumed case."

- In the setting of an outbreak with multiple confirmed cases of COVID-19 Disease, testing of new cases is not necessary, and the provider can make the diagnosis of COVID-19 Disease presumptively ("presumed case").

COVID-19 Clinical Workflows for Nursing

C. Resident Care: Suspected or confirmed COVID-19 (or PUI/possible PUI):

Immediately:

- Keep the door to the room closed, wear a **medical mask**, **gloves**, **gown**, and **eye protection** ("Enhanced Isolation Precautions"), and place a **medical mask on the resident** when anyone is in the room, unless the resident is unable to tolerate the mask. In a semi-private room, keep the privacy curtain closed and the residents separated as much as possible.
- Notify the resident and the resident's representative of the COVID-19 related illness.
- If the resident otherwise requires hospitalization, arrange for safe transfer to acute care.

Within 24 Hours:

- Review the patient's history to determine if the patient may be a "persistent positive" patient.
- Facility leadership to review the case with Infection Prevention & NYSDOH Regional Epidemiologist - (585) 423-8119
- Relocate the resident with COVID-19 to a room on a designated COVID-19 area, if available in the facility. If such an area is not available, and the resident's room is located in a high-traffic area, relocate the resident to a private room in a low-traffic area, preferably on the same unit. If a roommate also needs to be relocated, do **not** move the roommate to another semi-private room or a room on another unit.
- Determine if the patient should be moved to a facility with a designated COVID-19 unit and institute transfer procedures, if appropriate.

Ongoing:

- Residents with **confirmed** COVID-19 may be cohorted in a room or unit with other residents with **confirmed** COVID-19 as long as no other contraindications to cohorting exist as per usual infection prevention procedures. Avoid cohorting patients with **confirmed** COVID-19 with patients who have **presumed** COVID-19 or **previously recovered** from COVID-19.
- If there is a confirmed outbreak of COVID-19 on the resident's unit, newly-ill residents should be managed as presumptive-positive COVID-19 cases. If an outbreak is not already established, contact a provider for an order to send a nasopharyngeal swab for COVID- 19 PCR testing.
- Only staff **fitted** for an N95 respirator will perform aerosol-generating procedures, including suctioning (if not using an inline catheter), nebulizer administration, manipulation of BiPAP/CPAP mask, chest physiotherapy, and CPR. A portable UV/HEPA filtration device should be used in the room during the aerosol-generating procedure.
- Actively monitor the resident once per shift for at least two weeks
    - Interview for **new** symptoms, when resident is able
    - Measure body temperature and oxygen saturation
    - Additional observations to consider: Vital signs, Lung auscultation
- Residents with suspected or confirmed COVID-19 on a unit should be cared for by the same clinical staff, dedicated to the care of the COVID-19 patients whenever possible. Minimize the number of persons entering the resident's room, including clinicians performing non-clinical work or work of other clinicians as long as the work is within their scope of practice.
- The resident should only leave the room for medically-necessary procedures.

COVID-19 Clinical Workflows for Nursing

- Resident to perform hand hygiene (with assistance, if needed) & don medical mask before leaving the room.

COVID-19 Clinical Workflows for Nursing

D. Resident Care: Resident with exposure to COVID-19 outside of the facility:

- Actively monitor the resident once per shift
  - Interview for **new** symptoms, when resident is able
  - Measure body temperature and oxygen saturation
  - Additional observations to consider: Vital signs, Lung auscultation
- Resident to remain in his/her room
- Resident is placed on **Droplet** and **Contact** precautions precautions – staff should wear a **gown**, **gloves**, **eye protection**, and **medical mask**.
- Resident must wear a **medical mask** when staff enters the room, unless the resident is unable to tolerate the mask. The resident should also wear a mask, perform hand hygiene, and maintain social distancing when out of the room and when out of the building.
- Notify a provider if a resident develops symptoms and follow the workflow in Section (C) above.
- Infection prevention nurse to consider discontinuing these precautions in asymptomatic residents fourteen days after exposure

COVID-19 Clinical Workflows for Nursing

E. Facility exposed by a New case of Confirmed or Presumed COVID-19 in a Current or Previous Resident or Staff Member:

- Determine which units may have been exposed to the confirmed or presumed COVID-19 resident or staff member. Consider activating facility incident command center to coordinate changes in care and supply needs.
- Facility leadership to notify Infection Prevention & NYSDOH Regional Epidemiologist - (585) 423-8119
- Actively monitor all residents on the affected unit once per shift
    - Interview for **new** symptoms, when resident is able
    - Measure body temperature and oxygen saturation
    - Additional observations to consider: Vital signs, Lung auscultation

  Follow workflow (C) above for any resident newly displaying signs and symptoms, even if the resident previously tested negative.
- All residents on the affected unit(s) are to remain in their rooms
- All residents on the affected unit(s) are placed on **Droplet** and **Contact** precautions – staff should wear a **gown**, **gloves**, **eye protection**, and **medical mask**.
- All residents on the affected unit must wear a **medical mask** when staff enter their rooms, unless the resident is unable to tolerate the mask
- All residents should perform hand hygiene when leaving room (with assistance, if needed).
- Do not float staff to or from affected units
- All staff who worked on the affected units will self-monitor for symptoms and take their temperature two times per day.
- Continue these processes for at least 14 days after the onset of symptoms in the units' most recent patient with confirmed or presumed COVID-19-disease. After the 14 days are completed, The unit should follow workflow (F) below.
- Admissions & re-entries to an exposed unit may continue. Avoid new admissions of residents to the exposed unit who are immunocompromised, have diabetes or significant cardiac, kidney, or lung disease, or would have difficulty complying with room confinement or mask usage.

COVID-19 Clinical Workflows for Nursing

F. Facility Management of Units housing Patients with COVID-19 Disease

- Confirmed or presumed COVID-19 patients should be cared for using the workflow in section (C) above.
- Staff caring for confirmed or presumed COVID-19 patients should avoid caring for other residents or floating to other units. If caring for patients without COVID-19 Disease is unavoidable, for **all residents**, at a minimum, affected staff will:
  - Wear a **medical mask** and face shield (extended wear permitted)
  - Wear **gloves** (changed between residents and according to all infection prevention principles)
  - Wear a **gown** when performing **direct care activities** (such as bathing, dressing, toileting, incontinence care, feeding, transfers)
  - Follow the additional precautions required when caring for patients in workflows (C), (D) and (E) above.

  Note: Affected staff should follow these procedures from the start of the first shift until the end of the last shift each day, until there are no patients on the unit with COVID-19 Disease.
- If admitting a patient with COVID-19 Disease (with regulatory permission), the facility leadership is to notify Infection Prevention & NYSDOH Regional Epidemiologist - (585) 423-8119
- Residents with COVID-19 Disease should be cohorted in semi-private rooms or private rooms in the same general area of the unit. If possible, these areas should be sectioned-off by physical barriers or visual markers.

G. Discontinuation of precautions for a confirmed or presumed COVID-19 resident

1. At least 24 hours have passed since last fever without the use of fever-reducing medications, and
2. Symptoms (e.g., cough, shortness of breath) have improved, and
3. Fourteen (14) days to twenty-one (21) days have passed since symptom onset, depending on the severity of the patient's illness and presence of severe immunocompromise, as determined by the attending medical provider, and with concurring assessment by the facility infection preventionist. If the patient is asymptomatic throughout his/her infection, the date of the positive test begins the clock for the required isolation time.

   Note: Additionally, a resident with **persistent symptoms** from COVID-19 (e.g., persistent cough) should be placed in a private room, be restricted to their room, and wear a facemask during care activities **until all symptoms are completely resolved**.

COVID-19 Clinical Workflows for Nursing

H. Admission & Return of Residents to the Nursing Home:

- All patients admitted to a nursing home with a case of COVID-19 illness and the patient's representatives must be notified that the facility has had a case of COVID-19 disease.
- Residents with respiratory illness but without COVID-19 Disease
    - COVID-19 excluded
        - Positive PCR test for Influenza, RSV, or atypical pneumonia panel, OR
        - Negative COVID-19 assay, OR
        - Confirmatory review of the case by facility medical director
    - Residents with any communicable disease or ongoing symptoms of COVID-19 illness may require additional room placement or transmission-based precautions.
- Residents with COVID-19 Disease who are no longer contagious
    - At least 24 hours have passed since last fever without the use of fever-reducing medications, and
    - Symptoms (e.g., cough, shortness of breath) have improved, and
    - Fourteen (14) days to twenty-one (21) days have passed since symptom onset, depending on the severity of the patient's illness and presence of severe immunocompromise, as determined by the attending medical provider. If the patient is asymptomatic throughout his/her infection, the date of the positive test begins the clock for the required isolation time.

  Note: Additionally, a resident with **persistent symptoms** from COVID-19 (e.g., persistent cough) should be placed in a private room (or a room with another confirmed COVID-19 resident), be restricted to their room, and wear a facemask during care activities **until all symptoms are completely resolved.**
- Residents with confirmed or presumed COVID-19 Disease and PUIs (that is, potentially contagious) (with regulatory permission)
    - Admit to a unit designated to receive COVID-19 residents.
    - Admit the resident to a private room. Residents with **confirmed** COVID-19 may be cohorted with other residents with **confirmed** COVID-19 as long as no other contraindications to cohorting exist.
- Residents with known exposure to COVID-19
    - Preferably admit to a unit with prior exposure to confirmed COVID-19 or unit designated to receive COVID-19. If such a bed is not available, the resident may be admitted to a private room on any unit.
    - Follow the instructions in Section D, above.
- Admission or re-entry to the nursing home after hospital care for a non-respiratory illness requires no additional review.
- When possible, admissions may be cohorted by admission date to segregate the new admissions from the other residents in the facility.
- Regardless of any prior negative COVID-91 testing, institute contact and droplet precautions for 14 days for residents recently-hospitalized with a systemic illness, or vague or ill-defined symptoms such as malaise, fatigue, weakness, confusion, gait disturbance, or self-care deficits. These precautions may not be necessary for patients after elective surgery, at the discretion of the facility infection prevention nurse or designee.

COVID-19 Clinical Workflows for Nursing

- Admissions & re-entries to an exposed unit may continue. Avoid new admissions of residents to the exposed unit who are immunocompromised, have diabetes or significant cardiac, kidney, or lung disease, or would have difficulty complying with room confinement or mask usage.

COVID-19 Clinical Workflows for Nursing

Definitions

COVID-19 PUI: a patient who has developed symptoms consistent with COVID-19 disease, while waiting for results of a COVID-19 PCR or other diagnostic test.

COVID-19 Confirmed Case: a patient who has had a positive COVID-19 or other diagnostic test.

COVID-19 Presumed Case: a patient with a known exposure to COVID-19 and symptoms of COVID-19 disease, in which a diagnostic test is not performed.

COVID-19 Persistent Positive: a patient who has recovered from COVID-19 and subsequently tests positive for COVID-19, as determined by the NYSDOH epidemiologist.

References (you may need to copy and paste the link into your browser if it doesn't work by clicking on it)

https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

https://coronavirus.health.ny.gov/system/files/documents/2020/07/revised-march-13-guidance-07.10.2020-final.pdf

https://coronavirus.health.ny.gov/system/files/documents/2020/03/doh_covid19_protectnursinghomeresidents_032120.pdf - Notification 102906

https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh-covid-19-discontinuing-isolation-hospital-congregate-setting.pdf - Notification 102742

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

https://coronavirus.health.ny.gov/system/files/documents/2020/03/acfguidance.pdf

https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness- Checklist_3_13.pdf

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19_ltcf-ipcselfassesmenttool_041020.pdf

https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19_acf-nh_residentfamilycommunication_040420.pdf

https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19-_ppeshortages_040220.pdf

https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.18.pdf

https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.19.pdf

https://commerce.health.state.ny.us/hpn/ctrldocs/alrtview/postings/DOH_COVID19_NursingHomeCohortingFAQs_Final_1591451281923_0.pdf

Name of screener ____ (One screener per sheet)

Page #_____ **Screener Process** Today's Date____________

Friendly Senior Living – Friendly Home

Name	**Temp**	**Time**	**Have you had any chills or fever?**	**New or change in Cough?**	**Shortness of Breath?**	**Sore Throat?**	**Diarrhea?**	**Have you lost your appetite or been eating less lately?**	**Have you felt more tired than usual?**	**Do you feel weak, sick or like you are coming down**	**Muscle Aches?**	**Headache?**	**Do your eyes hurt?**	**Nausea?**	**Does food taste different to you, or have you lost your**	**OTHER than cases at work, contact with a confirmed**	**Have you had contact with someone ill, such as a respiratory infection or under**	**Have you traveled out of state in the last 14 days?**	**Anything else / Concerns**	**Screener Observe any signs or symptoms of COVID**	**Nurse Review, if needed**
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At the end of screening, remind the person as follows: ***"If you develop any of these symptoms, even ten minutes from now, please [stop working, notify your supervisor, and] return here to be screened again. Change mask every 4 hours. Reminder to test Monday or Thursday – every 7 day***

TITLE:	INFECTION CONTROL PROGRAM NS-25B			
DEPARTMENT:	NURSING			
ORIGINAL EFFECTIVE DATE: JUN 2010	**REVISION DATE:** **August 19, 2020**		**REVIEWED DATE:**	**SUPERSEDES:**
APPLICABLE ENTITIES (CHECK ALL THAT APPLY):	☒	The Friendly Home	**DEPARTMENT DISTRIBUTION:** All Departments	**REFERENCE(S):** F880 483.80
	☐	Cloverwood		
	☐	Glenmere		
	☐	Linden Knoll		

POLICY

The Facility has established and maintained an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility will conduct an annual review of its IPCP and update as necessary. The IPCP will follow national standards and CDC guidelines and the risks identified in the facility assessments. GUIDELINES

GENERAL INFORMATION

The facility's Infection Prevention and Control Program has been established in order to prevent, recognize, and control to the extent possible, the onset and spread of infection within the facility. The program will:

- Perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection; when and to whom to report possible incidents of communicable disease or infections within the facility and to local/state public health authorities.
- Prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions; when and how isolation should be used, including but not limited to the type and duration of the isolation.
- Use records of infection incidents to improve its infection control process and outcomes by taking corrective actions, as indicated;
- Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination;
- Properly store, handle, process, and transport linens to minimize contamination.
- Includes an antibiotic stewardship program.
- Includes an infection control risk assessment, which evaluates and determines the risk of potential vulnerabilities within the resident population and the surrounding community, which is reviewed annually.
- Covid-19 see attached.

COVID SPECIFIC INFORMATION

- All Covid positive Members/Patients are on droplet and contact precautions with N-95 mask worn for aerosol generating procedures.

- No communal dining, all Members will have meals in their rooms.
- Visitors restricted.
- All building staff are Covid screened upon entering building for work. Employees with Covid symptoms will be sent home, told to contact doctor and Employee Health.
- Staff working on double shift will be screened for Covid symptoms.
- Staff will ambulate one Member at a time in the hallway and the Member will wear a mask. Following Member ambulation, Members hands will be sanitized and Ambulatory device will be sanitized. If member ambulates holding onto hand rail, rail will be sanitized following ambulation.
- Non nursing staff will provide friendly visits during mealtime to promote socialization and provide mealtime encouragement to optimize nutrition. Staff will wear proper PPE and sanitize hands per policy.
- Families may visit if their family member is imminent; visiting guidelines will be explained to family by Nursing Management/Social Work.
- Member/Patients cultured positive for Covid will be transferred to the Covid unit. Covid unit staff will not float.
- Members/Patients will wear masks as tolerated during all staff contacts.
- New admissions/readmissions will be on 14 day isolation on TCC.
- All Members/Patients will have temperature, O_2 sat and evaluation for respiratory symptoms done 3 times daily.

DEFINITIONS

Definitions are provided to clarify terminology or terms related to infection control practices in nursing homes.

- **"Airborne precautions"** refers to actions taken to prevent or minimize the transmission of infections agents/organisms that remain infectious over long distances when suspended in the air. These particles can remain suspended in the air for prolonged periods of time and can be carried on normal air currents in a room or beyond, to adjacent spaces or areas receiving exhaust air.
- **"Alcohol-based hand rub" (ABHR)** refers to a 60-95 percent ethanol or isopropyl containing preparation base designed for application to the hands to reduce the number of viable microorganisms.
- **"Antifungal"** refers to a medication used to treat a fungal infection such as athlete's foot, ringworm or candidiasis.
- **"Anti-infective"** refers to a group of medications used to treat infections.
- **"Antiseptic hand wash"** is washing hands with water and soap or other detergents containing an antiseptic agent.
- **"Cleaning"** – removal of visible soil from objects and surfaces using water with detergents or enzymatic products.

- **"Cohorting"** Refers to the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents (cohorting residents). During outbreaks, healthcare personnel may be assigned to a cohort of residents to further limit opportunities for transmission (cohorting staff).

- **"Colonization"** Refers to the presence of microorganisms on or within body sites without detectable host immune response, cellular damage, or clinical expression.

- **"Communicable disease" (also known as "Contagious disease")** refers to an infection transmissible (as from person-to-person) by direct contact with an affected individual or the individual's body fluids or by indirect means (as by a vector).

- **"Community acquired infections" (a.k.a. present on admission)** refers to infections that are present or incubating at the time of admission, or generally develop within 72 hours of admission.

- **"Contact precautions"** are measures that are "intended to prevent transmission of infectious agents, including epidemiologically microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment.

- **"Droplet precautions"** refers to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.

- **"Hand hygiene"** is a general term that applies to washing hands with water and either plain soap or soap/detergent containing an antiseptic agent; or thoroughly applying an alcohol-based hand rub (ABHR).

- **"Hand washing"** the vigorous, brief rubbing together of all surfaces of hands with plain (anti non-microbial) soap and water, followed by rinsing under a stream of water.

- **"Health care associated infection [HAI]" (a.k.a. "non-socomial" and "facility-acquired" infection)** refers to an infection that generally occurs after 72 hours from the time of admission to a health care facility.

- **"Hygienically Clean"** means being free of pathogens in sufficient numbers to cause human illness.

- **"Infection"** refers the establishment of an infective agent in or on a suitable host, producing clinical signs and symptoms (e.g., fever, redness, heat, purulent exudates, etc).

- **"Infection prevention and control program"** refers to program (including surveillance, investigation, prevention, control, and reporting) that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of infection.

- **"Infection preventionist (IP)" (a.k.a. infection control professional)** refers to a person whose primary training is an either nursing, medical technology, microbiology, or epidemiology and who has acquired additional training in infection control.

- **"Isolation"** refers to the practices employed to reduce the spread of an infectious agent and/or minimize the transmission of infection.

- **"Isolation precautions"** see "Transmission-Based Precautions"

- **"Medical waste"** refers to any solid waste that is generated in the diagnosis, treatment, or immunization of human beings or animals, in research pertaining to, or in the production or testing of biologicals (e.g., blood-soaked bandages, sharps).

- **"Methicillin resistant staphylococcus aureus (MRSA)"** refers to Staphylococcus aureus bacteria that are resistant to treatment with semi-synthetic penicillins (e.g., Oxacillin/Nafcillin/Methicillin).

- **"Multi-Drug resistant organisms (MDROs)"** refers to microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent, these pathogens are frequently resistant to most available antimicrobial agents.

- **"Outbreak"** is the occurrence of more cases of a particular infection than is normally expected, the occurrence of an unusual organism, or the occurrence of unusual antibiotic resistance patterns.

- **"Personal protective equipment" (PPE)** refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury.

- **"Standard precautions" (formerly "Universal Precautions")** refers to infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions is a combination and expansion of Universal Precautions and Body Substance Isolation (a practice of isolating all body substances such as blood, urine, and feces). Standard precautions include hand hygiene, use of gloves, gown, mask, eye protection, respiratory hygiene/cough etiquette.

- **"Surveillance"** refers to the ongoing, systematic collection, analysis, interpretation, and dissemination of data to identify infections and infection risks, to try to reduce morbidity and mortality and to improve resident health status.

- **"Transmission-based precautions" (a.k.a. "Isolation Precautions")** refers to the actions (precautions) implemented, in addition to standard precautions, that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections.

- **"Vancomycin resistant enterococcus (VRE)"** refers to enterococcus that has developed resistance to vancomycin.

The program emphasizes the prevention and management of infections and responding to errors, problems, or other identified issues. Additional activities involved in program developed and oversight may include but are not limited to:

- •Identifying the staff's roles and responsibilities for the routine implementation of the program as well as in case of an outbreak of a communicable disease, an episode of infection, or the treat of bio-hazard attack;

- •Developing and implementing appropriate infection control policies and procedures, and training staff on them;

- •Monitoring and documenting infections, including tracking and analyzing outbreaks of infection as well as implementing and documenting actions to resolve related problems;

- •Defining and managing appropriate resident health initiatives, such as :

  - The immunization program (influenza, pneumonia, etc); and
  - Tuberculosis screening on admission and following the discovery of a new case, and managing active cases with State requirements;

- •Providing a nursing home liaison to work with local and State health agencies; and

- •Managing food safety, including employee health and hygiene, pest control, investigating potential food-borne illness, and waste disposal.

Persons with a disease in a communicable state are not admitted to the Home. Members diagnosed as having a communicable disease which cannot be properly treated in the Home are transferred as soon as possible to a facility which can render care, i.e.: confirmed TB. LTC facilities must be prepared to implement the appropriate infection control measures for members with infections or colonization.

Isolation precautions should be the least restrictive possible for the Member/Patient under the circumstances:

- Contact Precautions are instituted for all activities suspected MDRO infections, C-difficile, Norovirus, Covid-19.

Staff may not report to work with respiratory or flu symptoms or vomiting and diarrhea, skin or eye infections require assessment by the Nursing Supervisor or employee Health Nurse prior to the start of the shift.

- Droplet precautions are instituted for influenza illness for at least 7 days or until 24 hours after all fever have resolved.

All staff required to wash their hands before and after each direct Member/Patient contact for which hand washing is indicated by acceptable professional practice.

- Contact and droplet precautions for Covid-19 illness per Covid-19 clinical work flow.

Staff is required to wash hands after glove removal. Gloves are to be removed prior to exiting the Member/Patient room.

Staff must handle, store, process and transport linens to prevent the spread of infection.

Respiratory hygiene/cough etiquette includes resources and instructions for performing hand hygiene in or near lobby areas or entrances, during times of increased prevalence of respiratory infections in the community, the facility offers face masks to coughing or sneezing visitors. Symptomatic visitors are advised to wear face mask or to maintain a three feet separation from others in common areas.

Infectious organisms may be transmitted by direct or indirect contact.

- Direct contact transmission (person to person) occurs when micro-organisms are transferred from an infected or colonized person to another person. In nursing homes this may occur in common areas of the facility such as recreation rooms, rehabilitation rooms and dining rooms.

- Indirect contact transmission involves the transfer of an infectious agent through am inanimate object or person. High touch environmental surfaces (e.g. bedside tables, toilets, sinks, handrails) contributes to transmission of pathogens including C-difficle and norovirus.

Certain pathogens may contaminate and survive on equipment for long periods of time.

- C-difficle spores can live on inanimate surfaces for up to 5 months.
- Hepatits B virus can survive for a week on inanimate surfaces.
- Influenza virus can survive on fomites for up to 8 hours.

Decontamination of Member/Patient equipment, medical devices, and the environment is done to prevent infections through indirect contact transmission.

The facility may also utilize single-use disposable devices or designate re-usable equipment for only an individual Member/Patient.

RESPONSIBILITY	PROCEDURE
RN/LPN	1. Administers to every Member admitted to the Home the two-step Mantoux Test on admission. If PPD positive notifies physician and obtains order for chest X-ray. 2. Places in the appropriate category of isolation Members suspected of or diagnosed as having any communicable, contagious or infectious disease. 3. Bags contaminated dressings and places in a red bag labeled "Infectious". 4. Places the red bag in the container with red lettering labeled "Infectious" in the dirty utility room.
Nurse Mgr/Asst. Nurse Mgr/ Clinical Coord./Supervisor	1. Reports all clusters of infections per % of unit census in a 24 hour period to the Infection Control Nurse. 2. Reports all known or suspected infections to the Infection Control Nurse on a monthly basis on facility tracking tool.
Infection Control Nurse/Assistant Director of Nursing/Director of Health Services	1. Checks 24 Hour Report daily for newly acquired infections. Assesses the Members. 2. Monitors the rate of infections on daily needed basis. 3. Keeps records of all communicable diseases and nosocomial infections. 4. Updates Director of Health Services on all communicable dieses and nosocomial infections. 5. Completes annual review of Infection Control Risk Assessment. 6. Reviews Emergent Infection Control Plan annually.
Director of Health Services	1. Reports via DOH-4018 form to the New York State Department of Health Bureau of Communicable Disease Control all diseases and appropriate nosocomial infections. 2. Responds to the follow up report from the DOH in Albany.
EQUIPMENT AND SUPPLIES **ALL STAFF**	1. Uses disposable bedside equipment. Disposes of this equipment following the death or discharge of the Member.

RESPONSIBILITY	PROCEDURE
	2. Dedicates as much as possible any equipment (i.e.: thermometers, BP) which stays in members room for their use only. 3.Cleans and disinfects using Clorox wipe any "shared" equipment which can't be dedicated i.e.: glucometer, digital thermometer, lifts, nail clippers. 4. Electric razors (those without disposable heads) may not be shared. 5. Bladder scanner is disinfected with alcohol wipes between uses.
RN/LPN	1. Uses disposable equipment for all sterile procedures (syringes, catheters, feeding tubes).
Environmental Services	1. Picks up daily all dressings from infected wounds, which have been double bagged, from soiled utility room. 2. Arranges for proper disposal of contaminated equipment, needles and syringes.
Employee Health Nurse	1. Administers the two-step Mantoux Test to all new employees and maintains records of the results. Confirms immunity status of new employees. 2. Refers to TB Clinic or own physician any employee who reacts positively to the Mantoux Test. 3. Temporarily suspend annual employee PPD's until solution available. 4. Once PPD solution is available mailing will be sent to all employees to schedule a PPD appointment with Employee Health Nurse. 5. Once PPD solution is available all employees will be tracked for compliance. 6. Maintains records of pre-employment physicals, annual health assessments, Hepatitis B Vaccinations and results of Mantoux Tests. 7. Sends a Health Assessment Form to all employees annually. 8. Administers Hepatitis B Vaccine to any employee who has requested the three-injection series. Ensures that the employee attends an in-service program and signs an authorization form prior to receiving the Hepatitis B Vaccine.
Nurse Practitioner/Physician Assistant	1. Evaluates the health status of a new employee through a physical exam.
Staff Education	1. Presents infection control programs for all staff on an annual basis. 2. Presents information on Hepatitis and has staff sign Hepatitis B Vaccine Authorization Form during the first ten days of employment.
All Staff	1. Receives a pre-employment physical examination and the two-step Mantoux Test. Written documentation and results of a Mantoux Test within one month will be accepted in place of a Mantoux Test. 2. Completes a Health Assessment Form annually, and returns it to the Employee Health Office.

Covid-19 Nasal Swab Testing for Employee Testing

Nasal Swab specimen collection for employee testing will be performed by nursing staff.

Nasal Swab Testing: Nasal swab testing is a minimally-invasive procedure where a synthetic-tipped swab is inserted into the anterior (front) portion of the nostril ONLY to collect a specimen. Nasal testing is NOT the same as nasopharyngeal testing.

Environmental guidelines for collecting specimens on the unit:

- Considerations for multiple HCP being swabbed in succession in a single room:
    - Minimize the amount of time the HCP will spend in the room. HCP Awaiting swabbing should not wait in the room where swabbing is being done. Those swabbed should have a face mask or cloth cover in place for source control throughout the process, only removing it during swabbing.

- Cleaning and disinfection between individuals:
  Surfaces within 6 feet of where specimen collection was performed should be cleaned and disinfected using an approved disinfectant if visibly soiled and at least hourly.

- Terminal cleaning and disinfection of all surfaces and equipment in the specimen collection area should place at the end of each day.

Procedure for performing a Nasal Swab:

1. Prepare work station.
2. Perform hand hygiene and don PPE. **Full PPE (including an N95 mask) must be worn during specimen collection.**
3. Have staff enter testing area 1 at a time.
4. Instruct employee to slide mask down exposing only the nose but keeping the mouth covered. Tilt head back 70 degrees.
5. While gently rotation the swab, insert swab less than one inch into nostril (if you meet a point of resistance at turbines-**Do NOT** advance further).
6. Rotate the swab several times against nasal wall and repeat in other nostril using the same swab.
7. Withdraw the swab and place into prepared viral transport media vial. Make sure liquid medium covers the swab tip.
8. Break or cut the end of the swab and screw the vial lid on **tightly.** Place specimen in designated area for pick-up.
9. Employee should re-apply their mask and perform hygiene prior to leaving the testing area.
10. Remove gloves and perform hand hygiene.
11. Don new gloves and cleanse face shield as needed, wipe down testing area with approved sanitizing wipes.
12. Remove gloves, perform hand hygiene.

Nasal Swab Competency

Procedure for obtaining a Covid-19 Nasal Swab from an Employee	**Criteria Met?**	**Comments / Additional Instruction Required**
Gather supplies (consent forms, pen, test kits, tissues, gloves, hand sanitizer, Lysol wipes, trash receptacle, specimen receptacle) and set up work station.		
Perform hand hygiene and don full PPE (gloves, N95 mask, face shield and gown)		

Obtain verbal consent and complete any documentation needed for specimen collection		
Instruct employee to tip head back 70 degrees		
While gently rotation the swab, insert swab less than one inch into nostril (if you meet a point of resistance at turbines-**do NOT** advance further)		
Rotate the swab several times against nasal wall and repeat in other nostril using the same swab.		
Withdraw the swab and place it into the transport media vial. Ensure that the liquid medium covers the swab tip.		
Break or cut the end of the swab and screw the vial lid on **tightly.**		
Place labeled specimen in designated container for pick up.		
Remove gloves, perform hand hygiene		
Don fresh gloves, if needed, sanitize face shield		
Wipe down work station and pen with Lysol wipes		
Remove gloves, perform hand hygiene		

Name: _____ Date: _____

Instructor Signature: _____

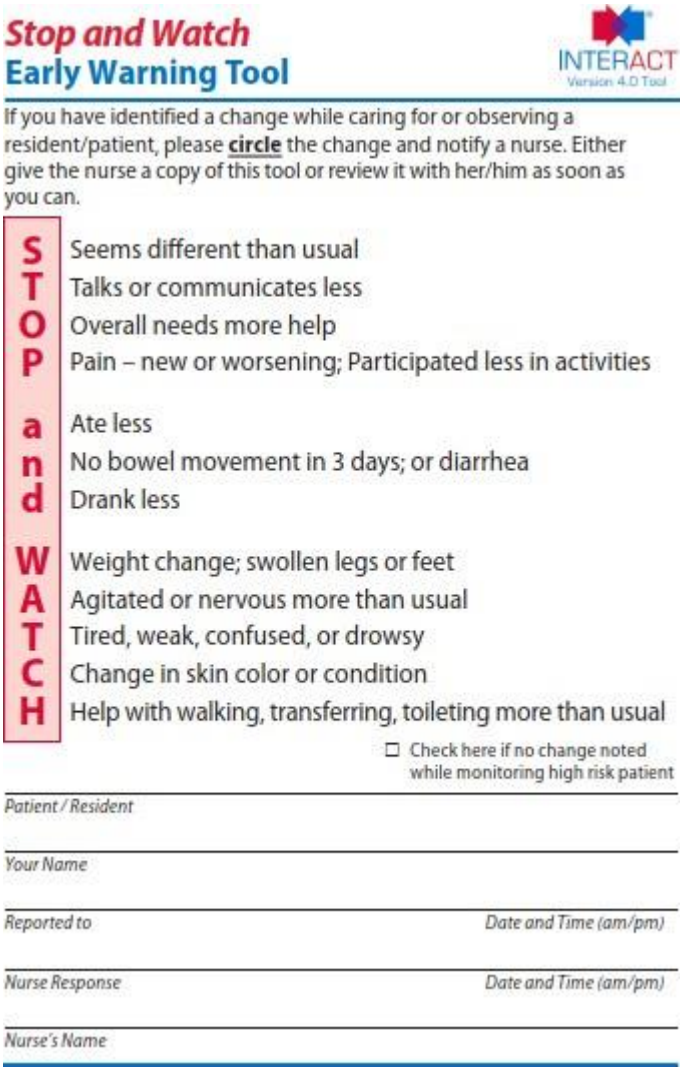
COVID-19

ROCHESTER REGIONAL HEALTH

COVID-19 Clinical Workflows for Nursing Homes

I. All Staff:

In the elderly, initial symptoms of acute infections are often non-specific. All staff should continue to use the Stop and Watch tool and notify the nurse of any changes in a resident. Additionally, all staff observing a resident with specific symptoms of respiratory infection (runny nose, sneeze, cough, sore throat, trouble breathing, fever) will notify the nurse immediately. The nurse should also be notified of any residents who do not have symptoms but report being in contact with someone who has developed a respiratory illness or fever.



Stop and Watch
Early Warning Tool

INTERACT
Version 4.0 Tool

If you have identified a change while caring for or observing a resident/patient, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change; swollen legs or feet
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

COVID-19 Clinical Workflows for Nursing

J. Clinical Staff:

A nurse will observe all residents for respiratory symptoms and obtain each resident's body temperature every shift and as needed. If possible, measurement of oxygen saturation should also be obtained.
Observations & Considerations for patients with a change in condition:

- ☐ If the resident is exhibiting respiratory signs or symptoms, keep the door to the room closed, implement **Contact** & **Droplet** precautions, and place a **medical mask on the resident** unless the resident is unable to tolerate the mask
- ☐ Obtain vital signs
- ☐ Fingerstick glucose (residents with diabetes)
- ☐ Alcohol intoxication or drug use (if a narcotic overdose is suspected, administer naloxone (Narcan) immediately)
- ☐ General: Chills, fatigue, loss of appetite, muscle aches
- ☐ Head: Runny nose, sore throat, headache, changes in the sense of smell or taste
- ☐ Respiratory: **New cough**, **abnormal lung sounds, Accessory muscle breathing, pursed-lip breathing, Respiratory distress**
- ☐ GI: **Nausea, vomiting, diarrhea, abdominal pain**, constipation, heartburn, abdominal distention or tenderness, rebound tenderness, bowel sounds
- ☐ Injuries (bruising, laceration, fractures), head trauma
- ☐ Assess all joints for change in the normal range of motion, weight-bearing, etc
- ☐ **Acute mental status change**
- ☐ Not eating or drinking as much as usual
- ☐ If pain: exact locations, pain scale, description (sharp, dull, burning), persistent or intermittent
- ☐ Fainting, dizziness or lightheadedness when standing up
- ☐ Acute decline in ADL abilities
- ☐ Thirst, signs of dehydration
- ☐ Jaundice
- ☐ Bleeding, hemorrhage
- ☐ Cardiovascular: Chest pain, new irregular pulse, cyanosis, mottling, edema
- ☐ GU: New or worsened incontinence, pain with urination, blood in urine, urinary retention/bladder scan
- ☐ Neurologic changes: consciousness/alertness, orientation, weakness, gait changes (unsteadiness, loss of coordination or balance)
- ☐ Very low urinary output (<30cc/hr)
- ☐ Skin: sweats (diaphoresis), cold/clammy/pale skin; any new skin condition, i.e., bruising (including potential head trauma), **rash, red fingers or toes**, infection/cellulitis

Nurse to notify provider immediately if the resident is exhibiting the bolded potential COVID-19 symptoms; for other changes in condition, follow the guidance at www.ssesbar.org.

Provider is to determine if findings potentially represent COVID-19 Disease.

- Assess for symptoms and signs of viral illness as outlined in *UpToDate* or similar reference
- **Notify nursing immediately of any resident suspected to have COVID-19 or diagnosed with COVID-19**
- Order COVID-19 testing.
    - If the resident is an "Index Case," that is, the first potential case of COVID on a nursing unit, contact Scott Schabel at 585-563-4312 regarding expedited testing options.
    - False-negative results are common. If, based on exposure and symptoms, the provider

diagnoses COVID-19 disease despite a negative result, the case should be considered a “presumed case.”

- In the setting of an outbreak with multiple confirmed cases of COVID-19 Disease, testing of new cases is not necessary, and the provider can make the diagnosis of COVID-19 Disease presumptively (“presumed case”).

COVID-19 Clinical Workflows for Nursing

K. Resident Care: Suspected or confirmed COVID-19 (or PUI/possible PUI):

Immediately:

- Keep the door to the room closed, wear a **medical mask**, **gloves**, **gown**, and **eye protection** ("Enhanced Isolation Precautions"), and place a **medical mask on the resident** when anyone is in the room, unless the resident is unable to tolerate the mask. In a semi-private room, keep the privacy curtain closed and the residents separated as much as possible.
- Notify the resident and the resident's representative of the COVID-19 related illness.
- If the resident otherwise requires hospitalization, arrange for safe transfer to acute care.

Within 24 Hours:

- Review the patient's history to determine if the patient may be a "persistent positive" patient.
- Facility leadership to review the case with Infection Prevention & NYSDOH Regional Epidemiologist - (585) 423-8119
- Relocate the resident with COVID-19 to a room on a designated COVID-19 area, if available in the facility. If such an area is not available, and the resident's room is located in a high-traffic area, relocate the resident to a private room in a low-traffic area, preferably on the same unit. If a roommate also needs to be relocated, do **not** move the roommate to another semi-private room or a room on another unit.
- Determine if the patient should be moved to a facility with a designated COVID-19 unit and institute transfer procedures, if appropriate.

Ongoing:

- Residents with **confirmed** COVID-19 may be cohorted in a room or unit with other residents with **confirmed** COVID-19 as long as no other contraindications to cohorting exist as per usual infection prevention procedures. Avoid cohorting patients with **confirmed** COVID-19 with patients who have **presumed** COVID-19 or **previously recovered** from COVID-19.
- If there is a confirmed outbreak of COVID-19 on the resident's unit, newly-ill residents should be managed as presumptive-positive COVID-19 cases. If an outbreak is not already established, contact a provider for an order to send a nasopharyngeal swab for COVID- 19 PCR testing.
- Only staff **fitted** for an N95 respirator will perform aerosol-generating procedures, including suctioning (if not using an inline catheter), nebulizer administration, manipulation of BiPAP/CPAP mask, chest physiotherapy, and CPR. A portable UV/HEPA filtration device should be used in the room during the aerosol-generating procedure.
- Actively monitor the resident once per shift for at least two weeks
    - Interview for **new** symptoms, when resident is able
    - Measure body temperature and oxygen saturation
    - Additional observations to consider: Vital signs, Lung auscultation
- Residents with suspected or confirmed COVID-19 on a unit should be cared for by the same clinical staff, dedicated to the care of the COVID-19 patients whenever possible. Minimize the number of persons entering the resident's room, including clinicians performing non-clinical work or work of other clinicians as long as the work is within their scope of practice.
- The resident should only leave the room for medically-necessary procedures.

COVID-19 Clinical Workflows for Nursing

- Resident to perform hand hygiene (with assistance, if needed) & don medical mask before leaving the room.

COVID-19 Clinical Workflows for Nursing

L. Resident Care: Resident with exposure to COVID-19 outside of the facility:

- Actively monitor the resident once per shift
  - Interview for **new** symptoms, when resident is able
  - Measure body temperature and oxygen saturation
  - Additional observations to consider: Vital signs, Lung auscultation
- Resident to remain in his/her room
- Resident is placed on **Droplet** and **Contact** precautions precautions – staff should wear a **gown**, **gloves**, **eye protection**, and **medical mask**.
- Resident must wear a **medical mask** when staff enters the room, unless the resident is unable to tolerate the mask. The resident should also wear a mask, perform hand hygiene, and maintain social distancing when out of the room and when out of the building.
- Notify a provider if a resident develops symptoms and follow the workflow in Section (C) above.
- Infection prevention nurse to consider discontinuing these precautions in asymptomatic residents fourteen days after exposure

COVID-19 Clinical Workflows for Nursing

M. Facility exposed by a New case of Confirmed or Presumed COVID-19 in a Current or Previous Resident or Staff Member:

- Determine which units may have been exposed to the confirmed or presumed COVID-19 resident or staff member. Consider activating facility incident command center to coordinate changes in care and supply needs.
- Facility leadership to notify Infection Prevention & NYSDOH Regional Epidemiologist - (585) 423-8119
- Actively monitor all residents on the affected unit once per shift
    - Interview for **new** symptoms, when resident is able
    - Measure body temperature and oxygen saturation
    - Additional observations to consider: Vital signs, Lung auscultation

  Follow workflow (C) above for any resident newly displaying signs and symptoms, even if the resident previously tested negative.
- All residents on the affected unit(s) are to remain in their rooms
- All residents on the affected unit(s) are placed on **Droplet** and **Contact** precautions – staff should wear a **gown**, **gloves**, **eye protection**, and **medical mask**.
- All residents on the affected unit must wear a **medical mask** when staff enter their rooms, unless the resident is unable to tolerate the mask
- All residents should perform hand hygiene when leaving room (with assistance, if needed).
- Do not float staff to or from affected units
- All staff who worked on the affected units will self-monitor for symptoms and take their temperature two times per day.
- Continue these processes for at least 14 days after the onset of symptoms in the units' most recent patient with confirmed or presumed COVID-19-disease. After the 14 days are completed, The unit should follow workflow (F) below.
- Admissions & re-entries to an exposed unit may continue. Avoid new admissions of residents to the exposed unit who are immunocompromised, have diabetes or significant cardiac, kidney, or lung disease, or would have difficulty complying with room confinement or mask usage.

COVID-19 Clinical Workflows for Nursing

N. Facility Management of Units housing Patients with COVID-19 Disease

- Confirmed or presumed COVID-19 patients should be cared for using the workflow in section (C) above.
- Staff caring for confirmed or presumed COVID-19 patients should avoid caring for other residents or floating to other units. If caring for patients without COVID-19 Disease is unavoidable, for **all residents**, at a minimum, affected staff will:
  - Wear a **medical mask** and face shield (extended wear permitted)
  - Wear **gloves** (changed between residents and according to all infection prevention principles)
  - Wear a **gown** when performing **direct care activities** (such as bathing, dressing, toileting, incontinence care, feeding, transfers)
  - Follow the additional precautions required when caring for patients in workflows (C), (D) and (E) above.

  Note: Affected staff should follow these procedures from the start of the first shift until the end of the last shift each day, until there are no patients on the unit with COVID-19 Disease.
- If admitting a patient with COVID-19 Disease (with regulatory permission), the facility leadership is to notify Infection Prevention & NYSDOH Regional Epidemiologist - (585) 423-8119
- Residents with COVID-19 Disease should be cohorted in semi-private rooms or private rooms in the same general area of the unit. If possible, these areas should be sectioned-off by physical barriers or visual markers.

O. Discontinuation of precautions for a confirmed or presumed COVID-19 resident

4. At least 24 hours have passed since last fever without the use of fever-reducing medications, and
5. Symptoms (e.g., cough, shortness of breath) have improved, and
6. Fourteen (14) days to twenty-one (21) days have passed since symptom onset, depending on the severity of the patient's illness and presence of severe immunocompromise, as determined by the attending medical provider, and with concurring assessment by the facility infection preventionist. If the patient is asymptomatic throughout his/her infection, the date of the positive test begins the clock for the required isolation time.

   Note: Additionally, a resident with **persistent symptoms** from COVID-19 (e.g., persistent cough) should be placed in a private room, be restricted to their room, and wear a facemask during care activities **until all symptoms are completely resolved**.

COVID-19 Clinical Workflows for Nursing

P. Admission & Return of Residents to the Nursing Home:

- All patients admitted to a nursing home with a case of COVID-19 illness and the patient's representatives must be notified that the facility has had a case of COVID-19 disease.
- Residents with respiratory illness but without COVID-19 Disease
    - COVID-19 excluded
        - Positive PCR test for Influenza, RSV, or atypical pneumonia panel, OR
        - Negative COVID-19 assay, OR
        - Confirmatory review of the case by facility medical director
    - Residents with any communicable disease or ongoing symptoms of COVID-19 illness may require additional room placement or transmission-based precautions.
- Residents with COVID-19 Disease who are no longer contagious
    - At least 24 hours have passed since last fever without the use of fever-reducing medications, and
    - Symptoms (e.g., cough, shortness of breath) have improved, and
    - Fourteen (14) days to twenty-one (21) days have passed since symptom onset, depending on the severity of the patient's illness and presence of severe immunocompromise, as determined by the attending medical provider. If the patient is asymptomatic throughout his/her infection, the date of the positive test begins the clock for the required isolation time.

  Note: Additionally, a resident with **persistent symptoms** from COVID-19 (e.g., persistent cough) should be placed in a private room (or a room with another confirmed COVID-19 resident), be restricted to their room, and wear a facemask during care activities **until all symptoms are completely resolved.**
- Residents with confirmed or presumed COVID-19 Disease and PUIs (that is, potentially contagious) (with regulatory permission)
    - Admit to a unit designated to receive COVID-19 residents.
    - Admit the resident to a private room. Residents with **confirmed** COVID-19 may be cohorted with other residents with **confirmed** COVID-19 as long as no other contraindications to cohorting exist.
- Residents with known exposure to COVID-19
    - Preferably admit to a unit with prior exposure to confirmed COVID-19 or unit designated to receive COVID-19. If such a bed is not available, the resident may be admitted to a private room on any unit.
    - Follow the instructions in Section D, above.
- Admission or re-entry to the nursing home after hospital care for a non-respiratory illness requires no additional review.
- When possible, admissions may be cohorted by admission date to segregate the new admissions from the other residents in the facility.
- Regardless of any prior negative COVID-91 testing, institute contact and droplet precautions for 14 days for residents recently-hospitalized with a systemic illness, or vague or ill-defined symptoms such as malaise, fatigue, weakness, confusion, gait disturbance, or self-care deficits. These precautions may not be necessary for patients after elective surgery, at the discretion of the facility infection prevention nurse or designee.

COVID-19 Clinical Workflows for Nursing

- Admissions & re-entries to an exposed unit may continue. Avoid new admissions of residents to the exposed unit who are immunocompromised, have diabetes or significant cardiac, kidney, or lung disease, or would have difficulty complying with room confinement or mask usage.

Definitions

COVID-19 PUI: a patient who has developed symptoms consistent with COVID-19 disease, while waiting for results of a COVID-19 PCR or other diagnostic test.

COVID-19 Confirmed Case: a patient who has had a positive COVID-19 or other diagnostic test.

COVID-19 Presumed Case: a patient with a known exposure to COVID-19 and symptoms of COVID-19 disease, in which a diagnostic test is not performed.

COVID-19 Persistent Positive: a patient who has recovered from COVID-19 and subsequently tests positive for COVID-19, as determined by the NYSDOH epidemiologist.

References (you may need to copy and paste the link into your browser if it doesn't work by clicking on it)

https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

https://coronavirus.health.ny.gov/system/files/documents/2020/07/revised-march-13-guidance-07.10.2020-final.pdf

https://coronavirus.health.ny.gov/system/files/documents/2020/03/doh_covid19_protectnursinghomeresidents_032120.pdf - Notification 102906

https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh-covid-19-discontinuing-isolation-hospital-congregate-setting.pdf - Notification 102742

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

https://coronavirus.health.ny.gov/system/files/documents/2020/03/acfguidance.pdf

https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19_ltcf-ipcselfassesmenttool_041020.pdf

https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19_acf-nh_residentfamilycommunication_040420.pdf

https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19-_ppeshortages_040220.pdf

https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.18.pdf

https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.19.pdf

https://commerce.health.state.ny.us/hpn/ctrldocs/alrtview/postings/DOH_COVID19_NursingHomeCohortingFAQs_Final_1591451281923_0.pdf