

SECTION E: EMERGENCY PROCEDURES FOR SPECIFIC EVENTS

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.

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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 your 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 on an annual basis.

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.

When visitation is restricted, the facility will update resident families or responsible parties on a regular basis on how they can remotely keep in touch with residents.

The facility will update families and responsible parties of infected residents on a daily basis as to the residents' condition.

Any residents who are hospitalized during one of these events will be readmitted to the facility after treatment in accordance with applicable laws and regulations.

The facility will maintain or have access to a two (2) month supply of Personal Protective Equipment (PPE). This supply of PPE will either be stored onsite or will be readily accessible by the facility.

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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 Incident Command System (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 also 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.

It is assumed that the facility will form an Emerging Infectious Disease Support Team during pandemic or infectious disease events to include 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.

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Every disease is different. The local, state, and federal health authorities (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 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, as needed, 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 60-day PPE stockpile requirement will be determined for each type of required PPE as follows:
 - **Gloves**, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 24
 - **Gowns**, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 3
 - **Surgical masks**, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 1.5

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- **N95 respirator masks**, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 1.4
- 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 F – Emergency Resources and 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) and National Healthcare Safety Network (NHSN) Reporting.
- The facility will provide initial fit testing for staff that provides 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:

- Executive Health Director/Associate Executive Director/Deputy Director
- Director of Nursing / Nursing Supervisor

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 change the scope of the operations, the objectives, or strategies must be approved by the Incident Commander.

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ADMINISTRATION / CLINICAL LEADERSHIP CONSIDERATIONS

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

Once notified by the 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 local/state Department of Health, the Centers for Disease Control and Prevention (CDC), or the local public health authorities.

Protecting the residents and staff shall be of paramount concern.

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.
- 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.

EXECUTIVE HEALTH DIRECTOR / 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 B*) to ensure procedures are in place.
- Reference the following EOP Sections to address the below listed considerations.
 - *EOP Section C: Incident Command System* and associated Job Action Sheets

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- 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.
- Assign a person the responsibility of 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 and National Healthcare Safety Network (NHSN) Reporting.
- Develop an action plan with the Command Center team and brief department managers and supervisors.
- Work with Director of Nursing 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 daily access to teleconferencing services, video conferencing, or other means as preferred and identified by residents and their families.
- When visitation is restricted, assign appropriate Social Work 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, such as Social Work and/or Nursing, to update families and responsible parties daily on the condition of infected residents or upon a change in a resident's condition.
- Approve requests for additional resources (e.g., supplies, equipment, staff, etc.).
- The Incident Commander / Executive Health Director 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 Emergency Operations Plan sections to address the below listed considerations.
 - *EOP Section A – Policies and Planning / Communications*

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- *EOP Section B – Procedures Applicable to All Hazards / Communications Plan*
- *EOP Section C – 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
 - CDC
 - Department of Health and Human Services
 - Healthcare Coalition and/or Greater Rochester Mutual Aid Plan 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.
- 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.
- Develop a communications plan and assign responsibility to interact with other external entities (local responders, healthcare coalitions, other healthcare facilities, etc.) during a regional incident.
- Establish a dedicated telephone hotline and/or 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.

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- *Section B: Procedures Applicable to All Hazards / Managing Resources and Assets during a Disaster*
- *Section B: Procedures Applicable to All Hazards / Managing Security and Safety during a Disaster*
- *Section F: Emergency Resources and Lists*
- *Appendix D: 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:
 - Number of affected residents and staff
 - Current resident census and number of open beds
 - Inventory of PPE types and quantities
- 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, Greater Rochester Mutual Aid Plan members and/or local/state EOC, as necessary and applicable.
- 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
 - Sanitizers and Disinfectants
- Ensure vendor support is available for medical waste disposal.
- Assess the need to order a Building Lockdown in order to control access to the facility for screening purposes. *Refer to the Emergency Operations Plan – Section B: Building Lockdown Procedures.*
- 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.

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- Resident Visitors: No one allowed in the facility. Relatives and responsible parties will be given appropriate information and location to wait as directed by the Command Center.

Staffing

- Reference the following Emergency Operations Plan sections to address the below listed considerations:
 - *Section B: 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.

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- 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. **Faith 5 East Rehab Unit** may be used for this purpose.
 - 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 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. *Refer to Emergency Operations Plan – Section B: Building Lockdown Procedure.*
- Cancel communal dining and all group activities, such as internal and external group activities, as necessary.

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- 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 as to how they can remotely keep in touch with residents when visitation is limited or restricted.
- Encourage residents to remain in their rooms. 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 (stay at least 6 feet away from others), when necessary.
- As assigned, provide updates to families and responsible parties daily on the condition of infected residents or upon a change in a resident's condition.

General Guidelines for Infection Control Practices for Resident Management

- 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.

The CDC continues to recommend the use of alcohol-based hand rub (ABHR) as the primary method for hand hygiene in most clinical situations. Alcohol-based hand rub (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.

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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, and facemasks), respiratory hygiene and cough etiquette, safe injection practices, and safe handling of equipment or items that are likely contaminated with infectious bodily 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, bodily fluids, visibly contaminated surfaces or after contact with objects in the resident's room.
- After removing personal protective equipment (e.g., gloves, gown, and 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 alcohol-based hand rub (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, bodily 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 bodily 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 bodily fluids.

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- 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

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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.

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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, bodily fluids, excretions, and secretions may occur.

PPE description, at a minimum:

- Gown (fluid resistant or impermeable)
- Facemask, or other necessary respiratory protection
- 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.

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- 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 a 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).

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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 or pouch prior to moving the body to any other location or released to a funeral director or coroner/coroner physician/medical examiner.
- Matching identification should always be attached to the outside of the body bag or pouch.
- 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.

FOOD & NUTRITION

- 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.

ENVIRONMENTAL SERVICES / LAUNDRY

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

- Assess supplies to determine how long you can continue operations. Take results to Command Center.
- Review policies and ensure sufficient supplies in the event deliveries cannot be made.
- Environmental cleaning: The facility will follow current CDC 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.

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- 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, bodily 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 environmental 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:



FACILITIES/SECURITY (or staff assigned security responsibilities)

- Determine ability to isolate sections of the building for contagious residents.
- Assist with implementing the facility's emergency Building Lockdown Plan. See *EOP Section B: 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.
- Assess supplies to determine how long you can continue operations. Take results to Command Center.
- Determine the need for additional staff to provide security or assist with the building lockdown. See *EOP Section B: 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.

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SOCIAL WORK / CHAPLAINS

- 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.

SUPPLY / RECEIVING AREA

- 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.

FINANCE AND 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.

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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 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.

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>

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CORONAVIRUS (COVID-19) SPECIFIC

STAFF SCREENING LOG

| Date | Dept. | Employee | Screening Questions (check box for a positive response) | If any screening questions + Restrict entry | Temp If temp. > 99.6 Restrict entry | Individual contacted for + screening questions or elevated temp (DON, Infection Control, Nursing Supervisor or Executive Health Director) |
|------|-------|----------|--|--|---|---|
| | | | <input type="checkbox"/> Illness <input type="checkbox"/> Travel <input type="checkbox"/> Exposure | | | |
| | | | <input type="checkbox"/> Illness <input type="checkbox"/> Travel <input type="checkbox"/> Exposure | | | |
| | | | <input type="checkbox"/> Illness <input type="checkbox"/> Travel <input type="checkbox"/> Exposure | | | |
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| | | | <input type="checkbox"/> Illness <input type="checkbox"/> Travel <input type="checkbox"/> Exposure | | | |
| | | | <input type="checkbox"/> Illness <input type="checkbox"/> Travel <input type="checkbox"/> Exposure | | | |

Illness: Do you have a fever, cough, shortness of breath, sore throat, nausea, vomiting or diarrhea?

Travel: Have you traveled to a coronavirus affected area in the past 14 days?

Exposure: Have you been exposed to anyone who has coronavirus or is under of investigation for coronavirus?

SECTION E: EMERGENCY PROCEDURES FOR SPECIFIC EVENTS

Monroe Community Hospital

Pandemic Emergency Plan (PEP) – Annual Plan Facilities Checklist

| Tasks | Person Responsible | Frequency | Date to be completed | Comments/Revisions made: |
|--|--------------------|-------------|----------------------|--------------------------|
| PEP plan review and necessary updates | | Annual | | |
| Review PPE Inventory and expiration dates. Update PEP Inventory List as necessary. Replace expired inventory. | | Semi-annual | | |
| Review Vendor agreements for critical supplies to ensure agreements are still valid and contact information is accurate. | | Annual | | |
| Ensure annual Incident Command System and Command Center training. Review and revise, as necessary, Command Center position appointees. | | Annual | | |
| Review and update membership of the facility's Emerging Infectious Disease Team and ensure administrative, clinical and support | | Annual | | |

SECTION E: EMERGENCY PROCEDURES FOR SPECIFIC EVENTS

| | | | | |
|--|--|--|--|--|
| team members are fully engaged and familiar with the PEP. | | | | |
| Review and update, as necessary, the facility Infection Control Plan. | | Annual | | |
| Provide annual in-service training to staff on the Pandemic Emergency Plan, Infection Control Plan, proper usage of PPE including donning and doffing. | | Upon hire, and then annually thereafter | | |
| Provide annual fit testing to staff that will be utilizing N95 respirators. | | Upon hire, and then annually thereafter | | |
| Ensure staff contact information is current in the Health Commerce System (HCS). | | Semi-annual | | |
| Ensure vendor and other external stakeholder contact information is up to date and readily available (in case of exposure notification). | | Annual | | |