Summary Emergency Preparedness Planning: Pandemic August 2020

Each of these areas have a summary following this page and a section for resources following summary pages.

Infection Control: Maintain infection control policies and procedures, updated where needed and increase transmission-based precautions. Train, re-Train, monitor

Staffing: Remind about hand hygiene and proper use of PPE. Tell them to stay home if they're sick. Screen all personnel coming into the building. Inventory, order, re-order for stock. Staff back-up- Agency, ECC, Call lists

Limit Interactions: Restrict all non-essential visitors and group activities. Implement social distancing within the facility.

PPE: Preserve your current supply if you're running low. Ask for help from local and state officials, consulted company, and document requests. Implement: conservation.

Communicate: Report suspected or confirmed cases to authorities. Keep residents, families and staff informed about your developing situation. Prepare for media inquiries.

Engagement: Keep residents connected with loved ones remotely and stimulated with meaningful activities adapted for this situation.

EMERGENCY PREPARDNESS – PANDEMIC (Specific)

Pandemic: A pandemic is defined as "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people". The classical definition includes nothing about population immunity, virology or disease severity. This document may also be used for "generalized epidemic" circumstances as well.

The CDC, CMS, Public Health Departments are responsible to outlining circumstances that facility may find themselves dealing with: Pandemic, Epidemic, Localized Outbreak.

1. Form a Team. Typically the team will consist of the organization's leadership; with the Administrator, in a Pandemic, the Infection Preventionist (IP) should also be a team member as well as other Clinical Support staff. The IP should not be primarily bogged down in broad meetings, policy drafting and such their main focus is on Preventionist of Infections and that is a front-line duty of care. Certainly, they should review policies and such but it is not this role to draft

2. Evaluate the scope and severity of the Pandemic effect: is it starting; growing, full effect? Gather accurate information about it, and report back to the Commander and other ECT members. In an emergency there may be limited or conflicting information about the event or its impact. "Facts" matter and may change several times as new information is available.

2. Plan Ahead With the team in place, who will coordinate communication to staff, residents, families. Who does external communications to regulatory agencies, the Press, inquiries, including social media • Practice how to handle inquiries from families (who may be in a panic) • Brainstorm possible scenarios/responses. Know the Stakeholders as tempting as it may be, management should not rely exclusively on one way to communicate (e.g. telephone) their statements and messages. There should always be options in a plan for using alternate communications channels -- like text, wired telephone, cell phone, Internet, etc.

Know How to Contact Stakeholders: Staff, Families, Regulatory.

Remind staff not to speculate or discuss an event, especially with media. Staff training is a necessity. Lack of preparedness in an emergency has many markers, including: • Emergency responses are slow and most likely inadequate • Residents, patients and staff are unnecessarily harmed or stressed out • Stakeholders, including families, are uninformed and probably agitated • Local media outlets are out of the loop •

EMERGENCY PREPARDNESS – PANDEMIC (Specific) Communications:

Transparent and accurate communications with stakeholders, especially the media, during and after a crisis contributes to a successful resolution of the problem, including a positive evaluation by stakeholders and the public. The Communications plan – consisting of policies, procedures, and an incident command structure -- is the primary tool management has to ensure employees follow protocols during an emergency in contacting stakeholders, the media, and others.

The Media Outreach is an essential part of the Communications plan. To help set management on the right path to developing a communications plan, the following outline can be a guide in the process of creating or modifying emergency preparedness communications procedures. Using this will help management gauge when emergency preparedness is on solid footing.

Communications Plan – Pandemic: Scope and Severity During an emergency (or "incident"), the Communications plan should govern all communications within an organization and with external stakeholders, including the media. However, with a Pandemic the plan needs flexibility; an organization's management may only need a portion of the incident command structure, depending on the scope and severity of the emergency, such as an elopement versus a Pandemic or natural disaster (hurricane, wildfires etc.).

Ensure communications flow with CMS, State, and Local Health Departments. Whether this communication is on testing results, vaccine distribution, and changes in guidance.

EMERGENCY PREPARDNESS – PANDEMIC (Specific) Infection Control (does not replace infection control policies or procedures just highlights specific things to plan/ review)

- See Infection Control Section – Line List, Tracking Log,
- Increase Infection Control In-Services
    - Transmission of Virus / Bacteria
    - Use of PPE – DON / DOFF / Approved Extended Use
    - Isolation Rooms-
    - Observation Isolation vs Communicable
        - Observation is precautionary of unknown because of New Admit or Re-Admit (these are not line listed)
    - Resident and Employee Health – Signs/ Symptoms
    -

EMERGENCY PREPARDNESS – PANDEMIC (Specific)

Staffing (does not replace staffing policies or procedures just highlights specific things to plan/ review)

- Staffing Policy
- Develop Staffing Contracts for Emergency Use
- Develop Updated Phone Tree Lists for Contact

EMERGENCY PREPARDNESS – PANDEMIC (Specific)

Personal Protective Equipment (does not replace PPE policies or procedures just highlights specific things to plan/ review)

- See McKesson Emergency Preparedness Guide Section (facility has a contract with McK for Emergency Supplies Interruption Delivery)
- **During NON- Pandemic Times – continue to purchase PPE at normal quantities to stock**
- Inventory Monthly PPE Supplies. Should always have 1 month supply of burn rate
- See CDC guidance on Conservation acceptable techniques – Follow guidance

EMERGENCY PREPARDNESS – PANDEMIC (Specific)

Visitation & Interactions (does not replace visitation policies or procedures just highlights specific things to plan/ review)

- Review Guidance on Visitation: Family, Outside Health Care Personal
- Restrict as Necessary
- Review Guidance on Dining, Activities and other Interactions
- Restrict as Necessary or Curtail as Needed
- Family Visits of Window Visits, Web Based Visits, Phone Visits, Outside Visits, Limited In-door visitation

EMERGENCY PREPARDNESS – PANDEMIC (Specific)

Resident Engagement (does not replace resident policies or procedures just highlights specific things to plan/ review)

- Developed Family Visits of Window Visits, Web Based Visits, Outside Visits, Limited In-door visitation
- Create activity calendar for engagement without groups
    - Doorway BINGO
    - Entertainment Outside
    -

Other areas to review and consider:

- Change Reception Policy to take family messages for units and pass off to assign Administrative Staff to return calls. Allow Nurses to provide care and not answer calls.
- Pull Updated DNR list and make sure readily available at Nursing Stations
- Discuss with Medical Director and ordering Physicians to adjust medication times and review orders of medications not imperative to possibly not be passed: vitamins, aerosols, etc.
- Create a "war board" dry erase of resident effected infection – update daily
- Ensure resident inventories are updated as room moves are likely
- Create signage:
    - Isolation
    - Required PPE
    - Guidance i.e., social distancing, wash hands
    - Vital Sheets
- Staff Burn-out- ensure communication and well-being checks with staff. Provide day off recommend at least 1 per pay-period; recommend even in crisis time staff not work more than 2 shifts in a row.

EMERGENCY PREPARDNESS – PANDEMIC (Specific) Resource Guidance:

https://www.cdc.gov/
https://www.dph.illinois.gov/ ILLINOIS
https://www.in.gov/isdh/ INDIANA
https://cookcountypublichealth.org/ COOK County IL
https://www.lakecountyin.org/ LAKE County IN
https://willcountyhealth.org/ Will County IL
https://www.dupagehealth.org/ DuPage County IL

Sample Continuum of Care

The table below illustrates how facility operations and delivery of care and management services might shift under different care standards. It is not intended to be prescriptive; rather, it is meant to demonstrate how conventional, contingency, and crisis might manifest in practice.

	Conventional	Contingency	Crisis
Standard of Care	• Normal or usual care and services provided. ○ Care delivered based upon the resident's wishes, as outlined in the plan of care	• Functionally equivalent care, but may be delayed or adapted	• Crisis care

Space	• Census is stable
	• Facility has enough space to quarantine new admits/readmits and isolate infected residents
		• Census change variant—potential growth from increasing hospital admissions; potential declines for transfers to area hospitals
		• Number of residents/patients with COVID-19 requires some contingency actions (e.g., more extensive within- or cross-facility transfers)
			• Census declines as residents with acute care needs are transferred, and new admissions and readmissions are deferred
			• Large number of residents with confirmed or suspected COVID-19 requires:
			  ○ use of non-certified beds or other spaces within the facility (e.g., communal dining areas), and/or
			  ○ transfers to non-certified alternative care sites (ACS) within the community

Staff	• Staffing ratios based on the resident assessment and care plan, as well as any state requirements	• Extended shifts, additional shifts, and/or change in allocation of staff	• Unable to meet registered nurse coverage regulations; • Significant change in certified nursing aide and nurse to resident ratios; and/or • Utilization of ancillary staff in supportive caregiving roles

Supplies	• Normal par levels of all supplies with access to supplies that are provided by off-site vendors	• Conservation, adaptation, substitution, and extended use strategies in place for certain supplies, in accordance with national recommendations	• Additional optimization strategies adopted, including
			  ○ rationing select supplies and services;
			  ○ using non-standard supplies[9]; and
			  ○ decontaminating and/or reusing PPE

[9]If healthcare personnel use respirators certified in accordance with the standards of other countries and jurisdictions, the respirators must also be permitted for use in healthcare under a U.S. Food and Drug Administration (FDA) emergency use authorization. *See* https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/faqs-euas-non-niosh-approved-respirators-during-covid-19-pandemic

Sample Indicators and Triggers

This table provides *sample* indicators, triggers, and tactics for PALTC facilities. The indicators, triggers, and tactics shown in the table are intended to help demonstrate the kinds of information and level of detail needed to develop useful indicators and triggers for a specific organization; they are not intended to be comprehensive or adopted wholesale without question. As a reminder, *indicators* are measures or predictors of changes in demand and/or resource availability; *triggers* are decision points.

	Contingency	Crisis	Transition to Conventional
Surveillance Data	**Indicators:** • X[10] or more new COVID-19 suspected and confirmed cases in the last week, or 1 confirmed resident case in a facility that was previously COVID-19 free • County positivity rate in the last week > 5% **Triggers:** • Suspected/confirmed new onset of resident infection • Public health alert that community cases are rebounding **Tactics:** • Anticipate activating the emergency plan and standing up an incident command to support its implementation • Relevant state and local authorities, including health department, notified of new positive or presumed positive resident case	**Indicators:** • X cases or X% of residents have suspected or confirmed COVID-19, and the facility is not dedicated to COVID-19 care • County positivity rate in the last week > 10% **Triggers:** • Weekly number of cases in community spiked rapidly • Number of cases in facility increasing week over week, signaling growing outbreak • **Tactics:** • Initiate the emergency plan, which includes activation of incident command system, and the crisis communication plan	**Indicators:** • 28 days have lapsed since last resident COVID-19 positive or presumed positive case • Downward trajectory (with no rebound) of confirmed COVID-19 cases in the community for three consecutive, 14-day periods **Triggers:** • Community and facility case status meets criteria for entry to phase 3 of Opening Up America Again and CMS' Nursing Home Reopening Recommendations for State and Local Officials, respectively **Tactics:** • Continue to collect surveillance data related to COVID-19

[10] Given the diversity of care and services provided in PALTC facilities, as well as the various populations they serve and contexts in which they operate, this document uses "X" to identify where specific, quantitative targets might be appropriate and useful. Facilities can customize the values based on state requirements, resident acuity, and other factors. SNFs may, however, choose to use the CMS guidance in Memo #QSO-20-31-All as a starting point, where applicable.

	Contingency	Crisis	Transition to Conventional
		• Relevant state and local authorities, including health department, notified of situation	
Community and Communications Infrastructure	**Indicators:** • Resident communication/contact with family, friends, and some (typically onsite) service providers (e.g., physical therapists) is limited in terms of visitor numbers, frequency, or modality (e.g., outdoor vs. indoor visits) • X% of local referral hospitals' ICU and/or inpatient hospital beds filled **Triggers:** • Staff shortages or facility circumstances (e.g., outbreak) limit in-person visits by family, friends, clergy and some non-essential service providers, except when needed to ensure that people with disabilities are not denied reasonable access to needed support persons, and in and compassionate care situations • Referral hospitals have communicated they are functioning under contingency standards of care **Tactics:** • Implement innovative methods to help residents remain connected with family, friends and one another while maintaining robust infection control practices • Leverage telehealth to help maintain resident access to specialty care providers	**Indicators** • Resident communications with family, friends, representatives, and non-essential service providers is limited, even through virtual/audio means • X% of local referral hospitals' ICU and/or inpatient hospital beds filled **Triggers** • Extreme staff shortages limit personnel availability to support critical communications functions (e.g., resident virtual visits with family; telemedicine visits with non-essential service providers) • Referral hospitals have communicated they are functioning under crisis standards of care **Tactics:** • Request administrative and communications support from state and local authorities, corporate office, or local/regional healthcare coalition partners • Collaborate with state/local authorities and healthcare coalition stakeholders (including EMS and hospitals) to establish alternative care sites to help manage patient surges and transfers between acute and PALTC settings	**Indicators** • Resumption of in-person visitation allowed for resident friends, families, clergy, and non-essential healthcare personnel and contractors • X% of local referral hospitals' ICU and/or inpatient hospital beds filled **Triggers** • Facility entry and in-person visitation allowed with screening and additional precautions (e.g., face mask/cloth face covering for visitors) • Referral hospitals have communicated they are functioning under conventional standards of care **Tactics** • Ability to use standard communication and reporting mechanisms reestablished • Routine protocols and processes for resident transfer/transport between acute and PALTC settings

	Contingency	Crisis	Transition to Conventional
	• Monitor hospital capacity and coordinate threshold for EMS transport when needed based on healthcare system demand		
Staff	**Indicators:** • Increased staff absenteeism • Certified nursing aide (CNA and licensed nursing staff to resident ratios reach X **Triggers:** • Increased staff absenteeism (due to staff infections, low morale, or social factors like transportation or housing) • Management/owner and state/local agencies notified of decrease in nursing staff to resident ratios **Tactics:** • Cancel non-essential business and redirect staff to focus on direct resident care • Notify PRN[11] pool of the potential shortage and begin scheduling coverage (require dedicated PRN staff to avoid cross-contamination)	**Indicators:** • Contingency staffing strategies maximized • CNA and licensed nursing staff to resident ratios reach X **Triggers:** • Staff absenteeism exceeds ability to provide contingency care • Management/owner and state/local agencies notified nursing staff to resident ratios fall below regulatory thresholds **Tactics:** • Utilize healthcare and trained ancillary workers (e.g., CNA students, physical and occupational therapy providers) to provide supportive care as allowed by state and federal authorities • Request state assistance from the National Guard and other government entities • Utilize office and other ancillary personnel to assume supportive duties, such as communication with families and serving meal trays	**Indicators** • Absentee rates have returned to contingency level with trend toward conventional care levels • CNA and licensed nursing staff to resident ratios return to mandated regulatory levels or pre-crisis operating levels, whichever is greater **Triggers:** • Temporary PRN[11] float pool and other emergency staffing sources are not required **Tactics:** • Maintain PRN float pool and relationships for staffing sources in case of a future outbreak

[11] PRN is an acronym for the Latin pro re nata, which translates to "as the situation demands." These staff serve as on-call or temporary personnel.