Atrium Post-Acute Care of Wayneview
Emergency Procedure – Outbreak Response Plan

Policy Statement

This facility has taken measures to prepare for an outbreak event.

Policy Interpretation and Implementation

1. All staff members will be trained on facility Outbreak Response Plan and related policies and procedures.
2. All prospective residents and employees shall be screened to identify exposure to outbreak. Screen for fever and respiratory symptoms following exposure for one (1) to five (5) days.
3. Outbreak Response Plan has been established and will be initiated when a novel virus is increasing and sustaining human-to-human transmission in the United States, and cases are occurring in the facility's state.

Emergency Procedure - Outbreak

The following procedure should be utilized in the event of an outbreak.

1. Declare a "CODE PURPLE" when a novel virus is increasing and sustaining human-to-human spread in the United States, and cases are occurring in the facility's state.
2. Notify the Administrator and Director of Nursing if they are not on the premises. Activate the Recall Roster if warranted.
3. Facility management staff should report to the Incident Command Post for briefing and instruction.
4. Activate the Incident Command System (ICS) to manage the incident. The most qualified staff member (in regard to the Incident Command System) on duty at the time assumes the Incident Commander position.
5. Follow guidelines of Outbreak Response Plan.
6. Residents, employees, contract employees, and visitors should be evaluated daily for symptoms. Employees should be instructed to self-report symptoms and exposure.
7. Follow Outbreak Response Plan in regards to managing high-risk employees and for guidelines as to when infected employees can return to work.
8. Adherence to infection prevention and control policies and procedure is critical. Post signs for cough etiquette. Adherence to droplet precautions during the care of a resident with symptoms or a confirmed case of an outbreak is a must.
9. Determine when to restrict admissions and visitations. Communicate this to the affected parties.

10. Contact local and state health departments to discuss the availability of vaccines and antiviral medications, as well as recommendations of usage.
11. Ensure adequate supplies of food, water, and medical supplies are available to sustain the facility if an outbreak occurs in the geographic region or at the facility.
12. Cohort residents and employees as necessary.
13. Implement contingency staffing plans as needed.

Outbreak Plan

1. This facility has designated the Infection Preventionist as the Outbreak Response Coordinator.
2. He/she and the Outbreak Planning Committee, a sub-committee of the Quality Assurance/Risk Committee, address outbreak illness preparedness.

Surveillance and Detection

1. The Outbreak Response Coordinator is responsible for monitoring public health advisories (federal and state) and updating the Outbreak Committee, particularly when an outbreak has been reported in the United States and is nearing the specific geographic location.
2. A protocol should be developed to monitor potential outbreak illnesses in residents and staff, which tracks illness trends.
    a. The admission policy includes that residents admitted during periods of an outbreak should be assessed for symptoms of the outbreak illness.
    b. A system is implemented to daily monitor residents and staff for symptoms of outbreak illness as well as confirmed cases of outbreak illness.
    c. Information from the monitoring systems is utilized to implement prevention interventions, such as isolation or cohorting.

Communication

1. The Outbreak Response Coordinator is responsible for communications with the public health authorities during an outbreak.
    a. Local health department contact information:

        Wayne Health Department: Diane Stabile

    b. State Health Department contact information:

        Jamie Weller– 609-571-0360

2. The Outbreak Preventionist is responsible for communicating with the staff, residents, and their families regarding the status and impact of the outbreak in the facility. One voice speaking for the facility ensures accurate and timely information.

3. Communication includes usage of the recall roster to notify staff members of the outbreak. Efforts must be made, such as phone calls and posted signage to alert visitors, family members, volunteers, vendors, and staff members about the status of the outbreak in the facility.
4. The Outbreak Preventionist also maintains communications with the Emergency Management Coordinator, local hospitals, local Emergency Management Services, as well as other providers regarding the status of the outbreak.
5. Family members and responsible parties are notified prior to an outbreak that visitations may be restricted during an outbreak to protect the safety of their loved ones.

Education and Training

1. **Director of Nursing/Infection Preventionist** is responsible for coordinating education and training on outbreak. Local health department and hospital-sponsored resources are researched, as well as usage of web-based training programs.
    a. Education and training of staff members regarding infection prevention and control precautions, standard and droplet precautions, as well as respiratory hygiene/cough etiquette should be ongoing to prevent the spread of infections, but particularly at the first point of contact with a potentially infected person with the outbreak illness.
    b. Education and training should include the usage of language and reading-level appropriate, informational materials, such as brochures, posters on outbreak illness, as well as relevant policies. Such materials should be developed or obtained from www.cdc.gov.
    c. Informational materials should be disseminated before and during outbreaks.

Infection Prevention and Control

1. Cleaning and disinfection for outbreak follows the general principles used daily in health care settings (1:10 solution of bleach in water).
2. Infection prevention and control policies require staff to use Standard and Droplet Precautions (i.e., mask for close contact with symptomatic residents).
3. Respiratory hygiene/cough etiquette should be practiced.
4. The IPCC shall develop procedures to cohort symptomatic residents or groups using one of more of the following strategies:
    a. Confining symptomatic residents and their exposed roommates to their room.
    b. Placing symptomatic residents together in one area of the facility.
    c. Closing units where symptomatic and asymptomatic residents reside, i.e., restricting all residents to an affected unit, regardless of symptoms.
    d. Develop criteria for closing units or the entire facility to new admissions during an outbreak.
    e. Ensure visitor limitations are enforced.

Occupational Health

1. Practices are in place that addresses the needs of symptomatic staff and facility staffing needs, including:
    a. Handling staff members who develop symptoms while at work.
    b. When staff members who are symptomatic, but well enough to work, are permitted to continue working.
    c. Staff members who need to care for ill family members.
    d. Determining when staff may return to work after having outbreak illness.
2. A contingency staffing plan is in place that identifies the minimum staffing needs and prioritizes critical and non-essential services, based on residents' needs and essential facility operations. The staffing plan includes collaboration with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.
3. Staff are educated to self-assess and report symptoms of outbreak illness before reporting to duty.
4. Mental health services or faith-based resources will be available to provide counseling to staff during an outbreak.
5. Outbreak illness vaccinations of staff are encouraged and monitored.
6. High-risk employees (pregnant or immuno-compromised) will be monitored and managed by placing them on administrative leave or altering their work assignments.

Vaccinations and Antiviral Usage

1. The Centers for Disease Control (CDC) and the Health Department will be contacted to obtain the most current recommendations and guidance for the usage, availability, access, and distribution of vaccines and antiviral medications during an outbreak, if applicable.
2. Guidance from the State Health Department will be sought to estimate the number of staff and residents who are targeted as first and second priority for receipt of vaccine or antiviral prophylaxis, if applicable.
3. A plan is in place to expedite delivery of vaccine or antiviral prophylaxis, if applicable**.**

Preparedness of Supplies and Surge Capacity

1. Quantities of essential food, materials, medical supplies, and equipment have been determined to sustain the facility for a six-week outbreak. A predetermined amount of supplies are stored at the facility or satellite location.
2. Plans include strategies to help increase hospital bed capacity in the community.
    a. Agreements have been established with area hospitals for admission to the facility of non-outbreak illness patients to facilitate utilization of acute care resources of more seriously ill patients.

    b. Facility space has been identified that could be adapted for use as expanded inpatient beds and information has been provided to local and regional planning contacts.
3. Capacity for deceased residents has been determined, including a space to serve as a temporary morgue.

Certain Phases of an Outbreak Alert Should Include Specific Precautions:

1. When an outbreak illness has been detected in the United States with increased and sustained human-to-human spread:
    a. All prospective residents and employees will be screened if they have had recent travels or close contact with other ill persons who have recently traveled to a previously affected outbreak illness area.
    b. Infection prevention and control training will be initiated for Outbreak Preparedness.
2. When an outbreak illness is increasing and sustaining human-to-human spread in the United States and cases are occurring in the facility's state:
    a. All prospective residents and employees will be screened to identify exposure to outbreak illness. Fever and respiratory symptoms will be screened following exposure for one to five days.
    b. Residents, employees, contract employees, and visitors will be evaluated daily for symptoms. Employees will be instructed to self-report symptoms and exposure.
    c. Guidelines will be established as to when infected employees can return to work.
    d. Adherence to infection prevention and control policies and procedure is critical.
    e. Signs will be posted to remind staff, residents and visitors of cough etiquette. Adherence to droplet precautions during the care of a resident with symptoms or a confirmed case of outbreak illness is a must.
    f. The Infection Preventionist will determine when to restrict admissions and visitations. Communicate this to the affected parties.
    g. Local and state health departments will be contacted to discuss the availability of vaccines and antiviral medications, as well as recommendations of usage.
    h. Adequate supplies of food, water, and medical supplies will be available to sustain the facility if outbreak occurs in the geographic region or at the facility.
    i. Residents and employees will be cohorted as necessary.
    j. Contingency staffing plans will be implemented as needed.

Cohorting Policy and Procedure

Policy

The facility will determine which residents can be cohorted. 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).

Procedure

1. When single patient rooms are available, assign priority for these rooms to patients with known or suspected outbreak illness colonization or infection.
2. Give highest priority to those patients who have conditions that may facilitate transmission; for example, un-contained secretions or excretions.
3. When single patient rooms are not available, COHORT patients with the same outbreak illness in the same room or patient care area.
4. When cohorting patients with the same outbreak illness is not possible, place outbreak illness patients in rooms with patients who have limited risk factors for acquisition of outbreak illnesses and associated adverse outcomes from infection.

Reporting Communicable Diseases

Purpose

The purpose of this procedure is to guide reporting of suspected and confirmed communicable diseases to the appropriate governmental agency or authority.

General Guidelines

1. All reportable infectious diseases (residents' or employees') must be reported to the Infection Preventionist as soon as a definite diagnosis is made or strongly suspected.
2. The Infection Preventionist is responsible for notifying the local, district, or state health department of confirmed cases of state-specific reportable diseases.
3. Diseases that are included in state lists of reportable diseases may also include diseases that must be reported to the CDC (Nationally Notifiable Diseases).
4. Reportable diseases are divided into several groups:
    a. Mandatory written reporting: a report of the disease must be made in writing.
    b. Mandatory reporting by telephone: a health care provider must make a report by phone.
    c. Report of total number of cases.
5. When a disease has been reported to the local, district, or state health department, the Infection Preventionist is responsible for maintaining an in-house report of such action, including the date and time of the report.
6. Should the resident or employee reside in another county, the disease must be reported directly to the county of residence (if known). If such information is not known, the disease will be reported to the local county health department.

Notification

Policy Statement

This facility has taken measures to notify residents, family, and staff in the event of an outbreak.

Notification

1. Each resident unit should immediately report any resident(s) or staff member(s) with a sudden onset of symptoms suggestive of outbreak illness to the person in charge and the infection prevention and control practitioner, who should immediately take appropriate action.
2. The medical director should be consulted any time the facility suspects an outbreak.
3. New cases of ill residents and staff should be recorded each shift using a line list.
4. Notify the local health department of any suspected or confirmed outbreak and consult with them about laboratory testing. The local health department will request the following information:
    a. Number of ill residents and staff
    b. Onset of illness
    c. Signs and symptoms of the illness
    d. Any laboratory tests complete or pending
    e. Job duties of any ill staff
5. Notify "sister" facilities that may share staff, facilities, or other resources with the affected facility or unit so they can implement proper infection prevention and control measures and monitor for illness.
6. Offer alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.)
7. On a case by case bases families will be allowed minimum visits for any resident on end of life crises or extenuating circumstance. This allowance must be approved by the Director of Nursing or Administrator.
8. Mandatory confidential daily screening of everyone who comes into the site (necessary visitors, contractors, volunteers, vendors, delivery persons and physicians, among others) for potential exposure will be done. This will include taking temperatures. For any individuals who decline to be screened or who will meet any of the criteria for potential exposure, they will be politely asked to leave the facility.
9. Staff Agency, Contractors, Private Aides, and Companions will be required to complete a screening and acknowledge that they will immediately report any signs and symptoms of respiratory infection to their manager/designee on duty AND that they received CDC handouts related to infection preventing and donning/doffing PPE.
10. Screening will be conducted every day with every individual who enters the facility, since exposure can occur at any time.

11. If employee develops symptoms while at work, the employee should stop working, put on a face mask immediately and notify the manager.
12. Follow HR sick leave policies that allow employees to stay home if they have symptoms of respiratory infection.

Monitoring

Policy Statement

This facility has taken measures to monitor residents, family, and staff in the event of an outbreak.

Monitoring

1. Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated). Infection preventionist will follow the CDC criteria to guide evaluation of PUI for COVID-19.
2. In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless suspected diagnosis required Airborne Precautions (e.g., tuberculosis).
3. Residents potentially exposed will not be transferred consistent with the most recent CMS guidelines unless their clinical status requires transfer and the physician orders it.
4. Staff who develop respiratory symptoms are to apply facemasks and report to the infection preventionist and human resources. Ill staff may not return to work until they have been afebrile longer than 24 hours (without antipyretic treatment) and respiratory symptoms have improved.
5. Infection preventionist should monitor their local and state public health sources to understand COVID-19 activity in their community.
6. The administrative staff, including the Director of Nursing Services, the Administrator and the Infection Control Coordinator will manage visitor access and movement within the facility.
    a. Visitors for residents in isolation for influenza will be limited to persons who are necessary for the resident's emotional well-being and care.
    b. Exemptions to visitor restriction may be considered at the discretion of the facility.
    c. Regardless of restriction policy, all visitors will be instructed to follow respiratory hygiene and cough etiquette precautions.
    d. Visits to residents in isolation for outbreak illness will be scheduled and controlled to allow for:
        i. Screening visitors for symptoms of acute respiratory illness before entering the facility; and
        ii. Providing instruction, before visitors enter residents' rooms, no hand equipment (PPE) while in the resident's room.
    e. Visitors will not be present during aerosol-generating procedures.
    f. Visitors will be instructed to limit their movement within the facility.

g. Visitors may be advised to contact their healthcare provider for information about outbreak illness.

7. The infection Control Coordinator will monitor outbreak illness activity.
    a. The Infection Control Coordinator has established procedures for monitoring and reporting outbreak illness activity in the facility.
    b. The Infection Control Coordinator maintains close communication and collaboration with local and state health authorities.

Infected Healthcare Workers

1. The Infection Preventionist and/or designee will monitor and manage ill healthcare personnel. Staff who develop fever and respiratory symptoms will be:

    a. Instructed not to report to work, or if at work, to stop resident-care activities, don a facemask, and promptly notify their supervisor and the Infection Preventionist and/or designee before leaving work.

    b. Reminded that adherence to respiratory hygiene and cough etiquette after returning to work is always important.

        (1) If symptoms such as cough and sneezing are still present, staff will wear a facemask during resident-care activities.

        (2) The importance of performing frequent hand hygiene (especially before and after each resident contact and contact with respiratory secretions) will be reinforced.

    c. Excluded from work until at least 24 hours after they no longer have a fever (without the use of fever-reducing medicines such as acetaminophen). Those with ongoing respiratory symptoms will be considered for evaluation by the Infection Preventionist and/or designee to determine appropriateness of contact with residents.

    d. Considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer, if returning to care for immunocompromised residents.

2. Staff with fever alone will follow the gener.al policy for staff with fever until a more specific cause of fever is identified or until fever resolves.

3. Staff who develop acute respiratory symptoms without fever may still have influenza infection and will be:

    a. Considered for evaluation by the Infection Preventionist to determine appropriateness of contact with residents.

    b. Reminded that adherence to respiratory hygiene and cough etiquette after returning to work is always important. If symptoms such as cough and sneezing are still present, staff will wear a facemask during resident care activities. The importance of performing frequent hand hygiene (especially before and after each resident contact) will be reinforced.

c. Allowed to continue or return to work unless assigned to care for immunocompromised residents.

d. If assigned to care for immunocompromised residents, considered for temporary reassignment or considered for exclusion from work for 7 days from symptom onset or until the resolution of all non-cough symptoms, whichever is longer.

4. The following human resources practices are in place:

a. Sick leave policies for staff are non-punitive, flexible and consistent with public health guidance to allow and encourage staff with suspected or confirmed influenza to stay home.

b. All staff, including staff who are not directly employed by the healthcare facility but provide essential daily services, are made aware of the sick leave policies.

c. Procedures are established for:

(1) Tracking absences;

(2) Reviewing job tasks and ensuring that personnel known to be at higher risk for exposure to those with suspected or confirmed influenza are given priority for vaccination;

(3) Ensuring that employees have prompt access, including via telephone to medical consultation and, if necessary, early treatment; and

(4) Promptly identifying individuals with possible influenza.

5. Staff will self-assess for symptoms of febrile respiratory illness. Decisions about work restrictions and assignments for staff with respiratory illness will be guided by clinical signs and symptoms rather than by laboratory testing for influenza.

Management of Residents

1. Restrict ill residents' activities until 48 hours after they are well.
2. Efforts should be made to minimize movement of residents from an affected unit of facility to an unaffected location. In most circumstances, asymptomatic, exposed residents should **not** be moved from an affected to an unaffected resident unit. The value in moving asymptomatic residents who have been exposed (e.g., to a symptomatic roommate) is uncertain since they may already be infected and be incubating the virus.
3. Evaluate the need to cancel communal meals and group activities until 48 hours after the well date of the last resident case.
4. Clean and disinfect all equipment between residents including, but not limited to: blood pressure cuffs, stethoscopes, electronic thermometers and transfer equipment. Consider dedicating commonly used equipment for use in affected areas only.
5. Ensure health care providers managing a symptomatic resident's medical care are aware of their resident's illness to determine if any changes to medical management are warranted.
    a. Consult with health care providers for residents experiencing vomiting or diarrhea who are also taking fluid-depleting drugs and/or laxatives.

    b. Consult with health care providers regarding the use of anti-emetics or anti-motility agents.
    c. For residents experiencing vomiting or diarrhea, monitor hydration status to include implementation of intake and output monitoring.

6. Limit new admissions until all cases have been asymptomatic for at least 48 hours. **If new admissions are being considered, consult with the infection prevention and control practitioner and the facility medical director first.**
    a. Consider admitting resident(s) to an unaffected unit or to a unit where all cases have been asymptomatic for 48 hours.
    b. Inform prospective residents and their health care provider about the ongoing outbreak in the admitting facility.

7. If any resident, regardless of symptoms, is transferred to a hospital or other facility, you should notify the facility.
8. Discourage sharing of resident's personal food supplies for the duration of the outbreak.

Laboratory Testing

Policy: Provide guidance to the staff in the appropriate testing and handling of cultures.

Procedure:

1. Cultures are to be obtained from residents upon a physician's order only.
2. Cultures are to be obtained, labeled and handled according to accepted policies and procedures of the lab.
3. Culture results are to be called or forwarded via fax to the physician as soon as they are available.
4. Completed culture reports are to be reviewed by the Director of Resident Care or wellness nurse.
5. In the event of an outbreak or other infectious emergency, the Director of Resident Care has the authority to:
    - Request cultures for screening, monitoring and/or follow-up as necessary under the direction of the appropriate health authorities.
    - Report findings and consult with appropriate health authorities.

Procedure:

1. Obtain a physician's order to collect a culture from a resident (unless under the direction of the Director of Resident Care, an outbreak or other emergency situation has occurred).
2. Gather appropriate equipment/supplies according to the lab policies and procedures for the type of specimen to be collected.
3. Wash hands.
4. Explain to the resident what you are going to do.
5. Follow the accepted nursing/lab procedures to collect the specimen.
6. Label and handle the specimen according to the accepted lab policies and procedures using universal infection control practices.
7. Wash hands.
8. Notify the lab of the need for a specimen pick-up per lab policies and procedures.
9. Sign off the physician's order as completed and record the collection of the specimen in the resident's medical record. Include the following:
    - Date/time collected
    - Type of specimen
    - Source for specimen (as applicable)
    - Description of specimen (amount, color, consistency, odor, etc.)
    - Date/time lab notified and picked up specimen
10. Record obtaining of culture on the Infection Log and 24 hour report as appropriate.
11. When culture results are reported to the community, notify the physician as soon as possible.
    - Call the physician directly and read the report. Document the physician notification and response in the resident's medical chart. Record in the culture report the date and time of the physician notification.

- Fax the culture report to the physician and follow-up with a phone call to assure that the physician received the report. Document all actions taken in the resident's medical chart.

12. If the physician orders an antibiotic:
    - Double check the resident's allergy information.
    - Check the sensitivity report, as available; to assure the antibiotic is appropriate for
    - Organism.
    - Alert the physician if any problems are noted with any of the above.
13. Notify the Director of Resident Care if the culture results show Methicillin Resistant Staphylococcus Aureus (MRSA) or Vancomycin Resistant Enterococcus (VRE).
14. Record culture results on the Infection Log as appropriate.