



Infection Outbreak Management Guidelines

POLICY

It is the policy of UM Communities that outbreak measures will be instituted whenever there is an incidence of infections above what would normally be expected, considering seasonal variations.

PURPOSE

- To establish that an outbreak exists
- To provide timely, appropriate monitoring of ill residents
- To decrease the risk of transmission of infection from one resident to others
- To provide community employees, medical and administrative staff, and state/local agencies with accurate, organized, and objective information
- To decrease the risk of future outbreaks of similar illness and to identify contributing factors

DEFINITIONS:

Outbreak:

Defined as the occurrence of cases of a disease (illness) above the expected or baseline level, usually over a given period of time in a community, geographic area, or in a specific population group. The number of cases indicating the presence of an outbreak will vary according to the disease agent, size, and type of the population exposed, previous exposure to the agent, and the time and place of the occurrence. It is the occurrence of more cases, or clustering of cases, of a particular infection or infectious disease (illness) than is normally expected; the occurrence of an unusual organism; or the occurrence of unusual antibiotic resistance patterns. Definitions of cases and outbreak vary with each disease/infection; see specific diseases for details (i.e. scabies outbreak, Influenza outbreak, GI outbreak etc.). **"Outbreak" means any unusual occurrence of disease or any disease above background or endemic levels. A sudden appearance of a number of cases with similar symptoms of infection either in residents or staff.**

Epidemic/Outbreak- represents an excess over the expected level of a disease within a geographic area. A sudden rise in the number of cases of a disease. Occurs when a infectious disease spreads rapidly to many people.

Endemic- represents the usual level of a disease within a geographic area

Pandemic -- A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality. Human have little to no immunity. Often caused by a new virus or strain of a virus that has not circulated among people for a long time/ A global disease outbreak.

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.

Cohorting - means the practice of grouping residents who are or are not colonized or infected with the same organism to confine their care to one area and prevent contact with other residents.

Quarantine – Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.

Compassionate Visit -can be define as end of life or as a need identified by the healthcare team or the interdisciplinary team that an in-person visit is paramount to a resident's care and well-being (i.e.: high risk of behavioral or mental health deterioration or physical needs such as feeding that cannot otherwise be supported by onsite healthcare staff.

SPECIAL INSTRUCTIONS/FORMS OR EQUIPMENT TO BE USED (*may be eliminated if no special instructions/forms/equipment apply*)

PROCEDURE

Outbreak Protocol:

- Outbreak measures will be instituted whenever there is an incidence of infections above what would normally be expected, considering seasonal variations.
- The SDC/Infection Preventionist will conduct outbreak investigation. In the absence of an Infection Preventionist, the Director of Nursing will conduct the investigation.
- Appropriate notifications will be completed within the community to the Medical Director, Administrator, all departments, attending physicians, and family members at a minimum and to appropriate state and local agencies.
- Outbreak surveillance and reporting will continue until resolution.
- The SDC/ Infection Preventionist will have the authority to implement control measures as appropriate, in coordination with administration, and medical staff as well as state and local agencies. For example, these control measures may include simple resident or household isolation or quarantine measures for the entire community.
- An interdisciplinary evaluation of the outbreak will be completed and recommendations for preventive measures will be presented at the quarterly QAPI Committee meeting

Outbreak Preparedness:

- The SDC/Infection Preventionist shall determine usual infection rate in their community.
- The SDC/Infection Preventionist shall determine threshold for considering the existence of an outbreak.
- UMC Communities will take proactive steps to protect the workplace in the event of an infectious disease outbreak. Associates are to be encouraged to engage in good hygiene

practices while at work using alcohol-based disposable hand wipes or gel sanitizers, and soap and water when appropriate per hand hygiene guidelines.

- Ensure Alcohol-based hand sanitizer for hand hygiene is available near every resident room (as possible), and other resident care and common areas (e.g., outside dining hall, in therapy gym)
- Associates of UMC are also encouraged to participate in UMC Wellness Program which provides annual influenza vaccination for associates.
- Associates who are sick should be instructed not to come to work if they are experiencing symptoms of infectious disease, such as vomiting or diarrhea, skin eruptions, cough, sore throat, fever, or cold symptoms.
- Policies to prevent outbreaks include food safety programs, immunization programs, isolation practices, and hand washing programs that include all staff, residents, and visitors.
- Education of staff on hand washing, appropriate isolation measures, and influenza vaccination on hire, annually, and as needed.
- Resident and staff education is provided on an ongoing basis to meet the needs of each resident by all members of the care team. Required education elements include: hand hygiene, infection prevention, and when indicated based on the resident's condition isolation precaution, UTI prevention, surgical site infection prevention, multi drug resistant organisms inclusive of methicillin resistant staph aureus (MRSA) education, Clostridium education, and COVID-19 education.
- Associates will be educated on the community's plan to control exposure to the residents. This plan will follow local department of health guidelines and may include:
 - All associates will be educated and will be responsible for self screening of symptoms and reporting any suspected exposure to an emerging infectious disease or outbreak while off duty to their supervisor and SDC/Infection Preventionist.
 - Precautionary removal of associates who report an actual or suspected exposure to the emerging infectious disease/virus.
 - Precautionary removal of associates who report an actual or suspected exposure to the emerging infectious disease or outbreak.
 - The prohibition of staff from reporting to work if they are sick until cleared to do so by the SDC/ Infection Preventionist or appropriate medical authorities and in compliance with appropriate labor laws.
- As part of the emergency operation plan, each community will:
 - Maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields, foot and head coverings, surgical masks, and gloves. A supply of disposable blood pressure cuffs and stethoscopes, and individual thermometers for use will also be maintained. The amount of PPE and supplies that are stockpiled, shall be minimally enough for one (1) to two (2) months of care, but will be determined based on storage space and costs, and supply chain demand.
 - Develop a process to address shortages of supplies at the community level including administration, nursing, plant operations - ideally this can be a corporate construct rather than at each community.
- Ensure there are hand held devices and laptop(s) available to be utilized for those residents requiring isolation.

- Signage is available to post at entrances and for each household to post.
- Develop a contingency plan for managing an increased need for postmortem care and disposition of deceased residents. An area in the community that could be used as a temporary morgue should be identified. Reach out to your local OEM to discuss local plans for expanding morgue capacity and possible contacts.

Outbreak Management

The outbreak case definition will be developed by the local health department or NJDOH epidemiologist with cooperation from the community based on the current situation.

An outbreak case definition describes the criteria that an individual must meet to be counted as an outbreak case, including clinical signs & symptoms, physical location and specific time period. This differs from a clinical case definition, which is a criteria of symptoms used to make a diagnosis.

The case definition will be developed collaboratively by the local county health department and the NJDOH epidemiologist with cooperation from the community based on the current situation.

The case definition may change over time as information is gathered on the outbreak. The NJDOH epidemiologist is available for consultation as needed.

An outbreak may be occurring if:

- Several residents who exhibit similar symptoms are in the same room, the same wing of a community or attended a common activity.
- Two or more residents develop illness within 24-72 hours of each other with same symptoms, infection or disease.
- "Outbreak" is defined as **one positive case of COVID-19 among either residents or staff**
- There is an increase in associate absences with many staff reporting similar symptoms.
- Suspicion of an outbreak will include:
- Laboratory surveillance of microbiology reports that may show an increase in the number of isolates of a single species.
- The occurrence of two or more cases of the same disease, infection or symptoms linked in time or place e.g. residents with nausea, diarrhea or vomiting, wound infections, respiratory infection, resistant organisms.
- A greater than expected rate of infection compared with the usual background rate for the particular place and time.
- A single case of a rare or serious infection i.e. Diphtheria, Legionella, Coronavirus, Ebola, etc.

Lab Confirmation:

- Lab testing in an outbreak setting may be done through the community's standard procedures when possible.
- If laboratory testing capabilities are limited, the community should make the local county health department aware and the local county health department should consult with NJDOH to discuss testing at the state Public Health and Environmental Laboratory (PHEL).

- The local county health department or NJDOH epidemiologist can assist with facilitating laboratory testing and/or specimen transport. All specimens sent to public health department must be pre-approved by NJDOH and properly labeled and packaged.
- The type of testing done and the type of specimen collected can vary by the disease that is suspected. Regardless of laboratory findings, public health control measures still need to be implemented.

Roles:

Clinical Staff will:

- It is the responsibility of all resident caregivers to be aware of signs of illness in visitors and notify the nurse of such.
- It is the responsibility of all clinical associates to self screen for symptoms prior to work.
- Will notify SDC/IP of a suspected outbreak or suspected exposure.
- Assist SDC/IP as requested, in assessing the presence or absence of an outbreak.
- Verify the diagnosis using clinical, epidemiological and lab test information, considering seasonal disease occurrence.
- Implement isolation transmission protocols
- License nurse will obtain orders and initiate treatments as needed.
- If feasible, ask the isolated person to wear a face mask or a tissue over face while staff is in the room. Provide care at the level necessary to address essential needs of the isolated individual unless it advised otherwise by local department of health.
- Document signs and symptoms on each resident identified with symptoms each shift.
- Document lab results in the EMR and communicate results to the physician and SDC/Infection Preventionist timely.
- Implement recommended corrective action as required.
- Assist as required in monitoring the results of the corrective action implemented.
- The scope of household or unit restrictions will be dependent on the extent of the outbreak activity within the community (one unit, one floor, one hall or the entire community), the ability to cohort staff to affected areas and severity of the outbreak (e.g., many residents and staff affected, and as new cases continue to develop in spite of implemented control measures).

SDC/Infection Preventionist will:

- Gather information to confirm an outbreak is occurring within the community; this would include initial information on the number of ill and well residents and staff.
- Verify diagnosis of identified residents and staff.
- Confirm or exclude the existence of an outbreak by carrying out the appropriate outbreak epidemiologic investigation.
- In consultation with the medical director shall establish the existence of an outbreak based on the epidemiology of the infectious disease.
- Staff will be educated on the community'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 emerging infectious disease or virus while off duty to their supervisor and public health.

- Precautionary removal of employees who report an actual or suspected exposure to the infectious disease or virus.
- Staff self-screening for symptoms prior to reporting to work.
- Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
- Sick call out procedures - staff are prohibited from reporting to work if they are sick until cleared to do so by the infection preventionist and in compliance with local DOH and CMS guidance. If an associate does not exhibit infectious disease symptoms at the beginning of their work shift but begins to exhibit symptoms at work, the associate should be sent home immediately.
- Activate the community's respiratory protection plan to ensure that associates who may be required to care for a resident with suspected or known case are not put at undue risk of exposure.
- Will follow NJDOH and CDC guidelines for control of outbreaks in long term care and other settings. Confirmed or suspected cases should be telephoned immediately to the local DOH. Reportables must be communicated to the local and state DOH agencies within 24 hours of diagnosis.
- Develop strategies for interrupting the outbreak as required.
- Identify and eliminate transmission sources when possible.
- Institute control measures, balancing infection control concerns with disruption of residents' quality of life routines.
- The SCD will collaborate with the DON and administrator to keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (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 as needed and supervision in the mode of transmission of this emerging infectious disease or virus, and the use of the appropriate PPE.
- Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health department, and in keeping with guidance from the CDC.
- Implement the isolation transmission precautions protocol in the community.
- Plan for providing just-in-time staff education via electronic and other non-classroom means including information about COVID-19 transmission, infection prevention and control measures, usual clinical symptoms and course, treatment, risk factors, normal stress response, and complications.
- Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the community along with the instruction that anyone who is sick must not enter the building.
- Evaluate effectiveness of control measures and modify as needed.
- Educate clinical staff on the findings and the reasons behind any corrective strategies.
- Monitor the outcome of the changes made for their effectiveness in interrupting the outbreak and preventing recurrences

- Convene a group to help define the outbreak, facilitate its control, and ensure maintenance of operations, prevent recurrences, and provide communication (as necessary).
- Act as a focal point for flow of information.
- Coordinate the investigational activities and follow NJ epidemiology guidelines for infectious diseases (i.e., GI and respiratory, and COVID19 outbreak guidelines).
- Will research the specific signs, symptoms, incubation period, and route of infection, the risks of exposure, and the recommendations for community as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal public health agencies.
- Maintain line lists, data update sheet, log of events and report information to local and state DOH daily or as requested.
- Develop infection detection process at the community to promptly detect and isolate residents and staff with suspected COVID-19 and monitor their close contacts
- Managers of areas where exposure of associates has occurred will instruct staff to contact the SDC/IP as appropriate in a timely manner. If the associate is not able to contact, the manager will provide any needed information (i.e. work schedules, home addresses, and telephone numbers) to the SDC/IP.
- The SDC/IP will consult with local department of health who have expertise in suspected disease process or organism when a disease with potential mass exposure is identified in a resident or staff member or when the potential exposure to other residents and staff members is beyond that which would normally be addressed by routine infection prevention and control practices.
- Based on the established routes of transmission of the infectious disease, control measures shall be instituted to contain the outbreak. Discontinuation of these measures shall occur only when the SDC/IP in consultation with the medical director and the local county health department determines that it is appropriate to do so.
Administration is to report to state authorities all outbreaks of communicable diseases as required. Refer to NJ DOH reportable guidelines.
- An investigation will be conducted by the SDC/IP in collaboration with the local health department in order to identify:
 - All suspected (symptomatic) individuals
 - All individuals having a significant exposure to the infectious disease (significant exposure is determined by evaluation of the mode of transmission of the infectious disease and the length of the exposure.
 - Summarize the investigation in a written report to communicate findings and review in the quarterly QAPI meeting

The Executive Director/NHA will :

- Working with advice from medical director, infection preventionist, local and state public health authorities, and others as appropriate, will stock up on medications, environmental cleaning agents, and personal protective equipment as indicated by the specific disease threat.

- Ensures that the community maintains a stockpile of supplies and PPE as per state guidelines.
- Ensure the same command and control structure detailed in the Emergency Operations Plan will be used during an infectious disease emergency.
- Ensure that adequate communication channels are established and that the "community's outbreak plan" is posted on the community's website for public view. The outbreak plan shall include communication methods to notify the residents, their families/representatives, and staff about any infectious outbreaks and shall include strategies and methods for virtual communication in the event of visitation restrictions.
- Initiate daily debrief meetings with the management team to assess the response and outcomes, identify urgent concerns, and provide support.
- Plan contingencies if appropriate levels of respiratory protection are unavailable.
- Evaluate the need for family support to enable staff to work (e.g., childcare, pet care).
- Make reasonable accommodations for associates such as permitting associates to work from home if their job description permits this.
- Develop a telemedicine service plan for use for the resident population.
- Discontinue routine in-person meetings in favor of conference calls or Zoom teleconference. Coordinate care and community operations by email, phone, and text messages whenever possible and effective.
- Separate departments and minimize in-person interactions between administrative and operations associates to the maximum extent possible.
- Ensure screening of all persons entering the community and screening of all staff at the beginning of each shift as per state and governing guidelines. Prohibit entry of those individuals identified as exhibiting symptoms of an infectious communicable disease or have been in contact with someone with an infectious communicable disease or under suspicion, or ill with a respiratory illness.
- Prohibit entry into the community for those individuals identified as having traveled from a state or region under NJ state designated travel advisory.
- Implement social distancing guidelines, modification of operations that may include shift work or teleworking.
- Determine vulnerable supplies and coordinate with vendors and health care partners to develop contingency plans/allocation plans.
- Collaborate to the ADR, SDC/infection preventionist to develop and provide just-in-time training to staff taking on non-traditional roles as required to maintain critical services.
- Determine likely resource shortages and identify relevant vendor, cache, and options for managing shortages.
- Determine screening process and location for testing.
- Engage union/labor leaders in relevant discussions of staff responsibilities and hours as needed to meet demands of outbreak or pandemic.
- Evaluate potential staffing and responsibility changes and how less-trained staff could contribute to operations.
- Consider ways to maintain staff resilience and morale when congregate gatherings and close physical contact are discouraged. This may need to include memorial services for staff members.

- Disseminate critical information as it becomes available to associates, families, resident representatives, and permissible visitors to safeguard the community promptly.
- Provide residents and families with education about the disease and the community's response strategy at a level appropriate to their interests and need for information.
- Ensure the community follow current CDC guidelines for environmental cleaning specific to the outbreak in addition to routine cleaning for the duration of the threat.
- In the event there are confirmed cases of an emerging infectious disease or outbreak in the community, the Executive Director may consider closing the community to new admissions, and limiting visitors based on the advice of local county department of health authorities.
- Activate quarantine interventions with collaboration of the SDC/Infection Preventionist, and the medical director for residents and associates with suspected exposure as directed by local and state DOH, and in keeping with guidance from the CDC.
- Implement the isolation protocol in the community (identify isolation rooms, cohorting, cancellation of group activities and social dining) as described recommendations by local, state, or federal public health authorities.
- Will meet daily with the infection preventionist or as required to review the progress of the outbreak and monitor the effectiveness of the control measures.
- Restrict the movement of staff from one health care setting to another.
- Determine virtual coordination mechanisms that will enable remote engagement of management staff to prevent exposures and maximize ability to engage in both daily and incident operations.
- Determine a process for expedited credentialing of supplemental staff and for the orientation/mentoring of supplemental or shared staff.
- Ensure that staff, residents, and/or new residents are not at risk of spreading the infectious disease or virus into the community by screening for exposure risk and signs and symptoms PRIOR to work, prior to an admission of a new resident, new hires, and the screening of all regular vendors and visitors .
- Ensure that the standards of clinical care are maintained by assisting with authorization of requisitions for additional supplies and ensuring staffing levels are maintained at adequate levels
- Ensure associates who refuse at any time to take the precautions set out in this and other sections of this policy and other infection control policies may be subject to discipline.
- Determine any potential regulatory relief (CMS 1135 or other waivers, state regulations relief, staffing requirements, etc.) that may be needed to effectively respond to COVID-19 as well as issues regarding staff licensure/certification.

Visitation:

- During a suspected or actual disease outbreak resident admissions, visitor contacts, and activities may be restricted. This decision will be directed by administration with consultation with the medical director, SDC/Infection Preventionist, and local county health department.
- UMC communities will close to visitation / resident intake due to an outbreak if directed to by the County Dept. of Health (Public Health) or by the guidance of the home office.

- Regular visitation is to be stopped and strongly discouraged until the outbreak is declared over.
- Non-essential visitors should be restricted from affected areas during an outbreak.
- The judgment as to whether a visit is essential is to be made primarily by the visitor with consultation with staff.
- All visitors must use hand hygiene upon entering the community and household/unit as well as before and after visiting the resident. Staff members are to educate visitors on proper hand hygiene practices if visitors are unaware.
- Staff should also provide instructions on how to don and remove the PPE required for the visit.
- All visitors should visit only close family members or those residents for whom the visit is necessary for their well-being or care.
- Visitors are to limit their movement (restricted to resident's room, may not be allowed visitation public areas such as the bistro or community living area based on outbreak guidelines) within the community and directly leave the community after they have finished visiting.
- Limit visitors to persons who are necessary for the resident's emotional well-being and care (CDC).
- Visitors may be screened for influenza like symptoms or exposure to others with such symptoms.
- Visitors who are ill may not visit unless granted permission for compassionate reasons such as end of life care, to be determined on a case by case basis with input from the community Infection Preventionist or Designee.
- **Compassionate and Essential Caregiver Visitation**-The interdisciplinary team or the health care team should review the rationale for the need of compassionate and essential caregiver visitation based on the resident's plan of care need and changes in their condition. This should be done by team consensus, with stakeholders including the resident, the resident's representative, the Executive Director and NHA lead, with consideration of involving other stakeholders who can provide input into the decision. These individuals are not limited to Social Workers, Clinical Nurse Leaders, Physicians/Nurse Practitioners, Risk Management, Spiritual Care, Community Life, and Infection Control.
- The need for compassionate and essential care giver visits must be included in the resident's individual plan of care and reviewed with the resident's GSE and the MDS schedule.
- Compassionate visitation should be limited to 1-2 visitors once per day for 2 hours with some exceptions permitted for residents identified with complex needs including behavioral and mental health needs.
- Essential caregiver visits should be limited to two (2) hours per visit, one (1) time per week during NJ state guidance of Phase 0 during pandemic or outbreak. Communities identified in NJ state guidance for Phases 1 or 2 may allow 2 visits per week and not to exceed a total of 4 hours per week. Communities identified in NJ guidance of Phase 3 may allow care-giving visitation under their regular visiting procedures. Refer to UMC Essential caregiver policy.
- **COVID19 visitation decisions** during an end of life situation or compassionate visitation should be made on a case by case basis, which should include careful screening of the visitor for fever or respiratory symptoms. Those with any symptoms should not be permitted to enter the community.

- Those visitors that are permitted must wear a face mask while in the community and restrict their visit to the resident's room or other location designated by the community. They should also be reminded to frequently perform hand hygiene.
- All visitors must wear a cloth face covering or face mask and be screen upon entrance to community during a COVID-19 outbreak and as needed for respiratory outbreak.
- Visitation will be prohibited if a visitor demonstrates the inability to demonstrate proper infection prevention and control or has traveled to area that has been identified on NJ travel advisory requiring a 14 day quarantine..
- Additional PPE should be provided as warranted to support the compassionate, end of life, and essential caregiver visits.
- Before visitors enter resident rooms, they are to be given instruction on hand hygiene, limiting surfaces touched, and use of Personal Protective Equipment (PPE).
- Compassionate or end of life visits must be documented in the clinical note section of the electronic health record by the social worker or assigned nurse on duty at time of visit.
- For Respiratory outbreaks, visitors will be instructed to follow the CDC Respiratory Hygiene and Cough Etiquette guidelines
at: <http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>
- **Visitor restrictions may apply to all visitors, including staff members and their families with the exception of essential caregivers that have been identified for the resident.**
Emerging infectious diseases such as COVID19, visitation restrictions will based on current NJ state DOH and CMS guidelines.
- Appropriate signage will be posted at the community entrance, and reception area
- In the most extreme situations, no visiting will be allowed. Exceptions to this will be permitted at the discretion of the administrator and the SDC/ Infection Preventionist.
- In less severe situations, visitors will be asked to use good judgment in deciding whether or not to visit:
- If they are experiencing cold or flu symptoms, nausea, vomiting or diarrhea, they are asked NOT to visit until symptoms have subsided.
- All visitors are requested to consult with staff members about appropriate isolation precautions while visiting with a resident.
- In the event that a resident is determined to be critically ill, family visits will be allowed despite above quarantine measures being implemented.
- If visitors exhibit signs of illness such as symptoms of the emerging infectious disease or outbreak, the nurse shall:
If deemed a communicable illness explain to visitor that to protect the resident, the ill visitor must leave the community and not visit until well. Contact the Executive Director if visitor or families refuse to cooperate with the outbreak protocol.

Resident Activity Restrictions:

- When a significant number of residents are exhibiting signs and symptoms of potentially infectious illness, the DRL/DON will restrict resident activity after discussion with the

SDC/Infection Preventionist and Administration. If the DON/DRL is unable to reach either of the above, she or he will make a decision about restrictions based on information available.

- Admission restriction will be determined by the local DOH at the time the outbreak is declared.
- A resident who is hospitalized at another facility prior to the outbreak should not be transferred back to the community until the outbreak is declared over. If there are extenuating circumstances, an outbreak community may initiate discussion with the DOH to further assess the specific situation.
- During an outbreak, consideration should be given to providing treatment such as therapy in the resident's room instead of a centralized area; however residents may be allowed if it is feasible to attend medically necessary activities or appointments provided measures are taken to minimize transmission.
- It is recommended that previously scheduled resident social and special events/activities (e.g., entertainers, school groups, community presentations, and/or communal meals for special holidays) on the affected unit(s) be canceled/postponed for the duration of the outbreak.

Resident Restrictions may include:

- Restriction of residents to their household
- Restriction of residents to their rooms
- Restriction of visitors (and contractors, beautician, etc.)
- Restriction of group activities, including dining room, recreation activities, and other group therapies
- All other restrictions deemed appropriate by the Supervisor or the Infection Control Professional

- Restriction will remain in effect until notification by the Administrator, or the Director of Nursing. This decision will be reached after consultation with the Medical Director and / or the Infection Preventionist, local DOH and state governing agencies.
- All residents will be provided with alternative activities in their own rooms/units, such as one-on-one visits by staff or family, audio or video conferencing presentations, games, puzzles, etc.

Communication:

- The Executive Director or the NHA in their absence will be responsible for disseminating critical information and updates to associates, residents, and resident representatives as it becomes available to safeguard the community.
- During an outbreak or pandemic response, the Executive Director will notify the Corporate VP of Marketing to solidify communication strategies and resources.
- To provide information to external audiences, the following strategies can be utilized:
 - Electronic Dissemination
 - Website posting, e-mail listserv
 - Telephone Dissemination- Blast Text
 - Email Dissemination- Emails sent to individuals or large groups
 - Traditional Mail- Interoffice mail, US Postal Service mail

Presentations. If staffing and time permit, in person presentations. Alternatively, presentations can be posted onto the website as well.

Alternative Dissemination- such as Onshift.

- The community should post outbreak notification signs and other appropriate signage at all entrances to the community during the outbreak.

Communication in the event of COVID19 and the rapid spread of this particular virus:

- When a UMC community receives information from its laboratory services that either a resident of the community or information that a community staff member has tested positive for COVID-19, the community shall follow the guidance provided by the local health department to implement the actions necessary to protect the health and well-being of its residents and staff.
- The community shall provide notification to its staff of the presence of a COVID-19 positive resident or staff member in the community in accordance with the direction provided by the local health department.
- The Executive Director or the NHA in the absence of the executive director, will disseminate critical information as it becomes available to residents, associates, families, resident representatives (contact person), and permissible visitors by **5 pm the next calendar day for each instance or for whenever there is a single case of COVID19 confirmed in the community or three (3) or more residents or staff with new onset of respiratory symptoms that occur within 72 hours of each other.**
- This communication must include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered.
- The information communicated should not include personally identifiable information; and shall include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. This information conveyed must be reported in accordance with existing privacy regulations and statute.
- Each community must designate a staff as a primary contact to families for inbound calls and conduct regular outbound calls to keep families up to date.
- Updates to residents and their representatives must be provided **weekly**, or each subsequent time a confirmed infection of COVID-19 is identified and/or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours. Host conference calls, webinars or virtual office hours at set times but at a minimum on a weekly basis when families can call in or log on to a conference line and the assigned community staff can share the status of activities in the community and family members can ask questions or make suggestions.
- Communication must be done in writing and in person (for example, phone call, Zoom, etc) with **ALL** residents as appropriate, **ALL** staff, and **ALL** permissible visitors.
- Families, the resident representative, as well as visitors may receive communication through mass emails, phone calls or other methods of communication **but communication must be followed up by 5pm the next calendar day to ensure timely notification.**
- During this time of restricted visitation, notification for subsequent confirmed or person under investigation cases may be done via telephone, email or other method of communication.

- The communication method that community chooses to use must be prominently displayed on their website and or social media platform. The community website must be updated at a minimum on a weekly basis to keep families updated on what is happening in the resident's environment. Updates should include food menus and any scheduled activities.
- The Executive Director will ensure that there is a method of communication in place that is easily understood and accessible to everyone (residents, families guardians, and staff) to manage urgent calls or complaints. This method of communication for complaints and urgent calls during an outbreak shall be posted on their website or social media platform with information on how and where complaints can be made and to whom.
- Each community must provide ombudsman access to the resident. Communities must facilitate resident communication (e.g., by phone or through use of other technology) with the ombudsman.
- Provide residents with alternative means of communicating to those who would normally visit them prior to the outbreak. Virtual communication through video communication or phone can be used in the place of a 1 on1 visit during visit restrictions. Develop a schedule to ensure regular communication takes place.
- **The outbreak plan must be posted on the community's website for public view.**

Palliative Care and Behavioral Health Needs:

- In coordination with the physician and interdisciplinary team, palliative care may be necessary to support residents with an acute infectious disease or virus. Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress, grief and loss reactions.
- Plans should be enacted early in an acute infectious disease or virus response to address and plan for palliative care needs as appropriate based on the pathogen. Additionally, due to impact of being infected, exposed, or treating individuals with an acute infectious disease or virus, plans may be required to support a surge in behavioral health needs of residents, family members, community members, and associates during an acute infectious disease incident.
- Palliative care and behavioral health response may need to continue long after an acute infectious disease response is demobilized.
- If a community needs assistance in coordinating the care of the deceased, the executive director should reach out to the local OEM. The OEM shall be able to provide guidance on protocols and handing of the deceased in the event morgues or funeral homes are full to capacity. Local mortuary services also have internal plans and protocols to handle the remains of acute infectious disease residents and can provide guidance.

Environmental cleaning

- The community will follow current CDC guidelines for environmental cleaning specific to the infectious disease or virus in addition to routine cleaning for the duration of the threat.
- Routinely clean all frequently touched surfaces in your workspace, such as workstations, mouse, desktop phones, cell phones, countertops, med carts, equipment, rails, and doorknobs.

Use EPA approved disinfecting wipes or spray to wipe-down common-surface places, where appropriate.

- Develop environmental services room decontamination and waste stream plans.
- Stockpile and track usage of essential disinfectant supplies to ensure adequate supply in the event of a supply chain disruption.
- Conduct a thorough, enhanced cleaning in all affected areas at the end of the outbreak.

Engineering controls

- The community will utilize appropriate physical plant alterations such as use of private rooms for positive or high- risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal agencies.
- The community will determine if a cohorting plan is feasible. This plan should identify a area within the unit or community for managing suspected and confirmed case. **If unable to cohort a confirmed or suspected case:**
- Place a resident who exhibits symptoms of the infectious disease or virus in an isolation room and notify local DOH
- Under the local DOH guidance, arrange a transfer of the suspected infectious resident to the appropriate care facility via emergency medical services as soon as possible.
- If the suspected infectious person requires care while awaiting transfer, follow policies for isolation procedures, including all recommended PPE for staff at risk of exposure

Considerations for Residents in Memory Care Units

Residents with dementia may have an impaired ability to follow or remember instructions regarding:

- Hand washing
- Wearing a mask
- Refraining from placing things in the mouth
- Staying in particular areas
- Taking medications appropriately
- Following any other procedures that would require intact memory and judgment

It is recommended that residents with dementia be placed on a supervised “hand washing schedule” followed by the use of moisturizer to avoid skin breakdown. Various approaches may be needed to ensure that these individuals use masks and remain in particular areas.

- Routines are very important for residents with dementia. Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent [hand hygiene](#), social distancing, and [use of cloth face coverings](#) (if tolerated). Cloth face coverings should not be used for anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- Limit staff on the unit to only those essential for care.
- Continue to provide structured activities, which may need to occur in the resident’s room or be scheduled at staggered times throughout the day to maintain social distancing.

- Provide safe ways for residents to continue to be active, such as personnel walking with individual residents around the unit or outside.
- Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel.
- Frequently clean often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time.
- Continue to ensure access to necessary medical care, and to emergency services if needed and if in alignment with resident goals of care
- Consider potential risks and benefits of moving residents out of the memory care unit to a designated COVID-19 care unit.
Moving residents with confirmed COVID-19 to a designated COVID-19 care unit can help to decrease the exposure risk of residents and HCP; however,
- Moving residents with cognitive impairment to new locations within the facility may cause disorientation, anger, and agitation as well as increase risks for other safety concerns such as falls or wandering.
- Additionally, at the time a resident with COVID-19 or asymptomatic SARS-CoV-2 infection has been identified, other residents and staff on the unit may have already been exposed or infected, and additional testing may be needed.
- The community may determine that it is safer to maintain care of residents with COVID-19 on the memory unit with dedicated staff.
- **If residents with COVID-19 will be moved from the memory care unit:**
Provide information about the move to residents (as feasible) or resident's representative
Prepare staff on the receiving unit about the habits and schedule of the person with dementia and try to duplicate it as much as possible.
Move familiar objects into the space before introducing the new space to the resident. Familiar objects such as favorite decorations or pictures can help make the person feel more comfortable; this applies to their new surroundings as well if residents are moved to new spaces.

Mitigation and Preventive Measures:

- The SDC/IP will complete an analysis of the outbreak once it has resolved and consider what program changes might be indicated for the future.
- The SDC/Infection Preventionist will monitor the incidence of infections that may be related to care provided at the community and will act on the data and use information collected through surveillance to detect transmission of infectious agents in the community.
- Ongoing education of staff, residents, families, and visitors about outbreak prevention and appropriate social distancing with physical separation will be provided as needed.
- The SDC/ Infection Preventionist will provide additional training in response to recognized lapses in adherence to infection control practices and to address newly recognized infection transmission threats (e.g., introduction of new equipment or procedures) as needed.

- Daily infection control issues, audits, and concerns shall be reviewed in the community's daily stand up meetings or a separate daily infection control meeting can be established to monitor and contain infection control outbreaks within the community.
- UM Communities will conduct mitigation activities to lessen the impact of an infectious disease emergency. Some of the mitigation activities related to an infectious disease emergency are listed below:
 UM Communities will conduct an annual Flu Vaccine Campaign
 Hand sanitizer stands shall be distributed throughout the community to help reduce the spread of disease.
 Communities are to report instances of infectious diseases including influenza, influenza-like illnesses and other communicable diseases and viruses to their local DOH.
- Outbreak incidents will be monitored daily and on a quarterly basis by the Infection Preventionist and findings will be reported at the quarterly QAPI Meetings.

Recovery

- Recovery will be based on the conclusion of an outbreak and clearance by local DOH and state governing agencies.
- UM communities will conduct recovery activities in the aftermath of an infectious disease outbreak or a pandemic event.
- Recovery activities will focus on returning the community to normal operations as well as developing any QAPI Plans to improve preparedness and response capabilities.
- Establish short- and long-term goals to return community to the pre-event baseline.
- Evaluate how the outbreak plan was carried out and identify gaps that occurred during the response.
- Identify lessons learned, missed opportunities and difficulties encountered
- Determine potential solutions to the gaps identified in the outbreak plan.
- Update the community outbreak plan to reflect lessons learned and recommendations.
- Revise outbreak plan as needed.
- Educate staff on changes in the community outbreak plan.

Resources:

http://reprolineplus.org/system/files/resources/IPC_M11_Programs.pdf

<https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/outbreaks.html>

<https://www.sfcidcp.org/wp-content/uploads/2018/01/ENTIRE-INFO-and-GUIDANCE-BRANCH-id690.pdf>

<https://www.cms.gov/files/document/qso-20-28-nh-revised.pdf>

<https://www.cms.gov/files/document/qso-20-29-nh.pdf>