Pandemic Emergency Plan:

Annex A

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Infection Control Program Policy

Effective: 9/14/2020	Revised:

POLICY STATEMENT

1. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement (QAPI) program.
2. The elements of the infection prevention and control program consist of co-ordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, employee education, and employee health and safety.

POLICY INTERPRETATION AND IMPLEMENTATION

1. Coordination and Oversight

a. The infection prevention and control (IPC) program is coordinated and overseen by an infection preventionist (IP).

b. The qualifications and job responsibilities of the IP are outlined in the *Infection Preventionist Job Description*.

c. The IPC committee is responsible for reviewing and providing feedback on the overall program. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include:

- *i.* Whether physician management of infections is optimal
- *ii.* Whether antibiotic usage patterns need to be changed because of the development of resistant strains
- *iii.* Whether there is appropriate follow up of acute infections

d. The committee meets regularly to review and revise any guidelines or policies

2. Policies and Procedures

a. Policies and procedures are utilized as the standards of the IPC program.

b. The IPC committee (medical Director, DNS and IP) and other key clinical and administrative staff will review the infection control policies at least annually. The review will include:

- i. Updating or supplementing policies and procedures as needed;
- ii. Assessment of staff compliance with existing policies and regulations; and
- iii. Any trends or significant problems since the last review.

3. Surveillance

a. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications.

b. Standard criteria are used to distinguish community-acquired from facility-acquired infections.

4. Antibiotic Stewardship

a. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.
b. Medical criteria and standardized definitions of infections are used to help recognize and manage infections.
c. Antibiotic usage is evaluated and practitioners are provided feedback on reviews.

5. Data Analysis

a. Data gathered during surveillance is used to oversee infections and spot trends.
b. One method of data analysis is by manually calculating number of infections per 1000 resident days.

6. Outbreak /Epidemic/Pandemic Management

a. Outbreak management is a process that consists of:
    i. Determining the presence of an outbreak
    ii. Managing the affected residents
    iii. Preventing the spread to other residents
    iv. Documenting information about the outbreak
    v. Reporting the information to appropriate public health authorities
    vi. Educating the staff, residents and healthcare representatives
    vii. Monitoring for recurrences
    viii. Reviewing the care after the outbreak has subsided
    ix. Recommending new or revised policies to handle similar events in the future

7. Prevention of Infection

a. Important facets of infection prevention include:
    i. Identifying possible infections or potential complications of existing infections
    ii. Instituting measures to avoid complications
    iii. Educating staff and ensuring that they adhere to proper techniques and procedures
    iv. Enhancing screening for possible significant pathogens
    v. Immunizing residents and staff to try to prevent illness
    vi. Implementing appropriate isolation precautions when necessary, and
    vii. Following established general and disease-specific guidelines such as those of the CDC.

8. Immunization

a. Immunization is a form of primary prevention
b. Widespread use of influenza vaccine in this nursing facility is strongly encouraged
c. Policies and procedures for immunization include the following:
    i. The process for administering vaccines;

ii. Who should be vaccinated;
iii. Contraindications to vaccinations;
iv. Obtaining consent;
v. Monitoring for side effects of vaccination, and
vi. Availability if the vaccine.

9. Employee Education

a. Infection Control Inservice on Orientation, and Annually and as necessary
i. The Chain of Infections
ii. The Spread of infections
iii. Transmission based Precautions
iv. Hand Hygiene
v. Glove usage
vi. Respiratory Protection Program
vii. Pandemic Emergency Plan

b. Competencies done on orientation and annually and as necessary
i. Hand Hygiene
ii. Use of PPE

c. Inservice any new recommendations made by the CDC and/or WHO

10. Monitoring Employee Health and Safety

a. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, and visitors, including:
i. Situations where these individuals should report their infections or avoid the facility (e.g. draining skin wounds, active respiratory infections with considerable coughing and sneezing, or frequent diarrheal stools);
ii. Pre-employment screening for infections required by law or regulation (such as TB);
iii. Any limitations (such as visiting restrictions) when there are infectious outbreaks in the facility; and
iv. Precautions to prevent these individuals from contracting infections such as Hepatitis and the HIV virus from residents or others

b. Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment (PPE).
i. The facility provides PPE, checks for its proper use, and provides appropriate means for needle disposable.
ii. A protocol is in place for managing those who stick themselves with a needle that was possibly or actually in contact with blood or body fluids.

Infection Control Surveillance

Effective: 9/14/2020	**Revised:**

POLICY:

The infection Preventionist (IP) will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventive interventions.

INTERPRETATION AND IMPLEMENTATION

1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent further infections.
2. Infections that will be included in routine surveillance include those with:
    a. Evidence of transmissibility in a healthcare environment;
    b. Available processes and procedures that prevent or reduce the spread of infection;
    c. Clinically significant morbidity or mortality associated with infections (e.g. PNA, UTIs, *C. difficile*);
    d. Pathogens associated with serious outbreaks (e.g. acute viral hepatitis, norovirus, influenza, COVID-19, other novel pandemic infections).
3. Nursing staff will monitor residents for signs and symptoms that may suggest infection (e.g. fever, chills and sweats, change in cough or new cough, sore throat, shortness of breath, nasal congestion, burning or pain with urination, redness/soreness/swelling in any area, vomiting, diarrhea, new onset of pain) and will document and report suspected infections to the RN Supervisor and/or Medical Doctor as soon as possible.
4. If a communicable disease outbreak is suspected, this information will be communicated to the RN Supervisor and/or IP as soon as possible.
    a. Staff at all levels and in all departments will be provided with education if an outbreak or novel pandemic infection is suspected. Education will include, but not be limited to risk factors, signs/symptoms and preventive measures associated with infection.
5. When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures.
6. The Unit nurse will notify the medical doctor and the IP of suspected infections. Same will be discussed with interdisciplinary team (IDT).
    a. A determination will be made whether transmission-based precautions are necessary
    b. Treatment of plan will be determined by the medical doctor and the IDT.
    c. Report infection, if necessary via the HCS NORA reporting and/or NHSN.
7. If transmission-based precautions or other preventive measures are implemented to slow or stop the spread of infection, the IP will collect data to help determine the effectiveness of such measures.

8. When transmission of HAIs continues despite documented efforts to implement infection control and preventive measures, the appropriate State agency and/or specialist in infection control and epidemiology will be consulted for further instructions.
9. When deemed necessary, the DON/Designee will establish Quality Assurance Performance Improvement (QAPI) projects and Performance Improvement Personnel (PIP) teams will be designated to identify root cause(s) and develop action plans. PIPs will report findings/results to the Quality Assurance (QA) Committee.

Gathering Surveillance Data

1. The IP or RN designee is responsible for gathering and interpreting surveillance data.
2. The surveillance should include a review of any or all of the following information to help identify possible indicators of infections:
    a. Laboratory records;
    b. Skin care sheets;
    c. Infection control rounds or interviews;
    d. Verbal reports from staff;
    e. Infection documentation records;
    f. Temperature logs;
    g. Pharmacy records;
    h. Antibiotic review; and
    i. Transfer log/summaries.
3. If laboratory reports are used to identify relevant information, the following findings merit further evaluation:
    a. Positive blood cultures;
    b. Positive wound cultures that do not just represent surface colonization;
    c. Positive urine cultures (bacteriuria) with corresponding signs and symptoms that suggest infection;
    d. Other positive cultures (e.g. stool, sputum); and
    e. All cultures positive for Group A Streptococcus.
4. Prioritize reports as follows:
    a. Signs/symptoms associated with novel pandemic infections
    b. Multi-drug resistant reports:
        i. All multidrug-resistant reports require immediate attention
        ii. Ensure appropriate precautions, if needed, are in place
        iii. If this is a new or unexpected report, notify the DNS and medical director.
    c. Blood cultures
    d. Positive wound cultures if there are corresponding signs and symptoms that indicate infection
    e. Positive sputum cultures
    f. Bacteriuria with corresponding signs and symptoms of UTI;
    g. Other positive cultures

Data Collection and Recording

1. For residents with infections that meet the criteria for definition of infection surveillance, collect the following data as appropriate:
    a. Identifying information (e.g. resident's name, unit, room #, attending physician);
    b. Diagnoses;

    c. Date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test);
    d. Infection site (be as specific as possible, e.g. PNA, right upper lobe)
    e. Pathogen(s)
    f. Invasive procedures or risk factors (e.g. surgery, indwelling tubes, Foley, fractured hip, malnutrition, altered mental status, etc);
    g. Pertinent remarks (e.g. temperatures, WBC, etc). Also, record if the resident is admitted to the hospital or expires.
    h. Treatment measures and precautions (interventions and steps taken that may reduce risk).
2. Using the current suggested criteria for HAIs, determine if the resident has a HAI.
3. DAILY: record signs and symptoms of infection on infection tracking form.
4. MONTHLY: collect information from individual resident infection reports and create line listing of infections by resident for the entire month.
5. MONTHLY: summarize monthly data
6. QUARTERLY: Compare incidence of current infections to previous data to identify trends and patterns. Use an average infection rate over a previous time period (e.g. over the past 12 months) as a baseline. Compare subsequent rates to the average rate to identify possible increases in infection rates.

Calculating Infection Rates:

1. Calculate the month's total resident days.
    a. Total resident days = daily census of each day in the designated time period added together.
2. To determine the incidence of infection per 1000 resident days, divide the # of new HAIs for the month by the total resident days for the month X 1000.

Interpreting Surveillance Data

1. Analyze the data to identify trends
    a. Compare the rates to previous months in the current year and to the same month in previous years to identify seasonal trends.
2. Surveillance data will be provided to the Infection Control Committee and Quality Assurance Performance Improvement Committee regularly.

References:

Patterson Bursdall, D. & Schweon, S.J. (2019). Surveillance, Epidemiology and Reporting. Association for Professionals in Infection Control and Epidemiology (*2nd Ed*.)

Personal Protection Equipment - PPE

Effective: 9/14/2020	Revised:

POLICY: It is the policy of the facility to ensure there are adequate numbers and items of PPE during a pandemic. In accordance with NYS Chapter 114 of the Laws of 2020, and based on the HERDS survey data for the period April 13-27, 2020, the facility will have on stock or on contract a 60-day supply of PPEs**.**

PROCEDURE:

1) The facility has an adequate supply of PPE, including types that will be kept in stock. The facility has initiated measures for procuring their own PPE supply (e.g., facemasks, N95 respirators, gowns, gloves and eye protection such as face shields or goggles and hand sanitizer.)
2) The Facility has existing contracts with has existing contracts or relationships with PPE vendors to facilitate the replenishment of stock. (See Emergency Prep Manual Vendor list).
3) The Facility will use PPE conservation strategies outlined by the CDC plan to address PPE supply shortages.
4) The facility will communicate with local and state and federal Emergency Management to procure PPE during a pandemic to ensure adequate supplies as needed.
5) Signs are posted immediately outside of resident rooms and any pandemic designated units indicating appropriate infection control and prevention precautions and required PPE in accordance with NYS and CDC guidance.
6) Residents' rooms requiring transmission-based precautions will have isolation carts containing PPEs outside of the residents' rooms for easy accessibility.
7) The Central Supply Coordinator in conjunction with Administrator and Infection Preventionist will track PPE usage and ensure adequate PPE is accessible to staff providing care.
8) The Central Supply Coordinator/Designee will distribute PPE for each shift ensuring adequate PPE is available and restocked as needed
9) The IP and Central Supply Coordinator will calculate the burn rate (determines the number/amount of a given supply) of PPEs to ensure adequacy of supplies.

Burn Rate = Quantity used/day

For example, on any given day, there are approximately 200 staff that will need to wear surgical masks. On average, that number of staff will need to each change masks 5-6 times per day. So 6 masks/day x 200 employees = 1200 masks/day. This will be the burn rate – or the number of masks the facility will burn (use) per day.

Environmental Services – Cleaning Resident Rooms

Effective: 9/14/2020	Revised:

DEFINITIONS

Cleaning: the removal of visible soil from surfaces through physical action of scrubbing with a surfactant or detergent and water.

Low-Level Disinfection: destroys all vegetative bacteria (except tubercle bacilli) and most viruses. Does not kill bacterial spores. Examples: hospital disinfectants registered with the EPA with HBV and HIV label claim (purple top wipes). These are generally appropriate for most **environmental surfaces.**

Intermediate-Level Disinfection: kills a wider range of pathogens than a low-level disinfectant. Does not kill bacterial spores. Examples: EPA-registered hospital disinfectants with a tuberculocidal claim (purple top wipes). May be considered for environmental surfaces that are visibly contaminated with blood.

Kill Claim: information about which pathogens the disinfectant kills; found on the product label.

Contact Time: the time a disinfectant should be in direct contact with a surface to ensure that the pathogens specified on the label are killed. In order words, the amount of time a surface has to stay wet after being cleansed/disinfected with the product. Example, purple top wipe, 2 minutes.

PURPOSE

To provide guidelines for cleaning and disinfecting residents' rooms and other environmental surfaces in order to break the chain of infection.

RESPONSIBILITY

Environmental Services (EVS) or Housekeeping staff are primarily responsible for following environmental cleaning and disinfection policies and procedures.

GENERAL GUIDELINES

1. Housekeeping surfaces (e.g. tabletops and floors) will be cleaned daily, when spills occur, and when these surfaces are visibly soiled.
2. All environments/areas (e.g. lobby, hallways, common areas, medication rooms, nurses' stations) and residents' rooms will be disinfected (or cleaned) daily and when surfaces are visibly soiled.
3. When there is an outbreak (e.g. Influenza, Norovirus), residents' rooms and other environmental surfaces (e.g. rails in hallways; elevators, to include keypads; common areas) will be disinfected and/or cleaned more often.
4. When there is a room with a known multi-drug resistant organism (MDRO), room environment will be disinfected and cleaned regularly; mops and cleaning cloths will be dedicated for use in this room only.
5. Utility rooms/porters' closets to be cleaned daily by housekeeping staff as determined by facility's schedule
6. Garbage will be removed at scheduled times per facility protocol.

7. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including:
    a. Recommended use-dilution
    b. Material compatibility
    c. Storage
    d. Shelf life, and
    e. Safe use and disposal
8. Walls, blinds and window curtains in resident areas will be cleaned at least every 3 months and when these surfaces are visibly contaminated or soiled.
9. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently.
10. Floor mopping solution will be replaced every 3 resident rooms, or at least every hour, whichever comes first.
11. Personnel should remain alert for evidence of rodent activity (droppings) and report findings to Director of EVS/Housekeeping and log in Pest Control Log Book.
12. Clean medical waste containers intended for reuse (e.g. garbage bins/pails) daily or when such receptacles become visibly contaminated with blood, body fluids or other potentially infectious materials.
13. Perform hand hygiene (wash hands with alcohol-based hand rub [ABHR] or soap and water for 20 seconds) after removing gloves.
14. Common intermediate and low-level disinfectants for smooth, hard surfaces and non-critical items include:
    a. Ethyl or isopropyl alcohol (70 - 90%)
    b. Sodium hypochlorite/household bleach (5.25-6.15% diluted 1:500 or per manufacturer's instructions)
    c. Phenolic germicidal detergent (follow product label for use-dilution)
    d. Iodophor germicidal detergent (follow product label for use-dilution)
    e. Quaternary ammonium germicidal detergent for low-level disinfection only (follow product label for use-dilution)

EQUIPMENT and SUPPLIES

1. Environmental service cart (do not take in resident's rooms)
2. Disinfecting solution
3. Cleaning cloths
4. Mop
5. Bucket
6. Personal protective equipment (e.g. gown, mask, gloves, as needed)

PROCEDURE

1. Gather supplies as needed
2. Prepare disinfectant according to manufacturer's recommendations
3. Discard disinfectant/detergent solutions that become soiled or clouded with dirt and grime and prepare fresh solution
4. Change mop solution water at least every three (3) rooms, or at least every hour; whichever comes first.

5. Change cleaning cloths when they become soiled. Wash cleaning cloths daily and allow cloths to dry before reuse.
6. Clean horizontal surfaces (e.g. overbed tables, chairs) daily with a cloth moistened with disinfectant solution. Use appropriate EPA-approved disinfectant for specific pathogens. Do not use feather dusters. In the event of a novel pandemic, refer to the EPA's recommendations for appropriate cleaning/disinfecting agents.
7. Clean personal use items (e.g. lights, phones, call bells, bedrails, bed remote, etc.) with disinfection solution daily.
8. When cleaning rooms of residents on isolation precautions, use personal protective equipment (PPE) as indicated.
9. When possible, isolation rooms should be cleaned last and water discarded after cleaning room.
10. Utilize disinfectant solution based on type of precaution.
11. Clean curtains, window blinds, and walls at least every 3 months or when they are visibly soiled or dusty.
12. Clean spills of blood or body fluids as follows:
    a. Use personal protective equipment, that is, gloves (heavy duty if available)
    b. Spray area with bleach
    c. Wipe spill or splash with a cloth or paper towels
    d. Discard saturated cloth or paper towels into red "biohazard" bag
    e. Repeat as necessary until the spill or splash area is dry.
    f. Spray disinfectant solution onto the discarded cloth or paper towels inside the plastic bag.
    g. Tie the bag. If the outside of the bag becomes contaminated with blood, body fluids, secretions, or excretions, place the contaminated bag into a clean plastic bag.
    h. Place the plastic bag into a designated red container for medical waste, located in the soiled utility room on each unit.
    i. Remove gloves, discard.
    j. Wash hands with soap and water (at least 20 seconds).
13. Refer to checklist for daily room cleaning.

TERMINAL ROOM CLEANING

1. Terminal room cleaning is done when a resident is transferred, discharged, or expires.
2. Gather cleaning equipment and supplies (gloves, disinfectants, cleaning cloth, plastic trash bag, mop, bucket).
3. Prepare disinfectant according to manufacturers' recommendations
    a. Use fresh solutions for terminal and thorough cleaning of all rooms
    b. Discard solution when the procedure has been completed
4. Clean all high-touch furniture items (e.g. overbed tables, bedside tables, chairs, and beds) with disinfectant solution or appropriate wipe
5. Clean all high-touch personal use items (e.g. lights, phones, call bells, bed rails, bed remote, etc.) with disinfectant solution.
6. Discard personal (e.g. toothbrush, toothpaste, mouthwash, lotion, soaps, bodywash, etc.) and single-resident use items (e.g. thermometers)

7. Clean all equipment, if present, in room (ex: nebulizer machine, tube feeding pump, IV poles, concentrator, etc.) and return to designated storage area.
8. Refer to checklist for terminal room cleaning

References:

CDC. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/tables/table1.html

CDC. Options for Evaluating Environmental Cleaning https://www.cdc.gov/hai/toolkits/evaluating-environmental-cleaning.html

EPA. Selected EPA-Registered Disinfectants. https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants

Yale, S.L. and Levenson, S.A. (2016). Infection Control Policy and Procedure Manual. Med-Pass, Inc.

Adapted from: CDC Environmental Checklist for Monitoring Daily Room Cleaning

Date:	**Unit:**
Initials of ES staff:	**Room Number:**

Evaluate the following priority sites for each patient room:

High-touch Room Surfaces	Cleaned	Not Cleaned	Not Present in Room
Bed rails			
Bed remote			
Overbed/Bedside table			
Call button			
Telephone			
Chair(s)			
Room sink			
Room light switches			
Room door knobs (inner/outer)			
Bathroom inner door knob			
Bathroom light switches			
Bathroom handrails by toilet			
Bathroom sink			
Toilet seat			
Toilet flush handle			
Toilet bowl brush			

Evaluate the following additional sites if these equipment are present in the room:
(May be cleaned Weekly)

High-touch Room Surfaces	Cleaned	Not Cleaned	Not Present in Room
IV pole			
Feeding tube pole			
Feeding tube pump			
Nebulizer machine			
Concentrator			

Mark the monitoring method used:

☐ Direct observation ☐ Fluorescent gel
☐ Swab cultures ☐ ATP system ☐ Agar slide cultures

Auditor's Name: _____ Date: _____

Adapted from: CDC Environmental Checklist for Monitoring Terminal Room Cleaning

Date:	**Unit:**
Initials of ES staff:	**Room Number:**

Evaluate the following priority sites for each patient room:

High-touch Room Surfaces	**Cleaned**	**Not Cleaned**	**Not Present in Room**
Closet(s) – inside & outside			
Windows, blinds, window sills			
Walls in room			
Bed rails			
Bed/TV remote			
Overbed/Bedside table			
Call button			
TV and Telephone			
Chair(s)			
Room sink			
Room light switches			
Room door knobs (inner/outer)			
Bathroom walls			
Bathroom inner door knob			
Bathroom light switches			
Bathroom handrails by toilet			
Bathroom sink			
Bathroom shower/tub			
Toilet seat			
Toilet flush handle			
Toilet bowl brush			

Evaluate the following additional sites if these equipment are present in the room:

High-touch Room Surfaces	**Cleaned**	**Not Cleaned**	**Not Present in Room**
IV pole			
Feeding tube pole & pump			
Nebulizer machine			
Concentrator			

Mark the monitoring method used:

☐ Direct observation

Auditor's Name: _____ Date: _____

Visitation During A Pandemic

Effective: 9/14/2020	Revised:

POLICY:

Visitation for residents, families and resident representatives will be limited or restricted based on guidelines established by the Centers of Disease Control and Prevention (CDC) and/or the New York State Department of Health (NYSDOH). The facility will make every effort to ensure safety and adherence to infection prevention and control strategies in order to minimize any potential spread of infection.

PURPOSE:

To prevent exposure to and spread of illness among residents.

PROCEDURE:

1. The facility Team may consider temporarily modifying visiting hours or procedures to facilitate monitoring in a situation of community transmission of a pandemic-level infectious pathogen.
2. If applicable, based on guidance from the CDC and NYSDOH, the facility will implement limited or restricted visitation guidelines.
3. The facility will notify residents, families and representatives of any changes or restrictions to visitation and the reason for the limitation/restriction via the facility's website, automated messaging system, postal mail, e-mail, and telephone call.
4. Allowances will be made for short visitation under extenuating circumstances (e.g. end of life situations, compassionate care).
    a. Visitor(s) must follow all established protocols for visitation to include transmission-based precautions, active screening and use of PPE as indicated.
5. Signage addressing visitation restrictions will be posted at all public entrances to the facility and on the facility's website.

Staff Screening Tool

Effective: 9/14/2020	Revised:

POLICY: In the event of a Pandemic, the facility will implement guidelines to screen staff for signs and symptoms associated with the infectious pathogen. Where applicable, the facility will follow guidelines established by the Centers for Disease Control and Prevention (CDC) and/or the New York State Department of Health (NYSDOH).

PROCEDURE:

1. The facility will develop a screening tool/questionnaire for employees to identify those who may be at risk for novel infectious pathogen.
2. The Receptionist will be responsible to ensure that each employee is given a Screening tool, if on paper, when they enter the facility.
    a. This may be done electronically via Kiosks, if available.
3. The employee will complete questionnaire/screening questions appropriately.
4. If temperature screening is indicated, the employee is responsible to document the temperature reading obtained when thermal screening is done.
5. Any employee who has symptoms associated with the infectious pathogen will not be allowed to enter the building beyond the lobby area.
6. The Department Head or RN supervisor is to be notified when an employee has symptoms associated with the infectious pathogen.
7. Employees who are symptomatic will be sent home or to the nearest emergency department if warranted based on presentation of symptomology.
8. The Department Head/RN Supervisor is responsible to notify the Infection Control Nurse who will contact the employee shortly after.
9. Employees who work more than eight hours are responsible to complete a 2nd Screening Tool.
10. Employees are responsible to give this Screening Tool, if done on paper, to their immediate Supervisor when they come to their assigned unit, office, department area.
11. The Daily Screening Tool, if done on paper, will be kept on file by each Department Head.
12. Sick Call logs will be reviewed daily by each Department Head/Designee and the names of employees who triggers for symptoms associated with the infectious pathogen will be communicated to the Infection Preventionist/Designee.
13. The Infection Preventionist/Designee will maintain a line list of all staff, regardless of department, who presents with symptoms associated with the infectious pathogen.
14. All employees are encouraged to stay home, alert the facility, and contact their primary care physician should they develop symptoms associated with the infectious pathogen.

Resident Screening During a Pandemic

Effective: 9/14/2020	Revised:

POLICY: In the event of a Pandemic, the facility will implement guidelines to screen Residents and any prospective admission for signs and symptoms associated with the infectious pathogen. Where applicable, the facility will follow guidelines established by the Centers for Disease Control and Prevention (CDC) and/or the New York State Department of Health (NYSDOH).

PROCEDURE:

In-House Residents

1. The facility will develop a screening tool/questionnaire for residents to identify those experiencing symptoms associated with the novel infectious pathogen. The screening tool may include temperature monitoring, symptom check, and other vital signs as stipulated by the NYS DOH/CDC guidelines.

2. The screening tool will be done daily or if indicated with any changes in condition.

3. The following interventions will be taken for Residents that trigger for signs/symptoms associated with the novel infectious pathogen:
    - RNS assessment
    - PMD notification
    - Transmission Based Precautions as indicated
    - Representative notification
    - Lab testing and diagnostic work up as ordered
    - Vital sign monitoring each shift including pulse oximetry as indicated

4. Residents that trigger for signs/symptoms associated with the novel infectious pathogen will be discussed at the Morning QI meeting and placed on the Line List for the novel infectious agent.

5. During the recovery phase all residents will have vital signs monitored daily.

Prospective Admissions/Re-admissions

1. All new and readmissions will be pre-screened by Admission Office for the presence of the novel infectious pathogen
    - The admission office will ascertain from the sending facility if the resident being admitted or re-admitted has been exposed to a confirmed or suspected of the infectious pathogen
    - The admission office will ascertain the type of transmission-based precautions that the resident received during has required airborne precautions while in acute care.
    - The admission department will ascertain if the resident was tested for the novel infectious pathogen in accordance with NYS DOH /CDC criteria.

- The DNS and Infection Control Preventionist will be notified and review information prior to admission to determine if the facility can provide the needed care for the resident.
- New /Readmissions will be cohorted based on infectious status and /or placed on quarantined with transmission-based precautions with vital sign monitoring daily and as needed in accordance with CDC and NYSDOH guidance.

2. Residents that are newly admitted and readmitted will have vital sings monitored each shift in accordance with the number of days the infectious pathogen can incubate.

Regulated Medical Waste – Biohazard

Effective: 9/14/2020	Revised:

POLICY: It is the policy of this facility to dispose of regulated medical waste in accordance with Chapter 738 of the Public Health law of 1993 and #10 NYCRR 70.
Also, in accordance with the above cited laws, it is the policy of the facility to receive and appropriately dispose of "sharps" (only) collected from private residences.

Definition of Regulated Medical Waste

1. "Regulated Medical Waste shall mean waste which is generated in the diagnosis, treatment or immunization of human beings…"

2. There are six (6) sub-categories within the general definition of regulated medical waste. Three (3) of these categories are not applicable to the Nursing Home setting. The three (3) categories that do not apply are as follows:

1. Human Pathological Waste

This waste includes organs, body parts and body fluids. Urine is not considered regulated medical waste, unless it is submitted as a clinical specimen for laboratory testing. However, if a patient is found to have a disease which may be transmitted through urine, then the material containing this fluid, including diapers, must be considered regulated medical waste.

Incontinence Materials (diapers, etc.) are generally not considered regulated medical waste, provided that the patient does not have an infectious disease which can be transmitted by urine. Since feces always contains microorganisms and since these microorganisms, even if potentially pathogenic, cannot be transmitted from trash containers or disposable sites; therefore, fecal contaminated materials, including diapers are not considered to be regulated waste.

2. Human Blood & Body Parts

"This waste shall include discarded human blood, discarded blood components, (9e.g. serum and plasma) containers with free flowing blood or blood components or discarded saturated materials containing free flowing blood or blood components and materials saturated with blood or blood products…"

3. Sharps

This waste includes sharps used in human patient care. Sharps include syringes with attached needles, needles and lancets. Because of the potential to break and give rise to puncture or laceration wounds, glass tubes, flasks, beakers, etc., must also be considered as sharps and be disposed of accordingly.

Procedures for Managing Regulated Medical Waste

1. The soiled utility room on each unit shall contain a sealed container with a leak proof and puncture resistant bag. Both the container and the door leading to the soiled utility room shall have affixed to them the “Bio-Hazard” sign.

2. Once each day, in the morning the Housekeeping Department will pick up the bags, appropriately tie them and place these bags in approved transporting boxes located in the “Infectious Waste” storage areas. This storage area is duly marked by a “Bio-Hazard” sign. This Infectious Waste storage area is to be locked at all times and only Housekeeping and Administration have keys.

Housekeeping personnel are provided with appropriate protective equipment, including gloves, aprons, etc., when handling regulated waste materials.

3. On a monthly basis, all regulated medical waste is picked up at the Home by a licensed Medical Waste Transporter.

4. The licensed Medical Waste Transporter (with whom the home maintains a written contractual agreement for services) prepares a manifest, listing the number of boxes taken. Both the name of the generator (the Home) and the name of the transporter are printed on each box. The manifest also contains name, address, and permit number of the “Disposer.”

5. Within thirty (30) days of pick-up, the facility receives via U.S. mail a copy of the manifest, signed by the Disposer. These signed manifests are to be kept by the Home for at least six (6) years.

Internal Procedures for Collecting Regulated Medical Waste

1. The Director of Nursing or her designee will notify the Director of Housekeeping of the need to isolate a resident.

2. Three (3) containers, each with leak proof and puncture resistant bags and Bio-hazard labels will be provided by the Housekeeping Department and Nursing personnel will place these containers in each resident’s ante-room. These containers will each be labeled as follows:

a. Linen

b. Personal Clothing

c. Trash

Housekeeping personnel should not enter the isolated room unless supervised by a Registered Nurse and then only with the appropriate protective clothing and equipment.

3. Daily, these labeled bags are collected by the Housekeeping Department from the Soiled Utility Room.

a. The **Linen** bags are stored in the Soiled Laundry Room in a secured area. These bags are picked up twice weekly by the outside laundry company and are washed in the double red bags, which are degradable.

b. **Personal Clothing Bags** are stored in the Soiled Laundry Room until they are washed in-house, after all other laundry has been washed. Since personal clothing cannot be washed together, Laundry personnel will wear appropriate protective clothing during the sorting and handling process.

After washing this clothing, the washing machine will be disinfected with Lysol liquid or bleach.

c. **Trash bags** are placed by Housekeeping personnel in approved transportation boxes in the Infectious Waste storage area and are handled in accordance with the guidelines from the above section “Managing Regulated Waste.”

Procedures for Managing Sharps/Disposable Razors Generated In-House
The primary container for discarded sharps shall be rigid, leakproof, puncture-resistant and closable, and may serve as a secondary container for purposes of transport, provided it meets the definition of a secondary container.

(e)(1) Under no circumstances shall a sharps container be filled beyond the fill line indicated on the container.

(2) Sharps containers shall be removed from patient care areas to a room or area designated for regulated medical waste storage, whenever the container has reached the fill line indicated on the container. Sharps containers shall be removed from patient care areas within thirty (30) days or upon the generation of odors or other evidence of putrification, whichever occurs first, without regard to fill level.

(f) Regulated medical waste, with the exception of sharps as provided in subdivision (e) of this section, may be held in patient care areas for a period not to exceed twenty-four (24) hours and at a clinical laboratory for a period not to exceed seventy-two (72) hours, at which time the waste shall be moved to a storage area.

(g)(1) Each storage area shall be adequate for the volume of regulated medical waste generated between scheduled waste pick-ups by a transporter, or, for facilities treating the waste on-site, the volume of waste that can be treated on-site within a twenty-four (24) hour period.

(2) Each storage area shall:

(i) display prominent signage indicating the space is used to store regulated medical waste;

(ii) be designed or equipped to prevent unauthorized access;

(iii) be designed or located to protect waste from the elements, and prevent access by vermin;

(iv) hold the waste at a temperature that prevents rapid decomposition and resultant odor generation;

(v) be appropriately ventilated; and

(vi) be of sufficient size to allow clear separation of regulated medical waste from any other waste, whenever waste other than regulated medical waste is stored in the same area.

(3) Regulated medical waste shall not be stored for a period exceeding thirty (30) days, except that a site generating under fifty (50) pounds of regulated medical waste per month and not accepting regulated medical waste for treatment from other facilities, may store waste for a period not exceeding sixty (60) days.

(h) Prior to transport off-site of the generating facility for treatment elsewhere:

(1) primary containers shall have affixed a label or imprint indicating the name and address of the generating facility; and

(2) primary containers, except as provided in (c)(2) of this section, shall be placed in a secondary container with an affixed label or imprint, indicating the name and address of the generating facility, and such container marked prominently with signage indicating that the contents are infectious or regulated medical waste; and, if applicable, with an affixed label indicating that the contents contain or are mixed with hazardous waste, and/or toxic drug waste.

- Sharps containers are located on each nursing unit and each medication cart
- Sharps containers for disposable razors are also located on each nursing unit and shower area
- Sealed Sharps containers are collected from all areas by Housekeeping personnel a minimum of monthly and as needed prior to the licensed Transporter pickup. Sealed Sharps containers are placed in approved transportation boxes and are processed in accordance with the guidelines from the above section “Managing Regulated Waste.”

Cleaning Up Spills

The following procedure is to be strictly implemented and adhered to in the event of an accidental spill of Regulated Waste as previously defined above.

1. Blood Spill Kits are located on each unit and will be utilized to clean up spills of Regulated medical Waste.

2. Additional equipment available: Mask, Goggles, Tongs (for picking up sharps), DustPan, Broom, Aprons, Germicidal Solution, and Small Sharps Container.

3. Housekeeping/ Nursing Personnel after having used this equipment to clean a spill should place same in a leak-proof bag, appropriately tie the bag and store in the Soiled Utility room for regular Housekeeping pickup.

4. The Housekeeping Department is responsible for cleaning up both small and large spills of Regulated Medical Waste. If Housekeeping Personnel have left the building, Nursing Personnel is responsible to clean both small and large spills.

Developing Cohorts During a Pandemic

Effective: 9/14/2020	Revised:

POLICY: It is the policy of the facility to continue to prevent and control the spread of any novel infectious pathogens and to protect and treat all residents affected in accordance with regulatory requirements.

The facility will attempt to separate the residents into groups of Negative, Positive, and Unknown cohorts as recommended by NYSDOH and CDC guidelines.

Cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other residents. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent.

PROCEDURE:

1. Residents will be cohorted by category: **Negative**, **Positive, Unknown** status requiring observation.
2. Residents will be assessed daily for any symptoms of the infectious agent. Symptoms check will include, but is not limited to fever, respiratory symptoms, any symptoms explicit to the specific infectious agent, or any change in condition.
3. If indicated, and when possible, laboratory and/or other testing will be conducted to detect presence of specific infectious agent.
4. The facility will create a designated area/unit for residents who have tested positive for the specific infectious agent.
5. Residents and roommates of residents who are suspected of being infected with the novel infectious agent will be placed on appropriate transmission-based precautions as necessary. If indicated, laboratory and/or other testing will be conducted to detect presence of infectious agent.
6. When feasible, the symptomatic resident will be moved to a private room on the same unit.
7. All Admissions/ Readmissions will have a review of hospital information prior to admission to determine appropriate placement in facility and if adequate infection prevention and treatment needs can be met at the facility.
8. Specific to the novel infectious agent, a screening tool will be done on all prospective admissions and re-admissions by the Admitting Department.
9. Residents who are newly admitted and develop any symptoms associated with the novel infectious agent will be transferred to the dedicated unit upon identification of symptoms.
10. Residents presenting with signs or symptoms of the novel infectious agent will be assessed by an RN and/or PMD.
11. All staff will continue to be actively screened for signs/symptoms associated with the novel infectious agent.

12. Residents and resident representatives will be notified daily of any newly confirmed (positive) cases in the facility as well as any resident deaths related to the infectious agent via the established auto hotline messaging.
13. The facility will continue to promote consistent staff and staff assignment on each unit:
    - The staffing coordinator, in conjunction with the DON/RNS, will make every effort to have residents that have been ***confirmed*** to be infected with the novel infectious agent to be grouped into one assignment.
    - Every effort will be made to have residents who are ***suspected*** of being infected with the novel pathogen to grouped into one assignment.
    - Every effort will be made to have residents who are ***asymptomatic*** to be grouped into one assignment.
14. Residents who are confirmed of being infected with the novel disease will be placed on appropriate transmission-based precautions and have appropriate signage on their room doors. An isolation cart containing necessary PPEs will be placed outside the room for easy accessibility.
15. Should a resident require transfer to another facility/setting, indicate on the Transfer Form the type of infection and type of transmission-based precaution(s) required. Also, relay this information to the transport personnel (e.g. EMTs).

References:

CDC. (Updated 2019). 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Health Care Settings. Taken from: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

CDC. (4/30/2020). Responding to Coronavirus (Covid-10) in Nursing Homes. Taken from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html

Dining Needs During A Pandemic

Effective: 9/14/2020	Revised:

Policy: The facility will promote a safe and comfortable meal service for residents to minimize the potential spread of infection and promote quality of meal service to residents. Residents and staff will be provided with education regarding hand hygiene, physical distancing, and any needed monitoring during meal service.

Procedure:

1. Residents on each unit will be reviewed to identify any special care needs during Meal Service.
2. Residents who are capable of feeding themselves, and are not at risk for choking will have their meals served in their room.
3. Residents who are served meals in their room will be provided with education on the importance of:
    - Performing hand hygiene prior to consuming meal
    - Utilizing the call bell to alert staff of any difficulties while consuming meal (i.e. coughing, difficulty swallowing etc.)
4. Caregivers will be educated to assist/provide hand hygiene for all residents prior to meal service and to ensure that the resident's call bell is within reach.
5. Residents with specific behavioral or nutritional issues may be brought into the dining room in intervals while maintaining social distancing.
6. Residents at risk for choking or on aspiration precautions may be provided meals in the dining room, while seated six feet apart or in a central corridor where they can be observed. Suction machine must be readily available with extension cord and plugged in.
7. Residents who require spoon feeding will be served meals last and caregivers will remain with resident and assist with meal consumption.
8. Unit assignments will reflect staff members specific responsibilities during meal time:
    - Tray distribution
    - Specific residents to feed
    - Corridors/Hallways to monitor during meal
9. Trays will be delivered to units in room order rather than by table number, except for those residents eating in dining room.
10. Residents requiring to be hand fed, may eat in the dining room, spaced six apart and caregivers will only feed one resident at a time.
11. When necessary, meals may be offered in intervals to allow fewer residents in common areas, and to ensure that the food temperature is maintained within desired range.
12. Dining room tables must be sanitized after each meal is completed.
13. Representatives will be notified of changes in meal service during a pandemic via Weekly Message.
14. Every effort will be made to redirect residents living with Dementia to ensure protocols are maintained.

Recreational Needs During A Pandemic

Effective: 9/14/2020	Revised:

Policy: The facility will promote each residents' highest level of well-being in alignment with State and Federal guidelines restricting group activities during a Pandemic. All measures will be taken to provide individualized activities of choice and to minimize the potential for transmission of the infectious agent.

Procedure:

1. The Activities Director in conjunction with the resident/resident representative and IDT team will identify resident specific activities needs/preferences by interviewing residents and reviewing care plans.
2. Residents who cannot be interviewed to elicit a coherent response secondary to cognitive impairment will have individual preferences/needs be ascertained through family interview and IDT knowledge of their preferences.
3. A unit list will be made identifying each resident's Therapeutic Recreational needs to include:
    - Contact with loved ones via phone, skype, or facetime.
    - Preference for TV shows and/or movies
    - Music Therapy and Preferences
    - Talking Books and Tapes
    - Arts and Crafts along with specific supplies needed
    - Puzzles and games
    - Manipulative objects for engagement
    - One to one visitation
    - Community outreach Phone calls
4. Unit staff will be informed of each resident's recreational needs and/or preferences.
5. The Recreation staff will ensure that each resident has adequate materials for recreation as per their preference.
6. The Activities Director will provide a calendar and daily timetable for activities to include:
    - Room visits
    - Face Time/Communication with family
    - Set up of talking books and tapes
    - Music Therapy
7. The recreational Therapist on each unit will ensure that each resident is participating in recreational preferences and identify and report any problem areas/areas of concern to the IDT.
8. Resident Council will be informed of any changes in activities with input as needed.
9. If a resident has a specific request, the Activity staff assigned to the unit will notify the Director and IDT team for follow up.

10. The resident’s Comprehensive Care Plan will be updated and revised as needed to reflect interventions put in place during a pandemic

Facility Communication During Pandemic/Emergency

Effective: 9/14/2020	Revised:

POLICY: The facility will implement effective, accurate, and ongoing communication with residents, family members and designated representatives during a pandemic.

PROCEDURE:

1. The facility will abide by all HIPPA regulations when disseminating information with regards to individual residents.
2. The Unit RNS/designee will contact family members of residents with an infection because of a pandemic daily.
3. Families/Representatives will be notified by RNS for any significant change in resident condition within 24 hours
4. The SW and IDT Team will determine the Resident Representative/Guardians preferred method of contact and document same in medical record/CCP.
5. The facility will contact all resident representatives weekly via an automated call to provide an update on the status of residents including # of infections of staff and residents and any deaths related to the pandemic.
6. Recreation and Social Services will ascertain if alert resident wishes to be informed when a resident in the facility expires related to the pandemic.
7. The following mechanisms will be utilized to inform residents, family members and designated representatives:
    - Letters sent via the mail
    - Telephone conversations and messages
    - Emails
    - Daily updates in the recorded voice message at facility number
    - Face to face meetings with residents using Social Distancing and appropriate PPE
    - The Overhead Paging System
8. The following information will be disseminated:
    - Any newly confirmed pandemic infections in the past 24 hours
    - The occurrence of 3 or more residents or staff members with new onset of symptoms within a 72-hour period.
    - The actions that the facility is taking to prevent and/or reduce the risk of transmission
    - Cumulative updates on a weekly basis
    - Deaths in the facility that occurred related to the pandemic
9. Incoming calls that are not answered at the unit level will be forwarded to DNS/designee with instruction to leave a message and a return call will be made within 24 hours or less.
10. Representatives and family members provided with direct cell phone number for Director of Nursing and Administrator as per their request.
11. Documentation of communication will be made in the Medical Record for each resident in Progress notes and/or CCP.

12. Weekly phone calls or Letter will be done by Social Work in conjunction with IDT Team to families and representatives to review current infection status at the facility, outline measures the facility is taking regarding infection prevention, as well as facility plans to assist in meeting residents' physical and psychosocial needs during the pandemic. The weekly update will include information to contact designated persons at the facility with contact number and regarding any concerns to designated department head.
13. Residents, family members, and designated representatives will be offered the opportunity to connect via videoconferencing (e.g. FaceTime, WhatsApp, Zoom, etc.) or via traditional telephone call at no cost. All residents' requests will be forwarded to the Director of Recreation.

Telehealth During Pandemic

Effective: 9/14/2020	Revised:

POLICY: The facility will incorporate telehealth technology during a pandemic to ensure residents clinical needs will be met while minimizing exposure to infection. The system in place shall comply with HIPPA and any other federal or state requirements and waivers implemented during a public health emergency. Health care professionals who use telehealth must adhere to the requirements and restrictions of their applicable licensure, scope of practice specific to their license, as well as training and experience.

Definitions

1. Telehealth, Telebehavioral Health, and Telemedicine: These terms are used interchangeably at (facility). Both describe the use of digital technologies to deliver medical services by connecting multiple users who are physically located in separate locations. Medical information is exchanged from one site to another via electronic communications to improve a resident's health or medical status.
2. Originating Site: This is the location where the resident is located at the time of service delivery. For psychiatry visits, the resident will be located on the property of (FACILITY), in one of our offices/site locations or room by themselves or if needed with Assistant. For mental health visits, the resident may be located anywhere in a private area.
3. Distant Site: This is the location where the health care provider is located at the time of service delivery. This could be an office location or another site that has been pre-approved. The requirements for this site will be that: the healthcare provider can attest to maintaining confidentiality and the privacy of the resident as well as the security of resident's personal health information in accordance with HIPPA.

Clinical applications include:

- Clinical treatments (medical, behavioral health, etc.)
- Clinical assessments and testing, including interpretation of results, and treatment recommendations
- Transmission of health data/assessment data (i.e., remote monitoring)
- Clinical consultation with other professionals
- Case management with interdisciplinary teams
- Clinical supervision of professional supervisees and trainees

Non-clinical applications include:

- Training (distance learning, continuing education, etc.)
- Administrative collaboration between providers, such as meetings and presentations

Procedures for Service Delivery

1. General hardware requirements include a desktop computer (or lap-top or tablet computer), high definition video camera, and audio system (headphones and/or external speakers). Existing laptop or desktop can serve as the foundation of a simple system

suitable for most videoconferencing sessions by simply adding a USB webcam and a USB desktop microphone to the computer.

2. Regardless of the manufacturer, videoconferencing equipment should meet patient privacy and data security requirements consistent with applicable local guidelines as well as the requirements specified under HIPAA.
3. Any telehealth service should be matched to the needs of the resident to be served. Not all potential patients may be appropriate candidates for telehealth services. For example, some cognitive or physical deficits (e.g., vision problems, loss of use of limbs or fingers) may impair operation of the technology (e.g., seeing a screen, touching small buttons). However, assistance by staff members or other assistive technologies may enable participation.
4. Telehealth will be delivered through a pre-approved platform. Use of any other platform for clinical service delivery will be employed in accordance with waivers during a pandemic.
5. Residents will need to be informed of all the telehealth procedures clinicians will utilize, including those in this policy. Written informed consent must be obtained prior to any telehealth service delivery the patient may make a voluntary choice to accept or refuse participation in the treatment or service unless waived during public health emergency.
6. Originating Site: Telehealth sessions for health will be conducted in a private, confidential manner. Clinicians will be expected to ensure that at their site:
    - Internet connectivity is through a secured network, not an “open” network unless waived during pandemic.
    - Sessions cannot be overheard by others such as family members, guests, colleagues, or others
    - The session is conducted in a quiet setting
    - The backdrop of the clinician’s image will show a professional setting, free from clutter in the background, and have adequate lighting to ensure the clinician’s image is broadcast clearly to the resident
7. Distant Site: The resident will be informed at the initial contact of the clinicians’ expectations regarding where the resident is physically located during sessions. Lighting at the distant site should be assessed during the initial session to allow for full access to resident facial expressions and body language.
8. If the technology fails during the session, the clinician will call the resident and nursing department to explain the problem. Depending on the situation, the session may need to be rescheduled:
9. At any time, the clinician may determine that telehealth services are not benefiting the resident, that the resident is not a good candidate for telehealth or circumstances have arisen where a referral to face-to-face service delivery is warranted. The clinician will make this recommendation verbally to the resident and Facility RNS, put it in writing in the medical record, and provide arrangements or referrals upon request of the resident.
10. Clinicians will document in HER utilizing remote accessed if granted by the facility. Any other documentation will be sent to facility DON via secure mail to be placed in medical record.
11. Password protected; preferably two-factor authentication is to be use
12. Device has been had updates and security patches installed at least once/month
13. Software updates are conducted quarterly

Delivery Systems for Vendors in Pandemic

Effective: 9/14/2020	Revised:

POLICY: In the event of a pandemic the Facility will adjust procedures to managing critical outsourced supplier services and deliveries.

The facility will ensure that critical services continue. If an in-person meeting or onsite service is critical (e.g., a vendor needs to come onsite to fix a piece of equipment or provide a service that can be done only in person), then a vendor may come only with prior approval of manager/point of contact.

PROCEDURE:

1. All deliveries shall check in at front desk and wait with vehicle for (facility) staff. The deliveries will be dropped at the loading dock/delivery entrance.

2. Department staff shall sign for and transfer materials to proper storage room.

3. We are screening all patients and staff at all our facilities. All vendors must be actively screened and tested in accordance with NYS and federal guidelines. Any vendor feeling sick must stay home.

4. All suppliers/contracted staff will be provided a face/procedure mask and any additional PPE required in accordance with CDC and NYS guidance.

Medically Necessary Consultant Services

Effective: 9/14/2020	Revised:

POLICY: It is the policy of this facility to provide medically necessary services to residents while ensuring the prevention and control of infection is prioritized to ensure resident safety and well-being. The facility IDT Team will review with resident/resident representative any specialty service request and defer as necessary non urgent consultant services during a pandemic.

PROCEDURE:

1. The Primary physician will assess and order any medically necessary consults including dental, podiatry, Psychiatry, Psychology, or any other consult needed for resident clinical needs.

2. The PMD in conjunction with Medical Director will determine if any consultant visit can be done via Telehealth. The facility will optimize telehealth services where possible.

3. All consultants will require active screening and testing for infection in accordance with NYSDOH and Federal regulations.

4. Upon entering the facility, Consultant may submit proof/results that the required testing was done and is negative for infection.

5. Consultant(s) will meet with the Infection Preventionist as needed to ensure Facility Infection policies and procedures are understood and adhered to.

6. Consultant will be screened and respond to questionnaire prior to entering facility. If consultant has temperature of 100 or any symptom of infection, they will not be permitted to enter facility.

7. A Facility Staff member will accompany/assist Consultant performing tasks (not including psychologist) as needed.

8. Consultant(s) can only provide services on negative cohorted units or in designated Medical offices.

9. All Facility cleaning and disinfection practices will be conducted in between each resident treatment as per Facility P/P.

10. Consultant will submit guidance for cleaning and disinfection procedure for any equipment utilized.

11. Consultant must follow strict hand hygiene.

12. Consultant will always wear mask upon entering facility and while in the facility.

13. Required PPE such as gloves, gown, or eye protection to be used according to Infection Control policy.

14. Dental, Ophthalmology and Podiatry may have equipment that warrant specific infection control procedures and need to submit specific procedure for the cleaning and disinfecting of equipment.

Readmitting Residents Safely during a Pandemic

Effective: 9/14/2020	Revised:

POLICY: During a pandemic, the facility will readmit hospitalized residents safely in accordance with Federal and NYS Bed Reservation Guidance NYS code 415.3 and CMS code 483.15(d). as well as all State and Federal Infection prevention and control regulations.

PROCEDURE:

1) The facility, in accordance with New York State Regulations, will reserve a bed for a resident who had been transferred to the hospital, providing the conditions below are met:

   - The facility will be able to provide the care for the resident at the time of readmission. This includes clinical treatment and/or management of infectious diseases as well as provision of appropriate transmission-based precautions.
   - The facility has the ability to group residents into appropriate cohorts.
   - The facility has an available bed in an area that can provide for residents recovering from an infectious disease.

2) Prior to readmission, the Director of Nursing/Designee will review hospital records to determine individual resident care needs. If needed a call will be placed to transferring hospital to clarify any clinical needs and/or concerns.

3) Prior to readmission, Unit Charge nurse will be informed of readmission and any specific isolation and cohorting needs of the resident.

4) For any transfers across care transitions, the RNS will document Infection status on transfer form and notify ambulance/EMT as needed.

5) If the facility cannot care for the resident based on needs, the Administrator/designee will contact the NYSDOH for guidance and inform hospital and resident representative of status.

*All Medicare or Medicaid nursing home eligible residents on leave due to hospitalization, and requiring skilled nursing facility services, will be given priority readmission for the next available bed in a semi-private room. If the facility determines that a resident who has transferred with an expectation of returning to the facility, cannot return, the appropriate discharge procedures will be followed.