HAZARD AND VULNERABILITY ASSESSMENT TOOL
NATURALLY OCCURRING EVENTS

EVENT (Click each event for additional information)	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	*0 - 100%*
Drought	1	0	0	2	2	2	1	**13%**
Earthquake	0	0	0	0	0	0	0	**0%**
Epidemic / Pandemic	3	3	3	2	1	1	1	**61%**
Extreme Temperatures	2	2	2	2	3	2	2	**48%**
Flood	1	1	2	2	1	2	2	**19%**
Hurricane / Coastal Storm	3	3	3	3	1	1	2	**72%**
Severe Thunderstorm	3	3	3	3	1	1	2	**72%**
Tornado	1	3	3	3	1	1	2	**24%**
Winter Storm / Blizzard	3	3	3	3	1	1	2	**72%**
AVERAGE SCORE								**36%**

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.36	0.63	0.57

9/14/2020

TECHNOLOGIC EVENTS

EVENT (Click each event for additional information)	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	*0 - 100%*
Communications Failure	1	1	1	2	1	1	2	**15%**
Electrical Failure	2	1	0	2	1	2	2	**30%**
Fire Alarm Failure	1	3	2	2	1	1	2	**20%**
Fire, External	1	1	1		1	1	2	**11%**
Fire, Internal	2	2	1	1	1	1	2	**30%**
Generator Failure	1	2	1	1	1	2	2	**17%**
HVAC Failure	1	1	1	1	1	2	2	**15%**
Information Systems Failure	1	2	1	1	1	2	2	**17%**
Medical Gas Failure	1	1	1	2	2		2	**15%**
Medical Vacuum Failure	0	0	0	0	0	0	0	**0%**
Natural Gas Failure	1	1	1	1	2	2	2	**17%**
Sewer Failure	1	1	1	1	2	2	2	**17%**
Steam Failure	0	0	0	0	0	0	0	**0%**
Structural Damage	1	2	1	1	1	2	2	**17%**
Supply Shortage	1	1	1	1	1	2	2	**15%**
Mass Transportation Failure	2	2	2	2	1	2	2	**41%**
Water Failure	2	1	0	2	1	1	2	**26%**
AVERAGE SCORE								16%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.16	0.37	0.42

EAST HAVEN

EVENT (Click each event for additional information)	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Active Shooter	2	2	2	2	1	1	2	37%
Bomb Threat	1	1	1	2	1	1	2	15%
Civil Disturbance	1	1	1	1	1	1	1	#REF!
Elopement	2	2	2	2	1	1	2	30%
Labor Action	1	1	1	2	2	2	2	19%
Mass Casualty Incident / Medical Surge	0	0	0	0	0	0	0	0%
Workplace Violence	1	1	1	1	1	2	2	15%
VIP Situation	1	0	0	0	2	2	2	11%
AVERAGE								15%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.15	0.38	0.40

EAST HAVEN

EVENT	SEVERITY = (MAGNITUDE - MITIGATION)							
	PROBABILITY	HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	RISK
	Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community/ Mutual Aid staff and supplies	Relative threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	*0 - 100%*
Biological Terrorism Event	2	2	2	2	2	2	2	**44%**
Chemical Event	1	1	1	1	1	2	2	**15%**
Explosive Event	1	1	1	1	2	2	2	**17%**
Nuclear Event	1	1	1	1	2	2	2	**17%**
Radiological Event	1	1	1	1	2	2	2	**17%**
AVERAGE								**21%**

**Threat increases with percentage.*

RISK =	PROBABILITY *	SEVERITY
0.21	0.40	0.52

rev 12/05/2019

Pandemic COVID-19 Preparedness Plan
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Pandemic COVID-19 Preparedness Plan

Policy Statement

A pandemic Coronavirus Disease 2019 (COVID-19) preparedness plan is incorporated into this facility's overall disaster preparedness plan.

Policy Interpretation and Implementation

1. This facility has identified key components for pandemic COVID-19 preparedness and regularly updates its readiness efforts.
2. A multidisciplinary Pandemic COVID-19 Planning Committee develops and oversees the facility's pandemic COVID-19 preparedness planning, including the written plan.
3. A Pandemic COVID-19 Response Coordinator is assigned to coordinate pandemic preparedness planning and to monitor public health advisories on a weekly basis (or more often, as necessary).
4. Components of the written pandemic COVID-19 preparedness plan include the following:
    a. A protocol for monitoring pandemic COVID-19 symptoms in staff and residents, including new admissions;
    b. Education and training programs and materials for staff, residents, families and visitors;
    c. An infection prevention and control plan for managing residents and visitors with symptoms of seasonal and pandemic COVID-19;
    d. A plan for addressing staff absences and working with limited staff;
    e. A plan for the use of vaccine and anti-viral medications; and
    f. A surge capacity determination and plan, including staffing and supplies.

Pandemic COVID-19 Planning Committee and Response Coordinator

A multidisciplinary Pandemic COVID-19 Planning Committee has been established to develop and oversee the facility's pandemic COVID-19 preparedness planning, including the written plan. A Pandemic COVID-19 Response Coordinator has been appointed to facilitate and implement the plan and to provide feedback to the committee.

Policy Interpretation and Implementation

The Pandemic COVID-19 Planning Committee is a multidisciplinary group established to develop and oversee this facility's pandemic COVID-19 preparedness.

Members of the committee include the following individuals and/or departments:

- Facility administration representative;
- Medical Director;
- Nursing Services;
- Infection Preventionist;
- Employee health representative;
- Staff Development Coordinator;
- Maintenance services;
- Environmental/Housekeeping services;
- Dietary services;
- Pharmacy services;
- Physical therapy services;
- Resident/family representative; and
- Other:

The COVID-19 Planning Committee appoints the Pandemic COVID-19 Response Coordinator to:

1. Help implement the pandemic COVID-19 preparedness plan throughout the facility;
2. Maintain contact with state and regional pandemic COVID-19 preparedness groups;
3. Attend regional meetings, workshops and training sessions to obtain information on pandemic COVID-19 preparedness and coordinate the facility's plans with other pandemic COVID-19 plans;
4. Monitor public health advisories on a weekly basis (or more often, as necessary);
5. Participate in facility surveillance of COVID-19 -like illness and confirmed disease (in collaboration with the Infection Preventionist);
6. Communicate with residents and family members regarding the status and impact of pandemic COVID-19 in the facility; and
7. Coordinate the training of facility staff (in collaboration with the Staff Development Coordinator).

EAST HAVEN

Pandemic COVID-19 Communications Plan
Refer to Facility Emergency Preparedness Plan for Contact Information for all Critical Points of Contact

Policy Interpretation and Implementation

1. Critical points of contact for all stages of a pandemic COVID-19 outbreak include:
    a. Local health department;
    b. State health department;
    c. State long-term care professional/trade association;
    d. Local emergency and pandemic COVID-19 preparedness groups;
    e. State emergency and pandemic COVID-19 preparedness groups;
    f. Other regional emergency and pandemic COVID-19 preparedness groups;
    g. Local area hospitals; and
    h. Other local healthcare providers (other long-term care facilities; emergency medical services; etc.).
2. The Pandemic COVID-19 Response Coordinator maintains a list of critical contact points and attends regional meetings, workshops and training sessions to obtain information on coordinating the facility's plans with other pandemic COVID-19 plans.
3. The Pandemic COVID-19 Response Coordinator communicates with staff, residents, and families regarding the status and impact of pandemic COVID-19 in the facility.
4. Various communication methods are utilized to disseminate information regarding the status of pandemic COVID-19 in the facility.
5. The Pandemic COVID-19 Response Coordinator will determine the most appropriate communication methods (signs, phone trees, internet, etc.) for the situation.

The Pandemic COVID-19 Response Coordinator receives a current list of facility residents and contact information of resident family members on a weekly basis.

EAST HAVEN

Pandemic COVID-19 Surveillance and Detection

Policy Statement

As part of the pandemic COVID-19 preparedness plan this facility has established a program for surveillance and detection of pandemic COVID-19 in residents and staff, and actively monitors public health surveillance and advisories.

Policy Interpretation and Implementation

The COVID-19 Planning Committee has appointed a Pandemic COVID-19 Response Coordinator to coordinate pandemic preparedness planning, surveillance and detection. The Pandemic COVID-19 Response Coordinator is (name and title): ____________________

____

____

____

and can be reached at (daytime and evening contact information):

1. The Pandemic COVID-19 Response Coordinator works closely with the Infection Preventionist in all areas of pandemic preparedness and response, including surveillance and detection of pandemic COVID-19 in residents and staff.
2. The Pandemic COVID-19 Response Coordinator monitors public health advisories (federal and state) at least weekly, and is responsible for updating the Infection Preventionist and the Pandemic COVID-19 Planning Committee when pandemic COVID-19 has been reported in the United States and is nearing the geographic area.
3. Weekly monitoring of COVID-19 -like illness and confirmed cases of COVID-19 in residents and staff is included in our overall surveillance of communicable disease and is reported to the Infection Preventionist and the Pandemic COVID-19 Planning Committee.
4. Evaluation and diagnosis of residents and/or staff with COVID-19 -like illness shall follow current CDC Guidelines for evaluation of symptoms and laboratory diagnostic procedures.
5. Enhanced surveillance (e.g., virologic testing) of residents and staff with COVID-19 -like illness will be considered on a case-by case basis in collaboration with the local public health department. Determination of enhanced surveillance will be based on the clinical presentation of symptoms, risk factors for exposure to novel COVID-19 viruses, and current CDC recommendations.
6. If an COVID-19 outbreak in the facility is suspected, virologic testing of residents may be used to determine the best course of managing the outbreak.

7. All novel A COVID-19 viruses identified by laboratory analysis will be reported to the local public health department and the CDC as a Nationally Notifiable Disease.
8. Assessment of COVID-19 -like symptoms is included in the evaluation of newly admitted residents. Current CDC Guidelines for isolation precautions will be followed to determine the appropriate placement of newly admitted residents with COVID-19 -like illness or confirmed disease.

Pandemic COVID-19 Training and Education

Policy Statement

This facility has developed an education and training program for disaster preparedness, including pandemic COVID-19 preparedness training for staff, residents, and families.

Policy Interpretation and Implementation

1. The Pandemic COVID-19 Response Coordinator, in collaboration with the Staff Development Coordinator, is responsible for developing and overseeing clinical training on disaster preparedness regarding pandemic COVID-19.
2. Staff training on disaster preparedness and pandemic COVID-19 includes the following components:
    a. Communication with residents and family during epidemics;
    b. Quarantine and/or visitor restrictions during epidemics or infectious disease outbreaks;
    c. Control measures, including vaccinations and infection control precautions, to prevent infection and control outbreaks of COVID-19 and other communicable diseases;
    d. Signs and symptoms of COVID-19; and
    e. The implications of a pandemic COVID-19 at the facility and community levels.
3. Local (e.g., health department, hospital-based) and long-distance (web-based) training opportunities have been identified and may be utilized for additional staff training.
4. Resident and family education regarding seasonal and pandemic COVID-19 will be provided by the Pandemic COVID-19 Response Coordinator and will include the following:
    a. Internet resources for general information about seasonal and pandemic COVID-19;
    b. The facility's current state of preparedness for disaster and/or pandemic COVID-19; and
    c. Information regarding written policies and procedures for pandemic COVID-19 planning.
5. Printed information distributed to residents and family will be in a language and reading level that can be understood by the resident and family.

Occupational Health
**** Refer to Facility Infection Control Manual – Employee Health****

1. The facility has sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill healthcare personnel (HCP) to stay home.
2. The facility instructs HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of respiratory infection, as a part of routine practice.
3. The facility has a process to actively screen HCP for fever and symptoms when they report to work.
4. The facility has a process to identify and manage HCP with fever and symptoms of respiratory infection.
5. The facility has a plan for monitoring and assigning work restrictions for ill and exposed HCP.
6. The facility has a respiratory protection plan that includes medical evaluation, training, and fit testing of employees.

Transfer and discharge
Admission of Residents with Communicable Disease
***Refer to Facility Infection Control Manual**

****The facility has incorporated the screening processes for COVID-19 recommended by the CDC and NYS Department of Health into this existing policy on screening and/or caring for new admissions found in the Infection Control Manual. This process is updated daily as new information is released from the Federal and State government agencies.**

Policy:

Admission to this facility depends upon our ability to provide appropriate medical and nursing care. This includes situations where a resident has a known communicable disease or infection.

Procedures:

1. Prior to or upon admission, the Infection Preventionist, or designee, will assess the following infection risks for each admission:
    a. COVID-19
    b. M. tuberculosis (TB) infection, by purified protein derivative (PPD) test or recent chest x-ray;
    c. Immunization status, by history;
    d. During the period of October 1 through March 31, current status of influenza immunization, by history;
    e. Evidence of continuing active infection or clinically significant colonization by multidrug-resistant organism by history and review of hospital discharge summaries;
    f. Clinical evidence of a current infection; and
    g. Evidence of pediculosis or scabies, by direct observation.
2. The Infection Preventionist or designee will request an Infection Control Transfer Form from the sending facility prior to the resident's transfer. This form should provide information on the resident's infection status, isolation precautions, signs and symptoms of infection(s), antibiotic usage, and influenza/pneumococcal immunization status.
3. The Infection Preventionist or designee will maintain a log of residents with current evidence of infection or colonization due to multidrug-resistant organisms, including methicillin-resistant staphylococcus aureus, vancomycin-resistant enterococci and

Clostridium difficile (MRSA/VRE/C. difficile). When considering room assignments, the log will be checked to prevent placing a resident with MDRO infection or colonization with a resident at risk of infection.

4. A resident who is transferred to an acute care facility with infection due to a multidrug-resistant organism should be reviewed prior to return for details of the status of any such infection and clarification of any possible infection control risks that the situation presents.
5. A resident admitted with colonization or infection due to a multidrug-resistant organism may be placed in a private room, or cohorted with another resident of the same sex who is colonized with a similar organism. A colonized resident also may be cohorted or placed with a non-colonized resident who is not immunocompromised, if no other bed is available.
6. Our facility will not deny admission to someone just because they have infection with the human immunodeficiency virus (HIV), or are HIV antibody positive.
7. Placement of individuals with other potentially infectious conditions such as herpes zoster or scabies will be made based on appropriate clinical evaluation by the Attending Physician and/or Medical Director of the status of the infection and risk for its dissemination.
8. The facility will not admit individuals with active tuberculosis or acid-fast bacillus (AFB) positive sputum until they have been treated elsewhere for long enough to no longer be considered contagious.
9. Persons found upon admission evaluation to have a positive PPD reaction or a suspicious chest X-ray will be evaluated promptly to determine whether they might have active TB, in which case they will either not be admitted, will be moved to a section of the facility where appropriate isolation can occur (if available), or will be discharged promptly to a facility where they can be isolated or treated appropriately for active TB.
10. Admissions requiring infection control restrictions will be placed on appropriate Isolation Precautions based on this facility's policies governing Isolation Precautions.

Postmortem care:

1. A contingency plan has been developed for managing an increased need for postmortem care and disposition of deceased residents.
2. An area in the facility that could be used as a temporary morgue has been identified.
3. Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.

Surge Capacity
***Refer to Facility Emergency Preparedness Plan**

Staffing:

1. A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.
2. A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during a COVID-19 outbreak.

Supplies and Resources:

1. Alcohol-based hand sanitizer for hand hygiene is available in every resident room (inside and outside the room), and other resident care and common areas (e.g., outside dining hall, therapy gym);
2. Sinks are well-stocked with soap and paper towels for hand washing;
3. Signs are posted immediately outside a resident room indicating appropriate IPC precautions and required personal protective equipment (PPE);
4. Facility provides tissues and facemasks for coughing people near entrances and in common areas with no-touch receptacles for disposal;
5. Necessary PPE is available immediately outside of the resident room and in other areas where resident care is provided;
6. Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).
7. Trash disposal bins should be positioned near the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another resident in the same room.
8. Facility ensures HCP have access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
9. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
10. The facility has a process to monitor supply levels.
11. The facility has a contingency plan, that includes engaging their health department and healthcare coalition when they experience (or anticipate experiencing) supply shortages.

Contact information for healthcare coalitions is available in the Emergency Preparedness Plan:

Consumables and durable medical equipment and supplies:

1. Estimates have been made of the quantities of essential resident care materials and equipment (e.g., intravenous pumps and ventilators, pharmaceuticals) and personal protective equipment (e.g., masks, respirators, gowns, gloves, and hand hygiene products), that would be needed during an eight-week outbreak.
2. Estimates have been shared with local, regional, and tribal planning groups to better plan stockpiling agreements.
3. A plan has been developed to address likely supply shortages (e.g., personal protective equipment), including strategies for using normal and alternative channels for procuring needed resources.
4. A strategy has been developed for how priorities would be made in the event
5. there is a need to allocate limited resident care equipment, pharmaceuticals, and other resources.
6. A process is in place to track and report available quantities of consumable medical supplies including PPE.

Considerations about Visitors:

1. The facility has plans and material developed to post signs at the entrances to the facility instructing visitors not to visit if they have fever or symptoms of a respiratory infection.
2. The facility has criteria and protocol for when visitors will be limited or restricted from the facility.
3. Should visitor restrictions be implemented, the facility has a process to allow for remote communication between the resident and visitor (e.g., video-call applications on cell phones or tablets) and has policies addressing when visitor restrictions will be lifted (e.g., end of life situation).

EAST HAVEN

Following are the letter to families concerning visitor restrictions currently in place and the visitor screening process that will resume once restrictions have been lifted:

Dear Family Members and Friends,

On Saturday, 03/07/20 Governor Cuomo declared a State of Emergency for New York State due to the spread of the 2019 Novel (new) Coronavirus (2019-nCoV). The Centers for Medicare and Medicaid (CMS) has also issued guidance to long-term care facilities relative to heightened infection control expectations.

In response to these official directives, [FACILITY] will suspend all visitation and remain quarantined beginning March 8, 2020 until further notice. These restrictions extend to all families and friends of residents, private duty aides and companions, entertainers, and volunteers.

Alternative mechanisms for resident and visitor interactions, such as video-call applications on cell phones or tablets will be explored on a case-by-case basis.

Exceptions based on end-of-life situations or when a visitor is essential for the resident's emotional well-being and care will be evaluated on a case-by-case basis by the interdisciplinary team.

Thank you for helping us to ensure the safety and well-being of our residents, staff, families and visitors. Should you have questions or concerns regarding the quarantine or the facility's infection control planning, please contact .

Sincerely,

[Name]
[Title]

Prevent COVID-19:
Visitor Screening

"…because of the ease of spread in a long-term care setting and the severity of illness that occurs in residents with COVID-19, facilities should discourage visitation and begin screening visitors even before COVID-19 is identified in their community." - *CDC, March 11, 2020*

ALL individuals (employees, family, visitors, government officials) entering the building should be asked the following questions:

1. **Has this individual washed their hands or used alcohol-based hand rub (ABHR) on entry?**
   - □ Yes
   - □ No – please ask them to do so.
2. **Ask the individual if they have any of the following respiratory symptoms?**
   - □ Fever (checking for temperature is not necessary)
   - □ Sore throat
   - □ Cough
   - □ New shortness of breath
   - If YES to any, ask them to not enter the building. They may or may not have COVID-19, and the potential consequences to COVID-19 entering the building is serious enough to ask them to not enter even though they may not have it. Many populations outside of the elderly do not show any symptoms but are able to transmit the virus to others.
   - If NO to all proceed to question #3.
3. **Ask the individual if they have:**
   - □ Travelled internationally within the last 14 days to areas where COVID-19 cases have been
     confirmed
   - □ Worked in another health care setting that has confirmed COVID-19 cases (this may changeas COVID spreads in the community)
   - If YES to any, ask them to not enter the building
   - If NO to all, proceed to question #4
4. **Ask the visitor the purpose for their visit/entry:**
   - □ Employees and contractors involved in meeting the resident's needs or maintaining the operations of the facility should be allowed

- □ Immediate family members, approved by the resident or resident's representative, who do not screen positive for #2 or #3 above, should be allowed
- □ Immediate family members' visits for critical or time sensitive reasons such as hospice related visits, complete medical authorizations, etc. should be allowed but need to use mask, gown and gloves.
- □ Routine social visits should be strongly discouraged

5. Remind the individual to:

- □ Wash their hands or use ABHR throughout their time in the building
- □ Not shake hands with, touch or hug individuals during their visit

NOTE: This is not a complete ban on all visitors, but routine social visits are discouraged. The rationale should be explained, and alternative methods of communications offered.

RATIONALE: COVID-19 is extremely dangerous for SNF residents with early estimates of at least a 15% mortality rate for older adults 80+ years old. Many populations outside of the elderly do not show any symptoms but are able to transmit the virus to others. The risk of entering the building is large enough to ask them to not enter.

CENTERS FOR DISEASE CONTROL (CDC)
MARCH 16, 2020

Source: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Standard and Transmission-Based Precautions
Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions that apply to patients with respiratory infections, including COVID-19, are summarized below. Attention should be paid to training and proper donning (putting on), doffing (taking off), and disposal of any PPE. This document does not emphasize all aspects of Standard Precautions (e.g., injection safety) that are required for all patient care; the full description is provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

HCP who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator or facemask, gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring Airborne Precautions (e.g., tuberculosis, measles, varicella). Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- **Hand Hygiene**
  - HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.

- HCP should perform hand hygiene by using ABHR with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.
- Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location.

- **Personal Protective Equipment**
  Employers should select appropriate PPE and provide it to HCP in accordance with OSHA PPE standards (29 CFR 1910 Subpart I)external icon. HCP must receive training on and demonstrate an understanding of:
  - when to use PPE
  - what PPE is necessary
  - how to properly don, use, and doff PPE in a manner to prevent self-contamination
  - how to properly dispose of or disinfect and maintain PPE
  - the limitations of PPE.

  Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with known or suspected COVID-19 includes:

  - **Respirator or Facemask**
    - Put on a respirator or facemask (if a respirator is not available) before entry into the patient room or care area.
    - N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol-generating procedure (See Section 4). See appendix for respirator definition. Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator or facemask. For guidance on extended use of respirators, refer to Strategies to Optimize the Current Supply of N95 Respirators
      - If reusable respirators (e.g., powered air purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Those that do not currently have a respiratory protection program, but care for patients with pathogens for which a respirator is recommended, should implement a respiratory protection program.

- **Eye Protection**
  - Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
  - Remove eye protection before leaving the patient room or care area.
  - Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.
- **Gloves**
  - Put on clean, non-sterile gloves upon entry into the patient room or care area.
    - Change gloves if they become torn or heavily contaminated.
  - Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.
- **Gowns**
  - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
  - If there are shortages of gowns, they should be prioritized for:
    - aerosol-generating procedures
    - care activities where splashes and sprays are anticipated
    - high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
      - dressing
      - bathing/showering
      - transferring
      - providing hygiene
      - changing linens
      - changing briefs or assisting with toileting
      - device care or use
      - wound care

3. Patient Placement

- For patients with COVID-19 or other respiratory infections, evaluate need for hospitalization. If hospitalization is not medically necessary, home care is preferable if the individual's situation allows.
- If admitted, place a patient with known or suspected COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom.

- Airborne Infection Isolation Rooms (AIIRs) (See definition of AIIR in appendix) should be reserved for patients who will be undergoing aerosol-generating procedures (See Aerosol-Generating Procedures Section)

- As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients. Dedicated means that HCP are assigned to care only for these patients during their shift.
    - Determine how staffing needs will be met as the number of patients with known or suspected COVID-19 increases and HCP become ill and are excluded from work.
    - It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will likely be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should not be housed in the same room as a patient with an undiagnosed respiratory infection.
    - During times of limited access to respirators or facemasks, facilities could consider having HCP remove only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator or facemask (i.e., extended use). Risk of transmission from eye protection and facemasks during extended use is expected to be very low.
        - HCP must take care not to touch their eye protection and respirator or facemask .
        - Eye protection and the respirator or facemask should be removed, and hand hygiene performed if they become damaged or soiled and when leaving the unit.
    - HCP should strictly follow basic infection control practices between patients (e.g., hand hygiene, cleaning and disinfecting shared equipment).
- Limit transport and movement of the patient outside of the room to medically essential purposes.
    - Consider providing portable x-ray equipment in patient cohort areas to reduce the need for patient transport.
- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- Patients should wear a facemask to contain secretions during transport. If patients cannot tolerate a facemask or one is not available, they should use tissues to cover their mouth and nose.
- Personnel entering the room should use PPE as described above.

- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- Whenever possible, perform procedures/tests in the patient's room.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use (See

EAST HAVEN

Emergency Staffing Plan– COVID-19 Pandemic

Policy:

It is the policy of this facility to provide adequate amount of qualified staff to meet residents' needs.

Purpose:

In the event of an emergency, the facility will identify basic resident needs and reorganize staffing assignments to best meet those needs. In an infection disease pandemic, the facility will augment staff with trained volunteers, licensed staff from other states, as allowed, and new employees as it is able. (April 2020 additions address the global COVID-19 pandemic.)

Procedure:

- Staff assignments shall be organized to abide by local, state and national guidance and direction related to the specific emergency.
- Staff may be cross- trained between departments to provide for adequate numbers of staff in various roles
    - Training and competencies will be documented.
- Staffing during the 2020 COVID-19 pandemic shall consider residents' basic needs, the suspicion or presence of the illness in the resident and/or staff populations and the amount of community spread.
- Staffing assignments will be made to minimize the spread of COVID-19 while meeting residents' basic needs.
    - Staff will be provided time to receive education and updates about the disease.
    - Staff will be provided time to be screened at the beginning of each shift worked.
    - Staff will be provided time to don and doff PPE as directed by the facility's leadership.
- Staff will be assigned to duties in a manner that decreases the risk for spreading the illness.
    - Consistent assignment of direct care staff and housekeeping staff will be used as much as is practicable.
- Staff providing hands-on care for residents with presumed or positive COVID-19 will not provide care for residents who do not have COVID symptoms on the same shift, unless there is an emergency or staff is able to use complete PPE including jumpsuits to cover clothing while in the COVID patient's room.
- Staff wearing full PPE to provide care should perform as many non-care tasks as possible while in the resident's room, such as wiping down hard surfaces with disinfectants, gathering trash and soiled linen, and disposing of meal items before doffing the PPE and leaving the resident's room.

This resource was developed utilizing Information from CDC and CMS.

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Best Practices:

Assess the number of staff that have secondary positions at other facilities. Ask them to consider limiting hours to one facility and to report exposure at their other job. Do not underestimate the amount of time and staff needed to move residents for cohorting and isolation. Now is the time for maximum efficiency.

• Can medication orders be trimmed down, such as orders to hold multivitamins? Ask the consulting pharmacist for assistance.

• Remove all non-care tasks from nurses and nursing assistants and elicit assistance from other departments and leaders.

• Non-nursing staff and volunteers can pass water pitchers, allocate incontinence products, etc.

• Bundle tasks in isolation rooms to minimize the number of staff interacting with the resident.

• Be prepared to have staff stay on-site. • Plan for food and sleeping rooms, personal laundry.

• Be prepared to be scrutinized by the State survey agency.

• Despite the emergency nature of the conditions, staff are still expected to follow the regulations and rules for infection prevention, basic, safe care, and resident dignity.

Resources The Centers for Medicare and Medicaid Services (CMS). Emergency Preparedness Rule (11/19). https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/SurveyCertEmergPrep/Emergency-Prep-Rule. The Centers for Disease Control and Prevention (CDC). Strategies to Mitigate Health Care Personnel Staffing Shortages. https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigatingstaff-shortages.html The Centers for Medicare and Medicaid Services (CMS). State Operations Manual. Appendix PP. https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf The Centers for Medicare and Medicaid Services (CMS) Appendix Z, Emergency Preparedness Final Rule Interpretative Guidelines and Survey Procedures" is found at https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf