Sapphire Nursing at Wappingers

Pandemic Emergency Plan

Annex P

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Sapphire Nursing at Wappingers			
Section: **Emergency Preparedness Plan:** ANNEX P			
Issue Date: 9/15/20	Revision Date:	Review Date: Annual/PRN	Prepared by: QAA Committee
Policy Subject: **Pandemic Emergency Plan (PEP)**			
Approved by: Administrator, Medical Director, Director of Nursing, QAA Committee			Page 1 of 6

POLICY:

The facility has taken measures to prepare for a pandemic event. All staff members and affected individuals are trained on the facility's Pandemic Emergency Plan (PEP) and other related policies and procedures, including those policies and procedures in in the facility's Emergency Preparedness Plan (EPP).

A copy of the PEP will be readily available to all staff, residents and visitors in the facility, as well as on the facility's website.

The PEP will be initiated when an infectious disease is increasing and sustaining human-to-human transmission in the United States an/or abroad, and a Pandemic has been declared by national, state, and/or local governing bodies.

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1. Emergency Procedure

The following emergency procedure will be utilized in the event of a pandemic:

a. Declare a "Code Silver."
b. Notify the Administrator and Director of Nursing if they are not on premises.
c. Activate the Labor Pool if warranted. (See Addendum 1: "EMERGENCY STAFFING CALL-IN FOR OFF-DUTY PERSONNEL" on Page 7).
d. Facility management staff should report to the Incident Command Center for briefing and instructions.
e. Activate the Incident Command System (ICS) to manage the pandemic. The most qualified staff member (in regard to the ICS) on duty assumes the Incident

Commander position.

f. Follow guidelines of Pandemic Emergency Plan.

2. Communication

a. The facility Infection Control Preventionist (ICP) or designee is responsible for communications with the public health authorities during a pandemic.
b. The ICP or designee, in conjunction with guidance from local, state, and national agencies, will determine when to restrict admissions and visitation, as well as resumption of such. Such restrictions or resumptions will be communicated to the affected parties via phone, mail, email, website, social media, text, or other standard communicable methods. (See Addendum 2: "Visitation, Infection Control During a Pandemic" on Page 9.)
c. The ICP or designee is responsible for communicating with the staff, residents, families and all affected individuals regarding the status and impact of the pandemic in the facility in accordance with required timeframes mandated by state and federal regulations. This communication includes number of pandemic deaths and number of new and active infections. This shall be done via phone, mail, email, website, social media, text, or other standard communicable methods. (See Addendum 3: "Resident and Family Communication During a Pandemic" on Page 13.)
d. All attempts will be made to provide all residents with daily access to free remote videoconferencing, similar communication methods, or, when feasible and allowable, resident/family requested methods of communication.
e. Communication during a pandemic includes notification of staff members, vendors, providers, and volunteers, etc. of the status of the pandemic outbreak. Alerting affected personnel can include, but is not exclusive to, phone calls, the facility website or social media pages, or posted signage and the facility entrance points.
f. The ICP or Designee also maintains communications with the Incident Commander, Emergency Management Coordinator, local hospitals, local Emergency Management Services, as well as other providers regarding the status of the pandemic.

3. Infection Control

a. This facility has policies and procedures related to its Infection Control Program. (See Addendum 4 – "Infection Control Program" on Page 16.)
b. The facility has policies and procedures for specific infectious diseases increasing and sustaining human-to-human transmission in the United States an/or abroad, and a pandemic has been declared by national, state, and/or local governing bodies.
c. The ICP or designee acts as the Pandemic Event Response Coordinator.
d. The ICP or designee will address all pandemic event preparedness associated with infection control measures: adherence to infection control policies and procedure, posting signs for cough etiquette, hand washing etiquette, donning and doffing of PPE supply in accordance with applicable transmission-based precautions for

each resident and unit. (See Addendum 5: "Handwashing Hand Hygiene" on Page 26 and Addendum 6: "Using Personal Protective Equipment PPE" on Page 32.)

e. The ICP or designee shall develop procedures to cohort confirmed positive, confirmed negative/non precautionary, suspected/precautionary, new admissions, re-admissions or groups using one of more of the following strategies:
    i. Confining confirmed positive, confirmed negative/non precautionary, suspected/precautionary, new admissions, re-admissions residents and their exposed roommates to their room or area.
    ii. Placing symptomatic residents together in one area of the facility.
    iii. Closing units where symptomatic and asymptomatic residents reside, i.e.: restricting all residents to an affected unit, regardless of symptoms.
    iv. Develop criteria for closing units or the entire facility to new admissions during pandemic outbreak.
    v. Limit, if possible, cross-assignment of staff between positive cohorts and the other cohorts.
    vi. Discontinue any sharing of bathrooms with others outside of the Cohort.
    vii. Discontinue all Communal activities such as Dining areas and group activities. (See Addendum 7: "Communal Programming During a Pandemic" on Page 41.)
    viii. All areas that have been isolated will be properly identified including signage for proper PPE to remind healthcare personnel
    ix. In the event that the facility cannot cohort such residents the ICP will notify appropriate local, state, and/or federal agencies.

f. Residents, employees, contract employees, visitors and all affected individuals will be evaluated daily upon entry to the facility for signs and symptoms of infectious disease as well as possible exposure to infectious diseases as it pertains to the current pandemic. Employees are instructed to self-report symptoms and exposure.

g. Cleaning and disinfection for a pandemic event shall follows the general principles used daily in health care settings (EPA-approved germicidal) or as Directed by the CDC or NYSDOH. These plans will comply with all applicable laws and regulations, including but not limited to 10 NYCRR 415.99, 415.3 (i)(3)(iii) and 415.26(i); and 42CFR 483.15(e) (See Addendum 8: "Guidance for Cleaning and Disinfecting" on Page 44.)

h. The facility will utilize experiences from other pandemic responses (such as Flu Pandemic, Covid-19 Pandemic) in order to strategically implement guidelines for new pandemic until measures are dictated by the governing officials.

i. The facility will have access to a 60-day supply of PPE or as specified by health official in accordance to prior pandemic situations. These PPE items will be stored at the facility or other satellite location in the state of New York. This amount will be regulated by census not capacity. Office of Emergency Management will be contacted for any assistance needed. PPE supplies that will be maintained at the facility or satellite location include but are not limited to: N95 masks or equivalent, Face shields, eye protection, isolation gowns, gloves, masks, sanitizers, and disinfectant in accordance with current EPA guidance. Plans will be made to conserve PPE this may include the distribution, sign out,

assigning of, or any other means of contingency including extended use practices in accordance with CDC guideline. All PPE will be accounted for at least on a weekly basis.

4. Occupational Health

   a. All staff are screened for pandemic illness and exposure prior to reporting to their assigned duties and as mandated based on shift duration.
   b. Practices are in place that addresses the handling of symptomatic staff and facility staffing needs, including:
      i. Handling of staff members who fail the facility screening protocol
      ii. Staff members who develop symptoms while at work.
      iii. When staff members who are symptomatic, but well enough to work, are permitted to continue working as dictated by the CDC or NYSDOH
      iv. Staff members who need to care for ill family members or infected residents.
      v. Determining when staff may return to work after having pandemic-related illness.
   c. Staff will consult with the ICP or designee prior to being excused from, or returning to, work.
   d. A contingency staffing plan is in place that identifies the minimum staffing needs and prioritizing critical and non-essential services, based on residents' needs and essential facility operations. The staffing plan includes collaboration with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis, as well as any active government waivers altering required licenses/certifications to provide resident care.
   e. All attempts will be made to have mental health services or faith-based resources available to provide counseling to staff and residents during a pandemic.
   f. If and when available, vaccinations of staff are encouraged and monitored.
   g. High-risk employees (pregnant or immune-compromised) will be monitored and managed by placing them on administrative leave or altering their work assignments.
   h. If staff have any questions including but not limited to: what to do during Pandemic, where to seek education, any responsibilities, etc. they are to speak to ICP, Designee, unit manager or supervisor.

5. Education and Training
   a. The ICP or designee is responsible for coordinating education and training on the pandemic event. Local health department and hospital-sponsored resources are researched, as well as usage of web-based training programs. The website www.cdc.gov is considered as a resource.
   b. Education and training of staff members regarding infection control procedures, transmission-based precautions, as well as respiratory hygiene/cough etiquette are ongoing to prevent the spread of infections, but particularly at the first point of

contact with a potentially infected person.

c. Education and training will include the usage of language and reading-level appropriate, informational materials, such as brochures, posters on Pandemic event, as well as relevant policies. Such materials should be developed or obtained from www.cdc.gov.

6. Vaccination and Antiviral Usage
   a. The facility will follow the guidance of the Medical Director in accordance with standards of practices from the NYSDOH and CDC as it pertains to prescribing and administering medication and treatments to residents and staff to treat the pandemic-related infectious disease.
   b. The ICP or designee will communicate with The Centers for Disease Control (CDC) and the Health Department to obtain the most current recommendations and guidance for the usage, availability, access, and distribution of vaccines and antiviral medications during a pandemic.
   c. Guidance from the State Health Department will be sought to estimate the number of staff and residents who are targeted as first and second propriety for receipt of the pandemic vaccine or antiviral prophylaxis. A plan is in place to expedite delivery of vaccine or antiviral prophylaxis to Skilled Nursing Facilities.
   d. Consent will be obtained from resident/family/affected person, and education provided, before administering any vaccine or antiviral medication.
   e. The facility will follow state and federal guidance for those resident/staff who refuse treatment.

7. Supplies, Surge Capacity, and Evacuaion

   a. The Planning Chief will ensure the facility has adequate supply of food, water, and medical supplies to sustain the facility if a pandemic occurs. A predetermined amount of supplies is stored at the facility or satellite location this amount is regulated by census not capacity. Office of Emergency Management will be contacted for any assistance needed.
   b. Plans include strategies to help decrease hospital bed capacity in the community.
   c. Director of Environmental Services shall provide plastic sheathing, duct tape, steel reinforcement etc. to construct isolation areas as needed.
   d. In the event of a facility evacuation, the facility will modify its evacuation procedure to ensure resident cohorts are kept in separate evacuation zones. (See "Evacuation of Facility" in the Emergency Preparedness Plan.)

8. Admissions and Readmissions
   a. The facility will follow state and federal guidance pertaining to the admission and readmission of residents with a communicable disease.
   b. All Admissions and Readmission will be screened prior to entrance to the facility and placed in a designated cohort as determined by the facility policies and procedures. (See Addendum 9: "Admission of Residents with a Communicable Disease.")

c. The facility has policies and procedures to cohort confirmed positive, confirmed negative/non precautionary, suspected/precautionary, new admissions, re-admissions or groups.
d. Facility will comply and adhere to the perseverance of resident's place at the facility when resident is hospitalized and will comply with all applicable state and federal laws and regulations, including but not limited to 18 NYCRR 505.9(d)(6) and 42 CFR 483.15

Addendum Table of Contents:

Other Resources:

- Facility EPP
- Facility Policy Guide
- CDC.gov
- Health.ny.gov

Sapphire Nursing at Wappingers			
Addendum 1		Policy #	
Issue Date: 02/01/2018	Revision Date: 06/28/2019	Review Date: Annual	Prepared by: Corporate DON – Cindy van Voorst RN
Policy Subject: **EMERGENCY STAFFING CALL-IN FOR OFF-DUTY PERSONNEL**			
Approved by: Administrator, Medical Director, Director of Nursing, QAA Committee			Page 1 of 2

Highlights	Policy Interpretation and Implementation
	In case of an emergency or disaster to meet minimum staffing and resident care needs, off-duty personnel shall be recalled to the facility as needed. 1. In case of an emergency situation or disaster in our facility, the Administrator or the ranking employee in charge shall have the authority to decide whether to recall off-duty personnel. 2. When the decision to recall off-duty personnel has been made, department directors shall be notified first. Department Directors shall notify respective department personnel. 3. Department Directors shall maintain a current roster of their department of their department personnel, which must include emergency contact telephone numbers. 4. The Nursing Administrator staff will be on-call to cover for emergency situation such as excessive licensed nurse call offs, weather emergencies etc. 5. The on-call schedule will be maintained by the Director of Nursing (DON) and updated monthly. 6. The on-call schedule will be located and filed in the Staffing Coordinator Binder. Licensed Nurses with on-call responsibilities will be as follows: 1. Administrator 2. DON 3. Assistant DON 4. Unit Managers 5. MDS Coordinator 6. Full-time RN Supervisors 7. Infection Control Preventionist/QA Nurse 8. LPNs 9. CNAs 10. Staff RNs The Administrator will contact the following Department Heads to contact ALL staff to come into the facility and assist the nursing staff with non-care interventions during emergency situations as follows: 11. Clerical Staff – will assist with contacting facility personnel during emergency situations/critical staffing, 12. Activities Staff - will assist with resident with transport, making beds etc. under the direction of a Licensed Nurse, 13. Therapy Staff – will assist with mealtime routine, resident transport under the direction of a Licensed Nurse,

	14. Dietary Staff –will assist with mealtime routine passing trays, picking up trays etc. under the direction of the Licensed Nurse,

	15. Housekeeping Staff – will assist nursing staff with making resident beds with transport under the direction of a Licensed Nurse, 16. Maintenance Staff – will assist with w/c transport to and from dining rooms, activities, therapy etc. under the direction of a Licensed Nurse, and 17. Admissions Staff - will assist with w/c transport to and from dining rooms, activities, therapy etc. under the direction of a Licensed Nurse.

References	
OBRA Regulatory Reference Numbers	§483.73 (b) (2) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency.
Survey Tag Numbers	E-0018; F725
Other References	Life Safety Code (2015 Edition)
Related Documents	Emergency Telephone Numbers/Employee Recall Roster
Version	

Sapphire Nursing at Wappingers			
Addendum 2		Policy #	
Issue Date: 11/01/2017	Revision Date: 05/10/2020	Review Date: Annual	Prepared by: Corporate Medical Director - Corporate DON – Cindy van Voorst RN
Policy Subject: **VISITATION, INFECTION CONTROL DURING A PANDEMIC**			
Approved by: Administrator, Medical Director, Director of Nursing, Infection Control Preventionist, QAA Committee			Page 1 of 3

Highlights	Policy Interpretation and Implementation
Policy Statement	The facility will restrict visitation to the nursing home, except for imminent end-of-life situations. Only essential Health Care Personnel (HCP) and essential contractors involved in meeting the resident's needs or for maintaining the operations of the facility will be allowed to enter the facility during a pandemic or infectious disease outbreak.
Posting Signs	1. The facility will post at all entrances and vestibules leading into the facility, **no visitation signs** advising all visitors that they cannot enter the facility.
Visitation	2. The facility will suspend all visitation except when essential for resident medical care, end-of-life care, or to meet the resident needs, or facility operations.
	3. The facility will limit access points into the building to ensure healthcare personnel and individuals who require screen checks enter the designated accessible entrance screening station/area.
Universal Source Control	4. The facility will require every individual, regardless of reason for entering the facility, to wear appropriate personal protective equipment.
Approved Visitation Essential Individuals	5. The following **essential HCP/individuals <u>will have approved visitation</u>** and access into the facility but will be required to have screening checks conducted prior to working or visiting: ▪ Facility employees and agency staff, ▪ Essential healthcare personnel including hospice staff, Medical Providers/Consultant contractors,

Restricted Non-Essential Individuals	▪ EMS personnel, ▪ Laboratory and diagnostic personnel, ▪ Transportation personnel (dialysis and chemotherapy appointments), ▪ Government personnel from NYSDOH, local DOH, CMS, and CDC, ▪ Family members, visitors, clergy, bereavement counselors (only during compassionate care visits approved by Administrator), ▪ Pharmacy vendor personnel (medication delivery), ▪ Essential contractors involved in meeting the resident needs or for maintaining the operations of the facility. 6. The following **non-essential HCP/individuals <u>will be restricted</u>** from visitation and will **<u>not have</u>** access into the facility to prevent potential transmission of illness: 1. Visitor/family routine social visits (except for end-of-life/compassionate visits), 2. Non-urgent medical consultation visits (telemedicine visits are preferred), 3. Food delivery drivers, 4. Barbers/hairstylist, etc., 5. Activity entertainment vendors, Volunteers Non-essential supply vendors (see below).

End-of-Life Visitation	7. Only the facility Administrator will approve compassionate care end-of life visitation to family member/legal representative on a case-by-case basis for those residents not confirmed or suspected of having the specified infectious disease. ▪ A compassionate care situation is defined as a situation when resident is actively dying and death is anticipated within less than 24 hours. Family members/legal representative will be advised at that time that they will be required to have a screening check conducted at the designated entrance

	to the facility prior to visiting the resident. 8. The Social Worker will coordinate end-of-life visits and advise the family members where the screening entrance is, PPE policy and room visitation restrictions.
Alternative Forms of Communication	9. During a pandemic or infectious disease outbreak, the facility will provide alternative forms of communication with residents and families in a variety of ways including telephone, e-mail, texting, video chat, social media, resident face-to-face window viewing during phone communication, etc. 10. The facility will implement various best practices and develop innovative ways to keep residents connected to their families and community to meet the psycho social needs of the residents, including emotional and physical well-being, self-determination, self-respect and dignity.
Family Communication	11. During an outbreak, the facility will notify residents, their representatives and families of confirmed or suspected infections among staff and residents, including information on mitigating actions implemented and any changes related to visitation and normal facility operations.
Non-Urgent Medical Appointment	12. Resident non-urgent medical appointments will be re-scheduled during a communicable disease outbreak to limit EMS/transport personnel from entering the facility to prevent the spread of disease transmission. Residents will continue to receive dialysis and chemotherapy outpatient treatments during communicable disease outbreaks.
Out-on-Pass Privileges	13. Residents' out on pass privileges will be prohibited during outbreaks to prevent the spread of the disease transmission. See policy and procedure entitled "*Activity Programming during a Communicable Disease Pandemic Outbreak*".

References	
OBRA Regulatory Reference Numbers	§483.80 (a) Infection Prevention and Control Program
Survey Tag Numbers	F880
Other References	Munoz-Price LS, Banach DB, Bearman G, et.al. 2015. SHEA Expert Guidance: Isolation

	Precautions for Visitors. *Infection Control Hosp Epid* 36 (7):1-12 CDC Guidelines CMS Guidelines New York Department of Health Guidelines
Related Documents	Notice to Visitors
Version	1.1 (H5MAPL0935)
Policy Revised	Date: 03/06/2020 By: _____ Date: 03/30/2020 By: _____ Date: 04/04/2020 By: _____

Sapphire Nursing at Wappingers			
Addendum 3		Policy #	
Issue Date: 04/19/2020	Revision Date: 05/07/2020	Review Date: Annual	Prepared by: Corporate DON – Cindy van Voorst
Policy Subject: **RESIDENT AND FAMILY COMMUNICATION DURING A PANDEMIC**			
Approved by: Administrator, Medical Director, Director of Nursing, QAA Committee			Page 1 of 3

Highlights	Policy Interpretation and Implementation
Policy Statement	The facility will implement various best practices and develop innovative ways to keep residents connected to their families and community to meet the psychosocial needs of the residents, including emotional and physical well-being, self-determination, self-respect and dignity. The facility will continue to promote and enhance quality of life and address social isolation and loneliness for the residents residing in the facility.
Communication Formats Between Facility and Resident and Family	▪ The facility will implement communication with residents and families in a variety of ways including telephone, e-mail, texting, video chat, social media, face-to-face window visits, listservs, template letters, website posting, paper notification, and recorded telephone messages. ▪ The facility will notify residents, their representatives, family members and next of kin by phone within 24 hours of a resident testing positive or suffering a pandemic related death. ▪ The residents and their representatives will receive ongoing updates of the facility's suspected or confirmed infections among staff and residents, as required. ▪ The facility will keep the residents, their representatives and family members abreast of the information on mitigating actions implemented in the facility to slow or stop the spread of pandemic-related illness. ▪ The facility will notify the residents, their representatives and families of changes related to visitation and normal facility operations on a regular basis and not less than weekly. ▪ Ongoing communications to the residents, representatives and families will include information related to the residents' health and well-being, social-related activities, care plan interventions, and scheduled IDT care plan meetings. ▪ The information reported to the resident and family members/legal representative will be reported in accordance with existing privacy regulations and stature. ▪ The IDT will implement care plan interventions and best practices to keep residents and family members engaged during the pandemic to meet the psychosocial, emotional, and physical well-being of the resident. Care plan intervention may include the following: Develop a face-to-face video call program.

IDT Psychosocial Care Plan Interventions	Develop a family call program where activities or Social Work Staff call families regularly with clinical updates, depending on the resident's condition. Establish an ambassador program that makes support staff available to answer phones and connect family members to nursing staff. Hold weekly webcasts from the leadership to answer live questions from families. Provide daily updates from the leadership of the facility on the facility's webpage.

Additional Ways to Connect Residents and Families	▪ Establish a bereavement support group for families of deceased residents. ▪ Modify the facility's webpage to include pandemic-related information and communication resources. ▪ Update facility website and/or provide written communication via e-mail and US mail with regular updates surrounding the facility's pandemic response plan. ▪ Arrange through-window calls or visits. ▪ Invite families to attend care plan meetings via telephone. ▪ Establish a pen pal program with the outside community. ▪ Continue to hold resident council meetings by modifying how they are conducted to maintain social distancing. ▪ Direct Social Worker to speak with each unit daily to identify any pandemic response issues with either residents or staff. ▪ Maintain regular Administrator rounds and post regular updates from the Administrator using the facility's social media outlets. ▪ Conduct phone conferences featuring the facility Medical Director or other key staff to provide information on the pandemic and to answer questions from families. ▪ Increase activity staffing hours for more in-room activities. ▪ Additional ideas to connect families and nursing home residents during the pandemic may include activity-related interventions such as: • Asking families to send care packages that include a note and a photo of sender to be used as a memory prompt. • Asking families to send video messages that can be replayed. • Have the resident's families load an electronic picture frame (or other device) with family photos for a loved one who cannot receive visitors. • The facility may create a virtual adopt-a-grandparent program where community members can virtually "adopt" a resident to either write letters, speak on the phone, or have virtual visits if the facility is able to coordinate. • The facility may partner with a local educational institution to ask kids and

Documentation	families at home to make greeting cards for residents. • The facility may hold weekly virtual family council meetings to allow families to connect with the nursing home's administration to address unique issues that may have arisen due to the pandemic crisis. ▪ The Social Worker will work together with the Activity Department to implement the above related activities and forms of communication to ensure the residents and families stay connected and socially involved. ▪ All resident and family communication will be documented in the resident's medical record by the members of the interdisciplinary team no less than weekly.

References	
OBRA Regulatory Reference Numbers	42 CFR §483.30
Survey Tag Numbers	F880
Other References	CDC COVID-19 Guidelines
Related Documents	
Policy Revised	Date: _____ By: _____ Date: _____ By: _____ Date: _____ By: _____

Sapphire Nursing at Wappingers			
Addendum 4		Policy #	
Issue Date: 12/01/2017	Revision Date: 9/15/2020	Review Date: Annual	Prepared by: Corporate DON – Cindy van Voorst RN
Policy Subject: **INFECTION PREVENTION AND CONTROL PROGRAM**			
Approved by: Administrator, Medical Director, Director of Nursing and QAA Committee			Page 1 of 9

Highlights	Policy Interpretation and Implementation
Policy Statement	1. The Infection Prevention and Control Program (IPCP) is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program.
	2. The elements of the Infection Prevention and Control Program consists of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, employee health and safety, identifying, recording and correcting ICP incidents, investigating and reporting communicable diseases and conducting an annual review of the IPC Program.
Coordination and Sight	3. The Infection Prevention and Control Program (IPCP) is coordinated and overseen by an infection prevention specialist (infection preventionist).
	4. The qualifications and job responsibilities of the Infection Preventionist are outlined in the *Infection Preventionist Job Description*.
	5. The Infection Prevention and Control 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: ▪ Whether Physician management of infections is optimal, ▪ Whether antibiotic usage patterns need to be changed because of the development of resistant strains, ▪ Whether information about culture results or antibiotic resistance is transmitted accurately and in a timely fashion, and ▪ Whether there is appropriate follow-up of acute infections.
Policies and Procedures	6. The Committee meets monthly and consists of team members from across disciplines, including the Medical Director.
	7. Policies and procedures are utilized as the standards of the IPCP.
	8. The Infection Prevention and Control Committee, Medical Director, Director of Nursing (DON), and other key clinical and administrative staff review the infection control policies at least annually. The review will include: ▪ Updating or supplementing policies and procedures as needed, ▪ Assessment of staff compliance with existing policies and regulations, and ▪ Any trends or significant problems since the previous review.
Surveillance	

	9. 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. 10. The information obtained from infection control surveillance activities is compared with that from other facilities and with acknowledged standards (for example, acceptable rates of new infections), and used to assess the effectiveness of established infection prevention and control practices. 11. Standard criteria are used to distinguish community-acquired from facility-acquired

	infections. 12. Surveillance will be ongoing, systematic collection, analysis, interpretation and dissemination of data to: ▪ Monitor trends of infection and pathogen, ▪ Detect outbreaks, ▪ Monitor staff adherence to IPC practices, ▪ Identify performance improvement opportunities, ▪ Track progress towards priorities, and ▪ Identification on annual IPC risk assessment.
Antibiotic Stewardship	13. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. 14. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. 15. Antibiotic usage is evaluated and practitioners are provided feedback on reviews.
Data Analysis	16. Data gathered during surveillance is used to oversee infections and spot trends. 17. One method of data analysis is by manually calculating number of infections per 1000 resident days as follows: ▪ The Infection Preventionist collects data from the nursing units, categorizes each infection by body site (these can also be categorized by organism or according to whether they are facility- or community-acquired), and records the absolute number of infections, ▪ To adjust for differences in bed capacity or occupancy on each unit, and to provide a uniform basis for comparison, infection rates can be calculated as the number of infections per 1000 patient days (a patient day refers to one patient in one bed for one day), both for each unit and for the entire facility, ▪ Monthly rates can then be plotted graphically or otherwise compared side-by-side to allow for trend comparison, and ▪ Finally, calculating means and standard deviations (using computer software) allows for screening of potentially clinically significant rates of infections (greater than two standard deviations above the mean).

Outbreak Management	18. The Medical Director will help design data collection instruments, such as infection reports and antibiotic usage surveillance forms, used by the Infection Preventionist. 19. Outbreak management is a process that consists of: ▪ Determining the presence of an outbreak, ▪ Managing the affected residents, ▪ Preventing the spread to other residents, ▪ Documenting information about the outbreak, ▪ Reporting the information to appropriate state and local authorities, NYS DOH, CDC when required, ▪ Educating the staff and the public, ▪ Monitoring for recurrences, ▪ Reviewing the care after the outbreak has subsided, and ▪ Recommending new or revised policies to handle similar events in the future. 20. Specific criteria will be used to help differentiate sporadic cases from true outbreaks or epidemics. 21. The medical staff will help the facility comply with pertinent state and local

Outbreak Management (continued)	regulations concerning the reporting and management of those with reportable communicable diseases. 22. Common outbreaks for: ▪ Respiratory pathogens (1) Influenza (2) Legionella species (3) Streptococcus pneumoniae (4) Parainfluenza (5) RSV ▪ Gastrointestinal pathogens (1) Norovirus (2) Clostridium difficile (3) Salmonella ▪ Group A Streptococcus ▪ Multi-drug resistant organisms ▪ Viral conjunctivitis ▪ Skin infestations ▪ COVID-19
Prevention of Infection	23. Important facets of infection prevention include: ▪ identifying possible infections or potential complications of existing infections, ▪ instituting measures to avoid complications or dissemination,

Immunization	▪ educating staff and ensuring that they adhere to proper techniques and procedures, ▪ enhancing screening for possible significantpathogens, ▪ immunizing residents and staff to try to prevent illness, ▪ implementing appropriate isolation precautions when necessary, and ▪ following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). 24. Immunization is a form of primary prevention. 25. Widespread use of influenza vaccine in the nursing facility is strongly encouraged. 26. Policies and procedures for immunization include the following: ▪ The process for administering the vaccines, ▪ Who should be vaccinated, ▪ Contraindications to vaccination, ▪ Potential facility liability and release from liability, ▪ Obtaining direct and proxy consent, and how often, ▪ Monitoring for side effects of vaccination, and ▪ Availability of the vaccine, and who pays for it.
Monitoring Employee Health and Safety	27. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers, including: ▪ Situations when these individuals should report their infections or avoid the facility (for example, draining skin wounds, active respiratory infections with considerable coughing and sneezing, or frequent diarrheal stools), ▪ Pre-employment screening for infections required by law or regulation (such as TB), ▪ Any limitations (such as visiting restrictions) when there are infectious out breaks in the facility, and

	▪ Precautions to prevent these individuals from contracting infections such as hepatitis and the HIV virus from residents or others. 28. Testing for medical conditions is done in compliance with other laws (such as the Americans with Disabilities Act), and regulations protecting individual confidentiality and/or prohibiting discrimination against those with certain disabilities or conditions. 29. Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment. ▪ The facility provides personal protective equipment, checks for its proper use, and provides appropriate means for needle disposal. ▪ 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.
Resident Care Practices	30. Policies and Procedures and review of resident care practices by staff to identify whether staff implementation and compliance with IPCP policies and procedures for:

Monitoring Employees	▪ Hand hygiene, ▪ Personal protective equipment (PPE), ▪ Infection safety, ▪ Point of care testing, ▪ Dialysis care, ▪ Use of transmission-based precautions, ▪ Catheter care, ▪ Incontinence care, ▪ G-tube care, ▪ Handling linen, ▪ Managing blood-borne pathogens, ▪ Wound/skin care, ▪ Respiratory care, ▪ Cleaning and disinfection, ▪ Medication administration/glucose blood testing (fingerstick), ▪ Any other clinical procedure involving resident care. 31. Monitor employees for: ▪ Environmental Cleaning/Disinfection (1) Routine cleaning (2) Disinfection of high-touch surfaces (3) Disinfection at time of discharge (4) Privacy curtain cleaning (5) Cleaning/disinfection of resident care equipment ▪ Occupational Health (1) Reporting staff illness (2) Work restrictions (3) Prohibiting contact with resident or food if have potentially communicable disease or infected skin lesion (4) Assessing TB risks (5) Monitoring and evaluating for clusters or outbreaks of staff illness (6) Exposure control plan

Policy and Procedure Implementations	32. Reviewed and approved ▪ Initial, annual and with changes 33. Facility will ensure accessibility to staff 34. Provide education and training including: ▪ Job specific ▪ On-hire, annual and when changes in P&P 35. Conduct performance monitoring and providing feedback.

System for Identifying and Recording Infections	36. The facility will implement system for recording incidents identified under IPCP and correcti based on investigation of incidents. Should include: ▪ Defining, identifying, analyzing and reporting incidents related to failures in infection cor the DON, Medical Director and the QAA Committee, ▪ Identification of methods by which you would obtain information on incidents from resid direct care/direct access staff, and ▪ A description of how you address and investigate the incident(s). 37. Data collection tool. 38. Nationally-recognized surveillance criteria: ▪ NHSN Long-term care criteria: https://www.cdc.gov/nhsn/ltc/index.html ▪ Facility SBARs based on McGeer criteria 39. Document follow-up activity in response to surveillance findings. 40. System for early detection and management of potentially infectious resident at time of admis 41. Communicating infection information at time or transfer. 42. Establish process and outcome surveillance.
Transmission Based Precaution	43. Will use when: ▪ Resident develops signs and symptoms of transmissible infection, and ▪ Arrives at facility with symptoms of an infection (pending lab confirmation). 44. Has laboratory confirmed infection and is at risk of transmitting it to others. 45. Policies identify the type and duration of precautions required and should be least restrictive on clinical situation and used for least amount of time. CDC Guidelines for current recommendations on standard and transmission-base http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html.
Outcome Surveillance	46. Outcome surveillance will be monitored by the facility the criteria that staff will use to ide evidence of a suspected or confirmed infection; and collecting/documenting data on individua and comparing the collected data to standard written definitions (criteria) of infections. Infections → Pathogens ▪ Pneumonia → Influenza ▪ Wound infections → Norovirus ▪ Urinary tract infections → C-difficile ▪ Gastroenteritis → Scabies → MDRO

	47. Facility will be monitored for: ▪ Comprehensive surveillance which is facility-wide and will track every infection event among entire resident population, and

	▪ Targeted surveillance which focuses activities on high-risk or high-consequence infections or pathogens based on their preventability and impact on resident population.
Recording Infections	48. The facility will record infections based on policies and procedures for system of surveillance and data to be collected by SBAR criteria and antibiotic stewardship program for infection site, pathogen, signs and symptoms, resident location and summary analysis of number of residents who develop infection; staff observations; identification of unusual outcomes, trends and patterns; and how the data will be communicated/shared. This will be presented to the Infection Prevention and Control Committee monthly. 49. Data collection tools are as follows: ▪ CDC's National Healthcare Safety Network (NHSN) https://www.cdc.gov./nhsn/ltc/index.html ▪ Electronic software resources ▪ Epi https://www.cdc.gov/epiinfo/index.html
Staff Education	50. Staff education includes: ▪ Triggers that will prompt notification of IP about possible infection event, ▪ Signs, symptoms and exam findings that should be assessed and documented when a resident is suspected of having an infection, ▪ Data sources to review, ▪ Data collection tools to complete and how to complete, ▪ Criteria to determine whether surveillance definition met, ▪ How, where and when performance monitoring should be performed, ▪ Which staff to target for performance monitoring, and ▪ IPC practices that must be performed for practice to be considered complaint.
Antibiotic Stewardship Program Overview	51. Our Antibiotic Stewardship Program promotes appropriate use of antibiotics, includes a system of monitoring to improve outcomes and reduce antibiotic resistance (ensuring antibiotics are prescribed for correct indication, dose and duration to appropriately treat resident) and includes the development of protocols and a system to monitor antibiotic use. 52. Antibiotic Stewardship protocols include: ▪ Reports related to monitoring antibiotic usage and resistance data, ▪ Monitoring of antibiotic use, ▪ Frequency and mode or mechanism of feedback to prescribing practitioners regarding antibiotic resistance data, their antibiotic use and their compliance with facility antibiotic use protocols, ▪ Standardized tools and criteria for assessing for infections, and ▪ Modes and frequency of education on facility's antibiotic stewardship program and protocols.
IPC Risk Assessment Review	53. IPCP and its standards, policies and procedures will be reviewed annually to ensure effectiveness and that they are in accordance with current standards of practice. Facility assessment may identify components of IPCP that need updated related to changes in population or facility characteristic. 54. IPC Risk Assessment will be completed annually and be used to:

	▪ Evaluate population and services provided to identify potential infection hazards, ▪ Set IPC program priorities and goals, ▪ Review and update policies, procedures and activities, and ▪ Determine IPC resources needed.
IPC Risk Assessment Team	55. The Risk Assessment Team will include the following: ▪ Infection Prevention and Control Officer (IPCO) ▪ Employee Health Nurse ▪ Medical Director or other Clinician ▪ Nursing Staff ▪ Laboratory ▪ Pharmacy ▪ Therapy ▪ Housekeeping ▪ Maintenance ▪ Administration ▪ Dietary ▪ Activities ▪ QAPI Leader ▪ Admissions
Infection Prevention Plan	56. Our Infection Prevention plan will include: ▪ Priority – from Risk Assessment ▪ Goals – to address each priority - should include: (1) limiting unprotected exposure to pathogens (isolation precautions and PPE use), (2) limiting transmission related to procedures, (3) limiting transmission related to equipment, devices and supplies, and (4) improving hand hygiene compliance. ▪ Measurable objectives – to achieve each goal ▪ Strategies - to achieve each objective ▪ Evaluation method – for each objective ▪ Current status/evaluation/next steps – how are we doing?
QAPI	57. Infection Prevention and Control CE Pathway (CMS-20054) will be utilized to evaluate effectiveness of IPCP (see attached). 58. IP involvement in QAPI will include: ▪ Element 1 Design and Scope – evaluating effectiveness of the IPC program

	▪ Element 2 Governance and Leadership (1) Ensuring adequate resources exist to support IPC program activities. (2) Creating a facility culture where staff feel comfortable identifying IPC concerns and opportunities for improvement. ▪ Element 3 Feedback, Data Systems and Monitoring (1) Reviewing surveillance data to identify infections. (2) Monitoring adherence to IPC practices and Infection Prevention, Control and Immunization Critical Element Pathway. ▪ Element 4 Performance Improvement Projects – conducting focused activities to examine and address IPC incidents

QAPI Process Examples	▪ Element 5 Systematic Analysis and Systematic Action (1) Conducting root cause analysis pf IPC incidents. (2) Implementing sustainable practice changes. 59. QAA Committee IPC responsibilities are the following: ▪ Provide input into development of annual facility IPC risk assessment, ▪ Review and approval of IPC policy and procedures, ▪ Review IPC surveillance data, and ▪ Resource to IP in developing plans of action to examine and correct IPC incidents. 1. IPC rounding on unit and noted nurse aide caring for resident on Contact Precautions without wearing a gown, Nurse aide stated that she was not wearing gown because there were no gowns available on isolation cart outside the room or on unit. ▪ IP asked various staff members about availability of gowns on unit and found they were frequently unavailable despite repeated requests to unit manager. 2. Conducted monitoring of accessibility of PPE supplies near resident room for all residents on Contact Precautions for next 2 days, which revealed inadequate supply of gowns. ▪ Convened a PIP team of key people impacted by the shortage of PPE and involved in the process of maintaining inventory. ▪ Conducted a facilitated RCA with the team, which identified: (1) There is no designated party responsible for checking and stocking PPE supplies in isolation carts or resident care locations. (2) There is no designated schedule to check PPE levels on the unit. (3) There are no established minimum levels for PPE supplies in designated locations on the unit. (4) Central supply is the only place where extra PPE supplies are available. 3. IP Response/Actions ▪ PIP team developed list of potential solutions for the PPE supply issue. ▪ Team proposed a PPE supply procedure to establish minimum supply levels.

	▪ Created supply checklist to place on all isolation carts and PPE storage areas on units. ▪ Created process for staff to check and refill PPE supply levels each shift. ▪ Identified clean storage on each unit to keep back-up supplies. ▪ Educated unit staff to inform them of the new PPE supply procedure and create a rotation to inform them of the new PPE supply procedure. ▪ Developed a PPE supply monitoring process to ensure the new procedure was working. 4. QAA Committee Involvement ▪ IP presented initial concern, findings from investigation and RCA and proposed action plan at QAA Committee meeting. ▪ IP recommended monitoring new process monthly by reviewing the supply checklists. ▪ QAA Committee supported the proposed actions and advised monthly monitoring of the changes for three (3) months, followed by quarterly review for the rest of the year.

References	
OBRA Regulatory Reference Numbers	§483.80 Infection Control
Survey Tag Numbers	F880
Other References	
Related Documents	Antibiotic Stewardship Policies Infection Prevention and Control Committee Infection Preventionist Policies and Practices – Infection Control
Version	1.0 (H5MAPL1445)

Sapphire Nursing at Wappingers			
Addendum 5		Policy #	
Issue Date: 11/01/2017	Revision Date: 04/01/2020	Review Date: Annual	Prepared by: Corporate DON – Cindy van Voorst RN
Policy Subject: **HANDWASHING/HAND HYGIENE**			
Approved by: Administrator, Medical Director, Director of Nursing, QAA Committee			Page 1 of 3

Highlights	Policy Interpretation and Implementation
	This facility considers hand hygiene the primary means to prevent the spread of infections.
Hand Hygiene Training	6. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 7. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 8. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. 9. Triclosan-containing soaps will not be used.
Hand Hygiene Products	10. Residents, family members and/or visitors will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets and/or other written materials provided at the time of admission and/or posted throughout the facility. 11. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: ▪ when hands are visibly soiled, and ▪ after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, *salmonella*, *shigella* and *C. difficile*.
Indication of Soap and Water	12. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ▪ before and after coming on duty, ▪ before and after direct contact with residents, ▪ when performing standard and transmission-based precautions, ▪ before and after touching contaminated PPE (e.g. face masks), ▪ before preparing or handling medications, ▪ before performing any non-surgical invasive procedures, ▪ before and after handling an invasive device (e.g., urinary catheters, IV access sites), ▪ before donning sterile gloves, ▪ before handling clean or soiled dressings, gauze pads, etc., ▪ before moving from a contaminated body site to a clean body site during resident care,

Indication of Alcohol-based Hand Rub	▪ after contact with a resident's intact skin, ▪ after contact with blood or bodily fluids, ▪ after handling used dressings, contaminated equipment, etc., ▪ after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, ▪ after removing gloves, ▪ before and after entering isolation precaution settings,

Hand Hygiene After PPE	▪ before and after eating or handling food, ▪ before and after assisting a resident with meals, and ▪ after personal use of the toilet or conducting your personal hygiene. 13. Hand hygiene is the final step after removing and disposing of personal protective equipment. 14. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.
Single-Use Disposable Gloves	15. Single-use disposable gloves should be used: ▪ before aseptic procedures, ▪ when anticipating contact with blood or body fluids, and ▪ when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. 16. Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities, and is prohibited among those caring for severely ill or immunocompromised residents. The Infection Preventionist maintains the right to request the removal of artificial fingernails at any time if he/she determines that they present an unusual infection control risk.
Prohibiting Artificial Fingernails	17. The following equipment and supplies are necessary for hand hygiene: ▪ alcohol-based hand rub containing at least 62% alcohol, ▪ running water, ▪ soap (liquid or bar; anti-microbial or non-antimicrobial), ▪ paper towels, ▪ trash can, ▪ lotion, and ▪ non-sterile gloves.
Equipment and Supplies	18. Washing Hands ▪ Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. Hot water is unnecessarily rough on hands. ▪ Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink.

Procedure: Handwashing Alcohol-Based Hand Rub Applying and Removing Gloves	▪ Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. ▪ Discard towels into trash. ▪ Use lotions throughout the day to protect the integrity of the skin. 19. Using Alcohol-Based Hand Rubs ▪ Apply generous amount of product to palm of hand and rub hands together. ▪ Cover all surfaces of hands and fingers until hands are dry. ▪ Follow manufacturers' directions for volume of product to use. 20. Applying and Removing Gloves ▪ Perform hand hygiene before applying non-sterile gloves. ▪ When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff.

	▪ When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. ▪ Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. ▪ Perform hand hygiene.

Attachments:

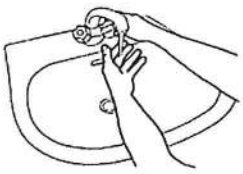
How to Handwash; How to Handrub

References	
OBRA Regulatory Reference Numbers	§483.80 (a) Infection Prevention and Control Program
Survey Tag Numbers	F880
Other References	SHEA/ISDA Practice Recommendation. Strategies to Prevent Healthcare-Associated Infections through Hand Hygiene (August 2014) *Infection Control and Hospital Epidemiology* 35 (8): 937-60. World Health Organization. WHO Guidelines on Hand Hygiene in Health Care (2009) CDC Guideline for Hand Hygiene in Health-Care Settings (2002). *Morbidity and Mortality Week Report* (https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf)
Related Documents	Standard Precautions
Version	2.2 (H5MAPL0362)

How to Handwash?

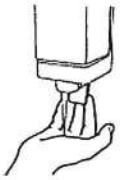
Duration of the entire procedure: 40-60 seconds

0



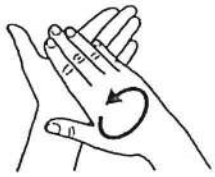
Wet hands with water;

1



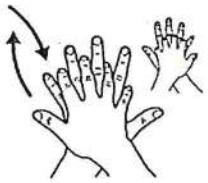
Apply enough soap to cover all hand surfaces;

2



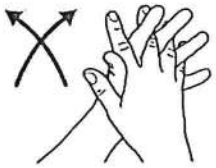
Rub hands palm to palm;

3



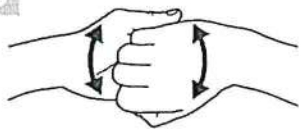
Right palm over left dorsum with interlaced fingers and vice versa;

4



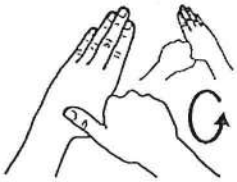
Palm to palm with fingers interlaced;

5



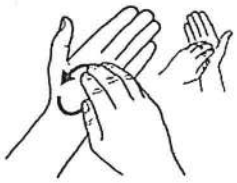
Backs of fingers to opposing palms with fingers interlocked;

6



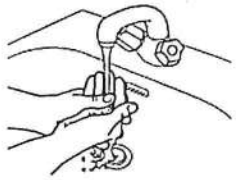
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

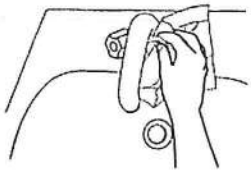


Rinse hands with water;

9

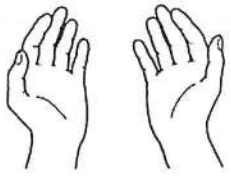
Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.

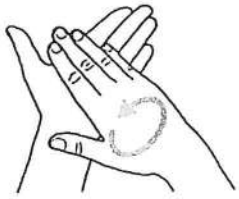
How to Handrub?

Duration of the entire procedure: 20-30 seconds

1

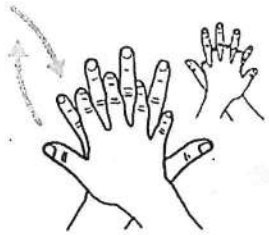
Apply a palmful of the product in a cupped hand, covering all surfaces;

2



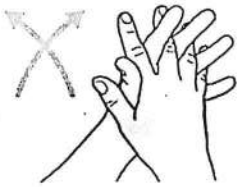
Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4

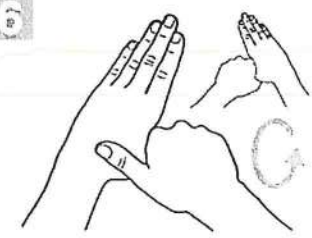


Palm to palm with fingers interlaced;

5

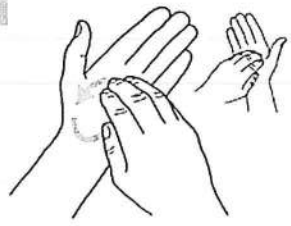
Backs of fingers to opposing palms with fingers interlocked;

6



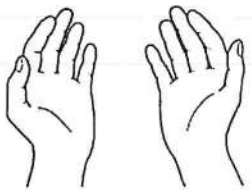
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



Once dry, your hands are safe.

World Health Organization | Patient Safety | SAVE LIVES Clean Your Hands

Sapphire Nursing at Wappingers			
Addendum 6		Policy #	
Issue Date: 11/01/2017	Revision Date: 04/15/2020	Review Date: Annual	Prepared by: Corporate DON – Cindy van Voorst RN
Policy Subject: USING PERSONAL PROTECTIVE EQUIPMENT (PPE)			
Approved by: Administrator, Medical Director, Director of Nursing, QAA Committee			Page 1 of 3

Highlights	Policy Interpretation and Implementation
	This facility will provide to its employees' personal protective equipment (PPE) appropriate to specific requirements of each task performed by our employees and is available.
Tasks that Require Exposure to Blood, Body Fluids	Employees required to perform tasks that may involve the exposure to blood, body fluids, or other infectious materials will be provided with the appropriate protective clothing and equipment (PPE) at no charge.
Criteria on Choosing the Type of PPE	All resident care tasks and procedures do not involve the same type or degree of risk, and therefore all tasks will not require the same kind or extent of protection. PPE will be utilized as required for standard precautions and transmission-based precautions including contact, droplet and airborne isolation (see related policies). The type of protective clothing and equipment is based on: ▪ the type of transmission-based precaution, ▪ the fluid or tissue to which there is a potential exposure including aerosol-generating procedures, ▪ the likelihood of exposure occurring, ▪ the potential volume of material, ▪ the probable route of exposure, and ▪ the overall working conditions and job requirements.
PPE Storage	Protective clothing and equipment provided to our employees include but are not limited to: ▪ gowns, aprons, lab coats (disposable, cloth, and/or plastic),

	▪ gloves (sterile, non-sterile, heavy-duty, and/or puncture-resistant), ▪ masks (surgical/procedural facemasks, N-95 filtering facepiece respirators, or NIOSH approved particulate filtering facepiece respirators), ▪ eyewear (googles or face shields), and ▪ disposable hairnet/foot covering. A supply of protective clothing and equipment required for standard precautions and transmission-based precautions is maintained inside and outside resident's room. Additional locations include: ▪ facility entrance, ▪ quarantine unit entrance, ▪ nurses' stations, ▪ treatment rooms, ▪ central supply rooms, ▪ crash carts, ▪ therapy and activity rooms, ▪ resident dining rooms.

Staff Education	Training on proper donning/doffing including use and disposal of PPE is provided during general orientation, annually and at regular intervals as required for communicable disease.
Area where to Remove Soiled PPE	The HCP will use PPE appropriately per facility policy, including gloves, gowns/aprons, facemasks, NIOSH N95 respirator or equivalent, goggles/face shields, hairnet and booties. Personal protective equipment will be worn during resident care procedures that may involve contact with the resident and/or the resident's environment. Soiled or contaminated personal protective clothing and equipment will be removed and discarded at the location where the soiling or contamination occurred e.g. before leaving resident room or quarantined unit.
Replacement of PPE	Personal protective clothing and equipment will be replaced as needed to maintain its effectiveness at no cost to employees. Protective clothing and equipment replacement will occur no less than weekly.

Investigation on Failure to Use PPE	Personal protective equipment use will be monitored by the Infection Control Preventionist/designee during routine infection control rounds. When low supply or deficient practice is identified, the Infection Control Preventionist will immediately re-educate employees on proper use and ensure supplies are re-ordered.
Conventional Capacity Strategies PPE	The facility will implement contingency and crisis capacity strategies when PPE is in short supply. These strategies include optimizing the supply of eye protection, isolation gowns, face masks, N-95 respirators and utilization of elastomeric respirators during surge-demand situations. (See policy and procedures entitled "*Coronavirus Disease 2019 COVID-19 Guidelines for Strategies to Optimize the Supply of PPE*").
PPE Burn Rate Calculator	The facility will use the PPE Burn Rate Calculator or alternative method to optimize the use of PPE and calculate average consumption rate to ensure adequate supplies are ordered and available.
Visitor and Resident Education	Visitors and residents who are asked to comply with transmission-based precautions will be educated on communicable disease information, proper use of PPE and handwashing. PPE and educational materials will be provided at no extra charge.
Inquiries	Inquiries concerning protective clothing and equipment should be referred to the Infection Control Preventionist.

Attachment:

- Sequence of PPE; Contact, Droplet, and Airborne Precautions

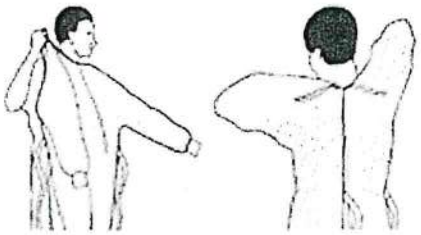
References	
OBRA Regulatory Reference Numbers	§483.80 (a) Infection Prevention and Control Program
Survey Tag Numbers	F880
Other References	CDC https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html Occupational Safety and Health Administration: www.osha.gov/SLTC/personalprotectiveequipment/index.html
Related Documents	Standard Precautions Isolation – Categories of Transmission-Based Precautions Isolation – Initiating Transmission-Based Precautions Sequence for Donning Personal Protective Equipment (PPE) – Poster
Version	2.0 (H5MAPL0619)

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

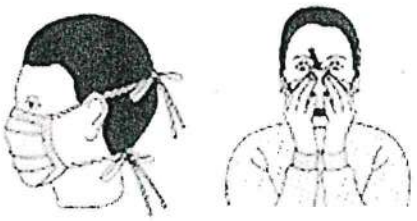
1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

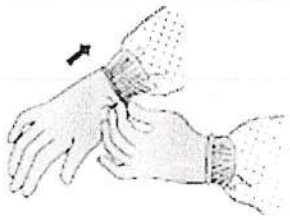


3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

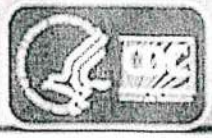
4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

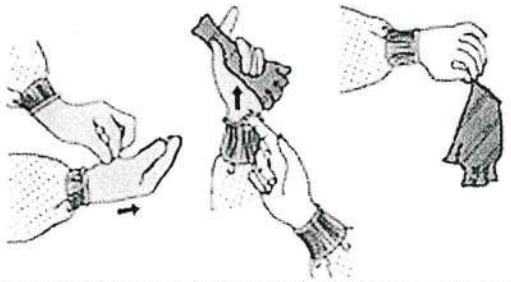


HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. Remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container

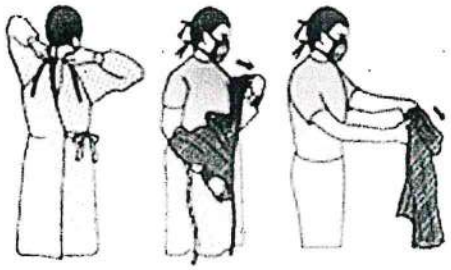


2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. GOWN

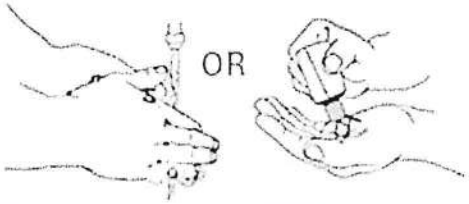
- **Gown front and sleeves are contaminated!**
- **If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer**
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container



4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room except a respirator, if worn.** Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container

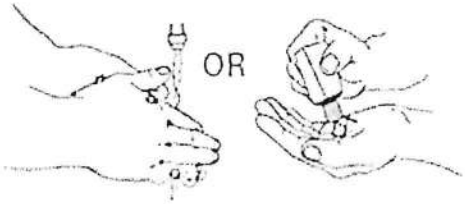
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- **If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer**
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

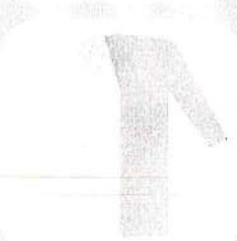
CONTACT PRECAUTIONS

EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

PROVIDERS AND STAFF MUST ALSO:

Put on gloves before room entry.
Discard gloves before room exit.



Put on gown before room entry.
Discard gown before room exit.

Do not wear the same gown and gloves for the care of more than one person.

Use dedicated or disposable equipment.
Clean and disinfect reusable equipment before use on another person.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS19-306M9-A

STOP

DROPLET PRECAUTIONS

STOP

EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

Make sure their eyes, nose and mouth are fully covered before room entry.

or

Remove face protection before room exit.

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Centers for Disease Control and Prevention

STOP

AIRBORNE PRECAUTIONS

STOP

EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

Put on a fit-tested N-95 or higher level respirator before room entry.

Remove respirator after exiting the room and closing the door.

Door to room must remain closed.

CDC

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS154056-A

Sapphire Nursing at wappingers	
Addendum 7	
Policy Date: 3/12/20	Prepared by: Corporate DON – Cindy van Voorst RN
Policy Subject: COMMUNAL ACTIVITIES DURING A PANDEMIC	
Approved by: Administrator, Medical Director, Director of Nursing, QAA Committee	Page 1 of 3

Highlights	Policy Interpretation and Implementation
	The facility will modify, restrict and/or cancel communal activities and dining services during a pandemic or communicable disease outbreaks during the emergency, in accordance with the recommendations or guidance of CDC, Local, State or Federal Health Agencies.
	Implementation of Avoidance of Large Groups
Communal Activities	**Communal Activities.** Any gathering for a mutually accomplished task or activity such as but not limited to, meal services in a group of ten individuals or less or an activity where social distancing principles are enacted for the purposes of the prevention of disease transmission (e.g. 6-feet distances between residents, and all residents will be required to wear cloth face covering at all times for universal source control and continue social distancing).
Social Distancing	**Social Distancing.** For the purposes of this policy, social distancing is the practice of remaining out of communal activities, avoiding religious service gatherings and maintaining physical distance to reduce the spread of disease per facility infection control policies and procedure related to disease requiring droplet and airborne precautions governed by CDC, State and Federal guidelines.
Notification	**Notification.**The facility will notify residents and their representatives of positive cases for any single case of a resident or employee testing positive for pandemic-related disease. Resident and representatives will receive ongoing updates including mitigating actions implemented in the facility to stop the spread of infection.
	Guidelines
Notification of Communicable Disease Outbreak	Upon recognition or announcement of a pandemic or communicable disease emergency necessitating the modification, restriction or cancellation or communal activities, including but not limited to communal dining services, the facility Infection Control Preventionist, facility Administrator and/or Director of Nursing (DON) will notify staff and residents of the communicable disease pandemic and the need to modify communal activities and practice social distancing and infection control policies and procedures (e.g. Influenza, COVID type illnesses).
Alternative Forms of Communication	Visitation will be restricted during outbreaks. Alternative forms of communication/electronic technology with the resident's family/representative such as Skype, Facetime, phone calls, face-to-face

	window viewing activities, will be utilized whenever applicable.
Universal Source Control	The facility will implement various best practices and develop innovative ways to keep residents connected to their families and community to meet the psychosocial needs of the residents, including emotional and physical well-being, self-determination, self-respect and dignity. To accommodate universal source control measures, all residents are required to wear a face cloth covering at all times when out of room and/or when activity programming is provided in their room.

Modifying Activities	Activities designed for life enrichment, such as but not limited to bingo, games, entertainment will be either be cancelled or where appropriate, modified in order to achieve proper social distancing and prevent the transmission of disease.
External or Contracted Entertainment	Activities requiring sharing of supplies for quiet games, crafts, puzzles will not be utilized during an outbreak. External or contracted entertainment will be cancelled whenever virtual entertainment is not feasible.
Activity Programming	Activity programming including ball bouncing, indoor bowling, ring toss, etc., will only be utilized if resident wears gloves, cloth face covering, frequent handwashing, and 6 feet distancing occurs. All infection control practices for cleaning and disinfecting activity room and supplies will be strictly enforced.
Adjusting Meal Services	The facility will adjust practices to ensure residents continue to receive nutritional support by adjusting meal services which may include: serving meals in the resident's room, providing supervised dining while preventing communal activities and adhering to 6-feet social distancing practices; in these instances, residents who meet the following criteria may be included in supervised meal services that are otherwise not communal, residents with swallowing problems or that are a choking hazard, behavioral problems that put themselves or others at risk if left unsupervised in a dining situation, and residents that require full assist with feeding, in supervised dining situations to minimize the risk of disease transmission, one staff member will be assigned to one resident and will not provide support to another resident until such time as the episode of care is complete and proper hand hygiene is performed. Staff will be encouraged to wear PPE where appropriate for the type of care being provided. All staff will wear a mask and utilize gloves when applicable, All residents that must be supervised in the dining room for choking and aspiration reasons will be required to wear a face cloth covering to and from the dining room.
Utilizing Internet Technologies	Activity programming with internet technologies will be utilized for individual and small group activities as recommended by the NYS DOH. See attached Recommendations to Support Resident Mental and Emotional Health
Adjusting	

Smoking Practices	resources. The facility will adjust practices for residents who smoke to avoid communal activities and promote proper social distancing. This may include: offering nicotine replacement when applicable, adjusting supervised smoking times to facilitate social distancing, in crisis situations, smoking privileges may be prohibited.
Personnel Responsible for Resuming Normal Communal Activities	All other communal activities not otherwise listed will be modified, restricted, or cancelled in keeping with the nature of the activity and the ability of the residents to maintain appropriate social distancing and infection control practices. Only the Administrator, the DON or Infection Control Preventionist may resume normal communal activities and only upon resolution of the emergency pandemic per the guidance of CDC, State and Federal government agencies.

Sapphire Nursing at Wappingers			
Addendum 8		Policy #	
Issue Date: 02/01/2017	Revision Date: 03/10/2020	Review Date: Annual	Prepared by: Corporate DON – Cindy van Voorst RN
Policy Subject: CLEANING AND DISINFECTION OF ENVIRONMENTAL SURFACES			
Approved by: Administrator, Medical Director, Director of Nursing, QAA Committee			Page 1 of 4

Highlights	Policy Interpretation and Implementation
	Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard.
Categories Distinguishing Levels of Sterilization/ Disinfection	1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care and those in the resident's environment: ▪ **Critical items** consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (e.g., urinary catheters) or the vascular system (e.g. intravenous catheters) are considered critical items and must be sterile. ▪ **Semi-critical items** consist of items that may come in contact with mucous membranes or non-intact skin (e.g. respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. (**Note:** Some items that may come in contact with non-intact skin for a brief period of time, e.g. hydrotherapy tanks, bed side rails, are usually considered non-critical surfaces and are disinfected with intermediate-level disinfectants.) ▪ **Non-critical items** are those that come in contact with intact skin but not mucous membranes. (1) Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors. (2) Most non-critical items can be decontaminated where they are used (as opposed to being transported to a central processing location).
Disinfection of Non-Critical Surfaces	2. Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions. ▪ Most EPA-registered hospital disinfectants have a label contact time of 10 minutes. ▪ By law, all applicable label instructions on EPA-registered products must be followed.
Disinfection of Devices	3. Devices that are used by staff but not in direct contact with residents (e.g. computer keyboards, PDAs, etc.) shall be cleaned and disinfected regularly (according to facility schedule) by the environmental services staff and as needed by the nursing staff.
Intermediate and Low-Level	4. Intermediate and low-level disinfectants for non-critical items include:

Disinfectants for Non-Critical Items	▪ ethyl or isopropyl alcohol, ▪ sodium hypochlorite (5.25-6.15% diluted 1:500 or per manufacturer's instructions), ▪ phenolic germicidal detergents, ▪ iodophor germicidal detergents, and ▪ Quaternary ammonium germicidal detergents (low-level disinfection only).

Manufacturer's Instructions	5. Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products including: ▪ recommended use-dilution, ▪ material compatibility, ▪ storage, ▪ shelf-life, and ▪ safe use and disposal.
EPA Registered Disinfectant for Resident Care Areas	6. A one-step process and an EPA-registered hospital disinfectant designed for housekeeping purposes will be used in resident care areas where: ▪ uncertainty exists about the nature of the soil on the surfaces (e.g. blood or body fluid contamination versus routine dust or dirt), or ▪ uncertainty exists about the presence of multidrug-resistant organisms on such surfaces.
	7. Detergent and water will be used for cleaning surfaces in non-resident care areas (e.g. administrative offices).
	8. High-level disinfectants/liquid chemical sterilant will not be used for disinfection of non-critical surfaces.
Housekeeping Surfaces	9. Housekeeping surfaces (e.g. floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.
Environmental Surfaces	10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g. daily, three times per week) and when surfaces are visibly soiled.
Walls, Blinds and Window Curtains	11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.
Preparation/ Replacement of Solutions	12. Disinfecting (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently (e.g. floor mopping solution will be replaced every three resident rooms, or changed no less often than at 60-minute intervals).
Decontamination of Mop Heads/Cleaning Cloths	13. Mop heads and cleaning cloths will be decontaminated regularly (e.g. laundered and dried at least daily).
Wet Dusting Horizontal Surfaces	14. Horizontal surfaces will be wet dusted regularly (e.g. daily, three times per week) using clean cloths moistened with an EPA-registered hospital disinfectant (or detergent). The disinfectant (or detergent) will be prepared as recommended by the manufacturer.
Blood Spills	15. Spills of blood and other potentially infectious materials (OPIM) will promptly be cleaned and decontaminated. Blood-contaminated items will be discarded in

Site Decontamination of Blood Spills or OPIM	compliance with federal regulations (e.g. OSHA Bloodborne Pathogens Standard). 16. The following procedures will be implemented for site decontamination of spills of blood or OPIM: ▪ Use protective gloves and other PPE (e.g. when sharps are involved use forceps to pick up sharps and discard these items in a puncture-resistant container) appropriate for this task, ▪ Disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent, a registered germicide on the EPA Lists D and E (e.g. products with specific label claims for HIV and HBV) or freshly diluted hypochlorite solution, ▪ If sodium hypochlorite solutions are selected use a 1:100 dilution to decontaminate nonporous surfaces after a small spill (e.g. <10 mL) of either blood or OPIM,

Appropriate PPE **Disinfecting Clostridium difficile Units** **Preparation and Storage of Chlorine Solutions** **Substitution for EPA-Registered Sodium Hypochlorite Product**	▪ If a spill involves large amounts (e.g. >10 mL) of blood or OPIM, or involves a culture spill in the laboratory, use a 1:10 dilution for the first application of hypochlorite solution before cleaning in order to reduce the risk of infection during the cleaning process in the event of a sharps injury, ▪ Follow this decontamination process with a terminal disinfection, using a 1:100 dilution of sodium hypochlorite. 17. If the spill contains large amounts of blood or body fluids, the visible matter will be cleaned with disposable absorbent material, and the contaminated materials discarded in an appropriate, labeled container. 18. Protective gloves and other, PPE appropriate for this task will be used. 19. In units with high rates of endemic *Clostridium difficile* infection or in an outbreak setting, dilute solutions of 5.25%–6.15% sodium hypochlorite (e.g. 1:10 dilution of household bleach) will be used for routine environmental disinfection. (**Note:** Currently, no products are EPA-registered specifically for inactivating *C. difficile* spores.) 20. If chlorine solution is not prepared fresh daily, it will be stored at room temperature for up to 30 days in a capped, opaque plastic bottle. (**Note:** A 50% reduction in chlorine concentration will occur by day 30.) 21. An EPA-registered sodium hypochlorite product is preferred, but if such products are not available, generic versions of sodium hypochlorite solutions (e.g. household chlorine bleach) may be used. Refer to policy and procedure entitled "*CDC COVID-19 Guidance for Cleaning and Disinfection*".

References	
OBRA Regulatory	§483.80 (a); §483.70 (b)

Reference Numbers	
Survey Tag Numbers	F836; F880
Other References	See also OSHA's Bloodborne Pathogens Standard and Enforcement Standards at www.osha.gov CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008 at http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov2008.pdf For Lists of Selected EPA-Registered Disinfectants see http://www.epa.gov/oppad001/chemregindex.htm
Related Documents	Cleaning and Disinfecting Resident's Rooms Cleaning and Disinfection of Resident-Care Items and Equipment
Version	1.1 (H5MAPL1198)