ARISTACARE
@MEADOW SPRINGS

Infection Control				
POLICY:	**Outbreak Plan**		**POLICY NO:**	
DEPT:	Administrative and Clinical Operations	**X New**	**Created:** **Revision:**	01-06-2021 03-22-2021 05-13-2021 05-19-2021 10-6-2021 11-5-21 11-12-21 1-17-22 03-01-2022

Policy Statement:

Outbreaks of Communicable diseases within the facility will be promptly identified and responded appropriately to decrease the risk of transmission to residents and staff which has a potential to pose a significant public health threat and danger of infection to the residents, resident representatives, and staff of the facility.

As required by Pennsylvania Department of Health, the facility's outbreak response plan is built to fit to the facility's needs. It is based upon national standards and developed in consultation with the facility's infection control committee. The facility's plan includes but shall not be limited to:

1. A protocol for isolating and cohorting infected and at-risk residents in the event of an outbreak of a contagious disease until the cessation of the outbreak.
2. Policies for the notification of residents, residents' families, guardians, visitors, and staff in the event of an outbreak of a contagious disease at a facility.
3. Information on the availability of laboratory testing, protocols for assessing whether facility visitors are ill, protocols to require ill staff to not present at the facility for work duties, and processes for implementing evidence-based outbreak response measures.
4. Policies to conduct routine monitoring of residents and staff to quickly identify signs of a communicable disease that could develop into an outbreak; and
5. Policies for reporting outbreaks to public health officials in accordance with applicable laws and regulations.

Outbreak- is defined as any unusual occurrence of disease or any disease above background or endemic levels.

Endemic Level- means the usual level of given disease in a geographic area.
Pandemic - A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.
Emerging Infectious disease -- Infectious diseases whose incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging." These diseases, which respect no national boundaries, include:

- New infections resulting from changes or evolution of existing organisms

- Known infections spreading to new geographic areas or populations
- Previously unrecognized infections appearing in areas undergoing ecologic transformation
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

Isolation – Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease. Cohorting- means the practice of grouping patients who are or are not colonized or infected with the same organism to confine their care to one area and prevent contact with other patients. Quarantine – Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been exposed to prevent the spread of the disease.

Outbreak Phases:

A. Pre-outbreak phase:

The facility's Infection Control Preventionist (ICP) will be vigilant and stay informed about infectious diseases around the world and will update the Outbreak Plan as needed as new communicable diseases develop.

- The Outbreak Plan will be maintained in the Emergency Disaster Plan and Infection Prevention and Control Manual.
- The facility's Infection Control Committee (ICC) will serve as the authority for outbreak preparedness and response. The ICC comprises of the Medical Director, Infection Control Preventionist, Administrator, Director of Nursing, Director of Environmental Services, and Human Resources
- The facility will maintain adequate emergency stockpile of personal protective equipment (PPE) including moisture-barrier gowns, face shields, surgical masks, assorted sizes of disposable N95 respirators, and gloves; essential cleaning and disinfection supplies so that staff, residents and visitors can adhere to recommended infection prevention and control practices.
- Addressing Engineering controls in coordination with the facility administrator for any appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state, and federal public health authorities.

B. Outbreak Heightened Alert Phase:

- This phase begins when a confirmed case of communicable disease is detected in the community.
- The Infection Control Preventionist will keep administrative leadership briefed as needed on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism, or other circumstances.
- Assess the facility stock pile of PPE, necessary supplies and equipment and review staffing contingency plans.
- Assess the availability of vaccines, antiviral medications, and other essential medications from the pharmacy, DHS, as well as state stockpile.
- Identify crucial gaps in infrastructure, resources and policies that may interfere with an effective response. Action will be taken to resolve.

- Staff will be educated on the exposure risks, symptoms, and prevention of the infectious disease, with special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation, and other infection prevention such as hand washing.
- Provide residents and families with education about the disease and the facility's response strategy at a level appropriate to their interests and need for information.
- Brief vendors/contractors on the facility's policies and procedures related to minimizing exposure risks to residents
- Establish a command center using the Infection Control Preventionist as coordinator. The Infection Control Preventionist will maintain frequent contact with the Administrator, the Medical Director and Director of Nursing.
- The administrator and or the Director of Nursing will hold a Staff Meeting to alleviate fear and answer staff concerns.
- Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of the facility along with the instruction that anyone who is sick must not enter the building.
- Alert the Food Service Department to assess the need to stockpile food and water.
- Review environmental cleaning procedures and frequency such as terminal disinfection, high touch areas, equipment, common areas and other.
- Staff that are exhibiting signs and symptoms of communicable disease, will be tested, and sent home. They will follow self-isolation and return to work protocol.
- Inform each department to review staffing contingency plans for any anticipated absenteeism and illness.
- The Infection Control Preventionist will initiate/maintain Line Listing as a mechanism to track specific infectious disease and symptoms in residents and employee illness related absenteeism increases that might indicate early cases of outbreak
- Identify and Screen residents, staffs and visitors, based on the outbreak identified.
- Isolate and or cohort residents with signs and symptoms of infectious disease following the facility's isolation/cohort plans and in accordance to PADOH and CDC guidance.
- Screening and or Diagnostic Testing will be done as warranted to identify specific infectious disease.
- The Social Service Department will reach out to local Funeral establishments to establish contact and procedures in coordination with the Infection Control Preventionist.

Screening Protocol:

A. Staff Self Screening -Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include:
    - Reporting any suspected exposure to the Infectious Disease while off duty to their supervisor and Infection Control Preventionist.
    - Precautionary removal of employees who report an actual or suspected exposure to the infectious disease.
    - Self-screening for symptoms prior to reporting to work.
    - Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws.
    - Will communicate with the Infection Preventionist nurse and or the Director of Nursing for clearance to return to work.

- Facility shall screen and log HCP and everyone entering the facility for symptoms of the infectious disease.

Screening will include:

See below under visitors.

B. Residents and Visitors – Identify and Screen residents, staff and visitors, based on the outbreak identified.

Residents:

- Facility will conduct active screening of all residents:

- Nursing Staff will monitor residents minimum of daily for symptoms of infectious disease including monitoring of temperature and oxygen saturation.
- Specific symptoms of infectious diseases will be identified and all residents will be monitored for these symptoms, as well as history of travel in affected geographic areas listed by the State DOH of the date of the visit within 14 days of onset, (or if otherwise specified by CDC).
- Resident will be monitored for signs and symptoms related to the infectious disease for those having confirmed close contact with someone that was infected.

Visitors:

- Facility will conduct active screening of **all** visitors **EXCEPT** EMS personnel
    - These services can continue with a policy for services to be rendered in a safe manner to include but not limited to infection control and precautions, physical distancing, hand hygiene, cleaning between clients for the barber/hair stylist and the use of well fitting source control.
    - The facility will advise everyone who enters the building to monitor for signs and symptoms of COVID 19 for at least 14 days after exiting the facility and if symptoms to self isolate at home and call us immediately to alert the ICP/Administrator immediately as to when they were in the building last and whom they visited with and where they visited. The facility will screen the individual/s who are a reported contacts and implement necessary actions based on the findings.
    - The facility MUST receive written, informed consent from visitors that they are aware of the possible dangers of exposure to COVID 19 for both the resident and the visitor, and that they will follow the visitation rules set by the facility.
        - A copy of the consent form must be provided to visitors confirming that they are aware of the risk of exposure to COVID 19 during the visit. than 100.4 degrees Fahrenheit or as further restricted by the facility.
    - Visitors MUST strictly comply with the policies of visitation.
    - Visitors MUST notify the facility upon receipt of a positive COVID 19 test result or exhibiting symptoms of COVID 19 that develop within 14 days of the visit.
    - The facility will have a designated area for visitors to log in and be screened.

Screening Protocol to consist of a completion of a questionnaire about symptoms and potential exposure which shall include at a minimum:

- Whether in the last 14 days, the visitor has had an identified exposure to someone with a confirmed diagnosis of COVID 19, someone under investigation for COVID 19, or someone with respiratory symptoms.
- Whether the visitor has been diagnosed with COVID 19 and has not yet met criteria for the discontinuation of isolation per guidance issued by DOH and CDC.
- Whether the visitor is experiencing;
  - Fever
  - Chills
  - Cough
  - Shortness of Breath or difficulty breathing
  - Sore Throat
  - Fatigue
  - Muscle or body aches
  - Headache
  - New loss of taste or smell
  - Congestion or runny nose
  - Nausea or Vomiting
  - Diarrhea
- You cannot mandate testing of visitors but it may be offered upon entrance prior to visitation

C. Source Control

- Universal Masking for all staffs, and visitors will be required when entering the facility as directed by the ICP.
- All staffs and visitors will maintain social distancing, six feet apart while at the facility unless the resident is fully vaccinated and choses close contact with or without mask wearing
- Visitors are encouraged to perform hand hygiene prior to visiting and will observe respiratory etiquette protocols.
- Staff will wear N95 respirators and eye protection (goggles/face shields) when in resident areas.

D. Outbreak Phase:

This phase begins when there is a confirmed case of communicable disease in the facility following the outbreak definition in accordance to DOH guidance.

- The Infection Control Preventionist (ICP) will direct the facility's planning and response efforts and is responsible for surveillance and is constant contact with the local and State Department of Health and notification of cases in accordance to mandated DOH, CDC reporting for communicable diseases.
  a. During the infectious disease outbreak, mechanisms for monitoring employee absenteeism for increases that might indicate early cases of outbreak will be utilized.
  b. Line listings will be utilized/maintained as mechanisms for tracking facility admissions and discharges of suspected or laboratory-confirmed cases of the

specific infectious disease outbreak in residents to support local public health personnel in monitoring the progress and impact of the outbreak

c. Assess bed capacity and staffing needs, and detect a resurgence in cases that might follow the first wave of cases
d. Update information on the types of data that should be reported to the state agency and/or local health departments (e.g., admission; discharges/deaths; resident characteristics such as age, underlying disease, and secondary complications;
e. Monitor illnesses in healthcare personnel and plans for how this data will be collected during an outbreak
f. Establishes criteria for distinguishing the type of outbreak from other respiratory diseases.

- The Infection Control Committee (ICC) will work with the ICP and assist with decision-making during an outbreak.
- Adhere to Standard and Transmission-based Precautions including use of a facemask, gown, gloves, and eye protection for confirmed and suspected case(s).
- Facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic individuals with COVID-19 incubation or infection. Community transmission levels can be assessed by referring to the DOH COVID-19 Activity Level. Universal eye protection in addition to source control and other infection prevention and control measures, should be instituted to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions, for all HCP and for all individuals who are unable to maintain social distancing.
- Provide all assigned staff additional training and supervision in the mode of transmission of this ID, and the use of the appropriate PPE.
- Assign dedicated staff to enter the room of the isolated person as feasible. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared for will enter the isolation room.)
- Implement the isolation protocol in the facility (isolation rooms, cohorting) as described in the facility's infection prevention and control plan and/or recommended by local, state, or federal public health authorities.
- Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.
- Administer available vaccines and antivirals according to priority group
- If mortality becomes an issue, facility will contact family pre-arranged Funeral homes

COHORTING: The facility will cohort residents as follows and as directed by DOH and CDC:

- Cohort 1 –Positive for Infectious disease outbreak. (COVID 19)

- This cohort consists of both symptomatic and asymptomatic patients/residents who test positive for COVID-19, regardless of vaccination status, including any new or re-admitted patients/residents known to be positive who have not met the criteria for discontinuation of Transmission-Based Precautions. If feasible, care for COVID-19 positive patients/residents on a separate closed unit. Patients/residents who test positive for COVID-19 are known to shed virus, regardless of symptoms; therefore, all positive patients/residents would be placed in this positive cohort.

- Cohort 2 – Unvaccinated, Exposed:

- This cohort consists of symptomatic and asymptomatic patients/residents who test negative for COVID-19 with an identified exposure (i.e., close contact) to someone who was positive. This includes new or re-admitted patients/residents who have tested negative and have been identified as a close contact in the past 14 days. Exposed individuals should be quarantined for 14 days from last exposure, regardless of negative test results or vaccination status. All symptomatic patients/residents in this cohort should be evaluated for causes of their symptoms. Patients/residents who test negative for COVID-19 could be incubating and later test positive. To the best of their ability, facilities should separate symptomatic and asymptomatic patients/residents, ideally having symptomatic housed in private rooms. Even though symptomatic COVID-19 negative patients/residents might not be a threat to transmit COVID-19, they still may have another illness, such as influenza. Asymptomatic patients/residents should be closely monitored for symptom development. Unvaccinated Patients/residents who are identified as close contacts should be quarantined for 14 days and have a series of two viral tests. In these situations, testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure. If testing is negative, the patient/resident should be tested again 5-7 days after exposure. If testing remains negative, patients/residents should complete the remainder of their 14-day quarantine period. Testing at the end of this period could be considered to increase certainty that the person is not infected.
- Fully vaccinated patients/residents identified as close contacts* should continue to follow the Centers for Disease Control and Prevention (CDC) infection prevention and control measures, including wearing well-fitting source control, getting tested as described above, and monitoring for symptoms for 14 days after exposure.

- Cohort 3 – Negative, Not Exposed:

- This cohort consists of patients/residents who test negative for COVID-19 with no COVID-19 like symptoms and are thought to have no known exposures. **This cohort includes all individuals who have clinically recovered from SARS-CoV-2 within 90 days of symptom onset or positive test, and all fully vaccinated individuals who have not been in close contact with a suspected or known COVID-19 case**. The index of suspicion for an exposure should be low, as COVID-19 has been seen to rapidly spread throughout the postacute care setting. In situations of widespread COVID-19 transmission in a facility, all negative persons in a facility would be considered exposed. **Cohort 3 should only be created when the facility is relatively certain that patients/residents have been properly isolated from all COVID-19 positive and incubating patients/residents and HCP**. Given facility-wide transmission levels, Cohort 3 may or may not be applicable.

- Cohort 4 – New or Re-admissions observation:
- Unvaccinated, new or readmission observation: These individuals consist of all unvaccinated new patients/residents from the community or other healthcare facilities and unvaccinated re-admitted patients/residents who left the facility for ≥24 hours. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be clinically compatible with COVID-19. Residents will be tested upon admission and on day 6. . In most circumstances, quarantine is not recommended for unvaccinated patients/residents who leave the facility for <24 hours and do not have close contact with a suspected or known COVID-19 positive person.
- *EXCEPTIONS TO CONSIDER:
    - Individuals who remain asymptomatic have met the criteria for discontinuation of transmission-based precautions for SARS-CoV-2

infection, and it has been <3 months after the date of symptom onset or positive viral test (for asymptomatic) of prior infection generally require no further restrictions based on their history of COVID-19.

- Consideration needs to be given to determine whether there is concern that there may have been a false positive viral test, whether the patient/resident is immunocompromised, and whether there is evidence of exposure to a novel SARS-CoV-2 variant.
- If a patient/resident experience new signs or symptoms consistent with COVID-19 and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then repeat viral diagnostic testing and isolation may be warranted even if they have clinically recovered within 3 months.
- Healthcare facilities should continue to follow the infection prevention and control recommendations for unvaccinated individuals when caring for fully vaccinated individuals with moderate to severe immunocompromise due to a medical condition or receiving immunosuppressive medications or treatments. This includes using transmission-based precautions for those who have had close contact with someone with SARS-CoV-2 infection.

Outbreak recommendations

In the event of widespread identified cases, focus should be placed on Cohorts 1 and 2. New admissions should stop until control measures are effectively instituted. Depending on a variety of factors (e.g., facility layout, private room availability, testing results) facilities may not be able to effectively cohort, as described above.

In situations where COVID-19 positive persons are located on multiple units/wings, the facility should follow the below recommendations:

Implement universal Transmission-Based Precautions using COVID-19 recommended PPE (i.e., NIOSH approved N95 or higher level respirator [or well-fitting facemask if unavailable], eye protection, gloves, and isolation gown) for the care of all patients/residents, regardless of presence of symptoms or COVID-19 status.

• Refer to CDC Optimizing PPE Supplies at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe/strategy/index.html

o These strategies offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted.

o Optimization strategies are meant to be considered and implemented sequentially (i.e., conventional > contingency > crisis). o Healthcare facilities should promptly resume conventional or standard practice as PPE availability returns to normal.

• Consider repurposing unused space such as therapy gyms, activity and dining rooms during this time to cohort patients/residents. Refer to the DOH COVID-19 Temporary Operational Guidelines.

• If there are multiple cases on the wing/unit and when movement would otherwise introduce COVID19 to another occupied wing/unit, do not relocate them. Ensure appropriate use of engineering controls such as curtains to reduce or eliminate exposures from infected individuals. Rapid isolation is key. Once there are multiple cases or exposures on a wing/unit, transition the wing/unit to the appropriate cohort and focus efforts on rapid implementation of control measures for unaffected wings/units (i.e., containment efforts).

• When spacing permits, COVID-19 positive individuals should be relocated to the dedicated COVID-19 positive area (Cohort 1). Otherwise, limit the movement of all patients/residents and HCP in general.

• Ensure appropriate use of engineering controls, such as curtains between patients/residents, to reduce or eliminate exposures from infected individuals. This is especially important when semi-private rooms must be used. Allocate private rooms to maintain separation between patients/residents based on test results and clinical presentation. For example: o COVID-19 positive persons may share a semi-private room to keep them grouped together.

♣ Patients/residents who are colonized with or infected with multidrug-resistant organisms (MDROs), including Clostridium difficile, should not be placed in a semiprivate room or group area when possible, unless their potential roommate(s) is/are colonized or infected with the same organism(s). o Private rooms may be allocated to isolate COVID-19 positive persons or quarantine close contacts, based on availability.

• Prioritize maintaining dedicated HCP to a wing/unit with a heightened focus on infection prevention and control audits (e.g., hand hygiene and PPE use) and providing feedback to HCP on performance

Documentation of outbreak-

a. Date and time of the first sign or symptom, when testing was conducted, when results were obtained, and the actions taken based on the results
b. Document the time and date of a new COVID 19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests.

Laboratory Testing:

- Facility has a contract agreement in-place with licensed laboratory company to perform laboratory testing.
- If a 48 hour turn around time cannot be met for results, the facility will document all efforts to obtain the quicker turn around results with the identified laboratory and contact the local and state department of health
- The facility has access to BinaxNow rapid tests as well.
- Diagnostic testing to identify specific infectious disease and Testing for infectious diseases such as COVID-19 for residents will be conducted in consultation with the local and state departments, the resident primary physician/ Medical Director and in accordance with NJDOH, CDC and other applicable regulatory testing requirements.
- The resident, resident representatives, and the physician will be informed when performing a diagnostic or surveillance testing. All residents will have an order for COVID testing.
- Routine testing and other appropriate diagnostic and surveillance testing for all staff including vendors will be conducted in accordance with DOH, CDC and other applicable regulatory testing requirements.
- Documentation of testing-
    - Staff
        - Name
        - Date of testing
        - Result of each test
    - Resident
        - Order to do the testing
        - Documentation in the EHR
            - Testing was offered

- Completed
- Results of the testing

- Staff or residents that have tested positive will not require further testing for 90 days from the date of their positive test
- Newly admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, will have a series of two viral tests for SARS-COV-2 infection; immediately and, if negative, again 5-7 days after their admission.
- Residents who are up to date with all recommended COVID-19 vaccine doses and residents who have recovered from SARS-CoV-2 infection in the prior 90 days do not need to be placed in quarantine but should be tested as described above. Quarantine might be considered if the resident is moderately to severely immunocompromised.
- Residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions or readmissions will be placed in quarantine, even if they have a negative test upon admission. COVID-19 vaccination will be offered to all residents and staff who are not up to date.
- Staff who test positive will RTW as per the CDC guidelines and when appropriate to their previous position
- Staff who are up to date with vaccination do not require testing unless they are symptomatic and/or the building is in outbreak testing.
- Staff who hold religious exemptions will be tested based on county transmission status.
- Staff who are not up to date will be tested based on county transmission status.
- Refusal of Testing-
    - Resident Refusal
        - Shall treat the individual as a PUI
        - Make a notation in the resident's chart
        - Notify any authorized family members or legal representatives of this decision.
        - Continue to check temperature on the resident at least twice per
        - Onset of temperature or other symptoms consistent with COVID-19 require immediate cohorting in accordance with the Plan.
        - At any time, the resident may rescind their decision not to be tested.
    - Employee Refusal
        - Employee will be removed from the schedule as this is a requirement of employment.

When prioritizing individuals to be tested, prioritizing individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak *investigation* (as specified below).

Testing Trigger	**Staff**	**Residents**
Symptomatic individual identified	Staff, regardless of vaccination status, with signs *or* symptoms must be tested.	Residents, regardless of vaccination ststus, with signs *or* symptoms must be tested.
Newly identified COVID-19 positive staff or resident in a	*Test all staff, regardless of vaccination status, that had a*	*Test all residents, regardless of vaccination status, that had close contact with a COVID-19*

facility that can identify close contacts	*higher-risk exposure with a COVID-19 positive individual*. Or test all staff	*positive individual or test all residents*
Newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts	*Test all staff, regardless of vaccination status, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility).*	*Test all residents, regardless of vaccination status, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility).*

Routine Testing | Based on Regional Positivity | Test all Exempt