

## Rego Park Health Care

### Pandemic Influenza, Infection Control Measures During

#### **Policy Statement**

When pandemic influenza is detected in the geographic region of the facility, aggressive infection control measures will be implemented to prevent introduction of the virus to residents, staff and visitors.

#### **Policy Interpretation and Implementation**

1. Due to the increased risk of mortality from influenza in the frail elderly, infection control measures to prevent the introduction or spread of the influenza virus is a priority.
2. Early prevention of influenza outbreak consists of the following measures:
  - a. Training clinical staff in the modes of transmission of the influenza virus;
  - b. Training residents, families and non-clinical staff on the symptoms of influenza and standard infection control precautions (e.g., handwashing, respiratory hygiene/cough etiquette, etc.);
  - c. Vaccination of residents and staff;
  - d. Early detection of influenza cases in the facility;
  - e. Use of antiviral medications to treat ill persons, as recommended by current clinical practice guidelines;
  - f. Isolation of infected residents in private rooms or cohort units;
  - g. Use of appropriate barrier precautions during resident care; and
  - h. Restriction of visitors who have been exposed to or are symptomatic of influenza.
3. If pandemic influenza is detected in the geographic region of the facility, the following measures will be taken to prevent or delay the introduction of the virus to the facility:
  - a. Display signs and/or posters (in appropriate languages) at the entry to the facility restricting entry by any persons who have been exposed to or have symptoms of pandemic influenza;
  - b. Train staff to visually and verbally screen visitors at facility entry points for respiratory symptoms of pandemic influenza;
  - c. Provide a telephone number for family and visitors to call for information regarding prevention and control strategies for pandemic influenza;
  - d. Screen all employees for influenza-like illness before coming on duty and send any symptomatic employees home;
  - e. Refer to Pandemic Influenza Plan for employee absences and contact Medical Director, Clinical consultants and or Division Medical Director; and
  - f. Increase resident surveillance for influenza-like illness. Notify local or state health department if a case is suspected.
4. If an outbreak of pandemic influenza occurs within the facility, strict adherence to standard and transmission-based precautions and other infection control measures will be implemented according to the most current CDC recommendations for pandemic influenza.

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<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73(a) Emergency plan.; §483.80(a) Infection prevention and control program.
<b>Survey Tag Numbers</b>	E-0004; F880
<b>Other References</b>	<a href="http://www.cdc.gov/flu">www.cdc.gov/flu</a> and <a href="http://www.pandemicflu.gov">www.pandemicflu.gov</a>
<b>Related Documents</b>	Pandemic Influenza Surveillance and Detection
<b>Version</b>	1.2 (H5MAPL1006)

# Rego Park Health Care

## Pandemic Influenza Communications Plan

### Policy Statement

As part of the facility's overall disaster plan, the Pandemic Influenza Planning Committee has a pandemic influenza communications plan.

### Policy Interpretation and Implementation

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

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually.
<b>Survey Tag Numbers</b>	E-0029
<b>Other References</b>	
<b>Related Documents</b>	Pandemic Influenza Planning Committee Roster

3. The Influenza Planning Committee appoints the Pandemic Influenza Response Coordinator to:
  - a. Help implement the pandemic influenza preparedness plan throughout the facility;
  - b. Maintain contact with state and regional pandemic influenza preparedness groups;
  - c. Attend regional meetings, workshops and training sessions to obtain information on pandemic influenza preparedness and coordinate the facility's plans with other pandemic influenza plans;
  - d. Monitor public health advisories on a weekly basis (or more often, as necessary);
  - e. Participate in facility surveillance of influenza-like illness and confirmed disease (in collaboration with the Infection Preventionist);
  - f. Communicate with residents and family members regarding the status and impact of pandemic influenza in the facility; and
  - g. Coordinate the training of facility staff (in collaboration with the Staff Development Coordinator).
4. Committee members' names, titles, and contact information are listed on the Pandemic Influenza Planning Committee Roster located in the written pandemic influenza communications plan.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73(a) Emergency plan
<b>Survey Tag Numbers</b>	E-0004
<b>Other References</b>	
<b>Related Documents</b>	Pandemic Influenza Planning Committee Roster
<b>Version</b>	1.2 (H5MAPL1007)

## Rego Park Health Care

### Pandemic Influenza Surveillance and Detection

#### **Policy Statement**

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

#### **Policy Interpretation and Implementation**

1. The Influenza Planning Committee has appointed a Pandemic Influenza Response Coordinator to coordinate pandemic preparedness planning, surveillance and detection.
2. The Pandemic Influenza Response Coordinator is (name and title):

Andrea Trujillo

Director of Nursing

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

718-592-6400

347-447-1298

3. The Pandemic Influenza Response Coordinator works closely with the Infection Preventionist in all areas of pandemic preparedness and response, including surveillance and detection of pandemic influenza in residents and staff.
4. The Pandemic Influenza Response Coordinator monitors public health advisories (federal and state) at least weekly, and is responsible for updating the Infection Preventionist and the Pandemic Influenza Planning Committee when pandemic influenza has been reported in the United States and is nearing the geographic area.
5. Weekly monitoring of influenza-like illness and confirmed cases of influenza in residents and staff is included in our overall surveillance of communicable disease and is reported to the Infection Preventionist and the Pandemic Influenza Planning Committee.
6. Evaluation and diagnosis of residents and/or staff with influenza-like illness shall follow current CDC Guidelines for evaluation of symptoms and laboratory diagnostic procedures.
7. Enhanced surveillance (e.g., virologic testing) of residents and staff with influenza-like illness will be considered on a case-by case basis in collaboration with the local public health department. Determination

of enhanced surveillance will be based on the clinical presentation of symptoms, risk factors for exposure to novel influenza viruses, and current CDC recommendations.

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8. If an influenza outbreak in the facility is suspected, virologic testing of residents may be used to determine the best course of managing the outbreak.
9. All novel A influenza viruses identified by laboratory analysis will be reported to the local public health department and the CDC as a Nationally Notifiable Disease.
10. Assessment of influenza-like symptoms is included in the evaluation of newly admitted residents. Current CDC Guidelines for isolation precautions will be followed to determine the appropriate placement of newly admitted residents with influenza-like illness or confirmed disease.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.80(a) Infection prevention and control program.; §483.73(a) Emergency plan.
<b>Survey Tag Numbers</b>	F881; E-0004
<b>Other References</b>	<a href="http://www.cdc.gov/flu/weekly/fluactivity.htm">www.cdc.gov/flu/weekly/fluactivity.htm</a> and <a href="http://www.cdc.gov/flu/professionals/diagnosis/labprocedures.htm#table">www.cdc.gov/flu/professionals/diagnosis/labprocedures.htm#table</a>
<b>Related Documents</b>	Outbreak of Communicable Diseases
<b>Version</b>	1.1 (H5MAPL1009)

## Rego Park Health Care

### Pandemic Influenza Training and Education

#### **Policy Statement**

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

#### **Policy Interpretation and Implementation**

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

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73(d) Training and testing
<b>Survey Tag Numbers</b>	E-0036
<b>Other References</b>	
<b>Related Documents</b>	

**Version**

1.1 (H5MAPL1008)

# Rego Park Health Care

## Pandemic Influenza Written Plan

### **Policy Statement**

A written pandemic influenza disaster plan is incorporated into this facility's overall disaster preparedness plan.

### **Policy Interpretation and Implementation**

1. This facility has identified key components for pandemic influenza preparedness and regularly updates its readiness efforts.
2. A multidisciplinary Pandemic Influenza Planning Committee develops and oversees the facility's pandemic influenza preparedness planning, including the written plan.

A Pandemic Influenza Response Coordinator is assigned to coordinate pandemic preparedness planning and to monitor public health advisories on a weekly basis (or more often, as necessary).

3. Components of the written pandemic influenza preparedness plan include the following:
  - a. A protocol for monitoring pandemic influenza symptoms in staff and residents, including new admissions;
  - b. Education and training programs and materials for staff, residents, families and visitors;
  - c. An infection prevention and control plan for managing residents and visitors with symptoms of seasonal and pandemic influenza;
  - d. A plan for addressing staff absences and working with limited staff;
  - e. A plan for the use of vaccine and anti-viral medications; and
  - f. A surge capacity determination and plan, including staffing and supplies.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73(a) Emergency plan.
<b>Survey Tag Numbers</b>	E-0004
<b>Other References</b>	
<b>Related Documents</b>	Long-Term Care and Other Residential Facilities Pandemic Influenza Planning Checklist

**Version**

1.1 (H5MAPL1010)

# Rego Park Health Care

## Preparations for Severe Weather

### **Policy Statement**

This facility is prepared to respond to multiple forms of severe weather.

### **Policy Interpretation and Implementation**

1. Staff training is provided upon hire, annually thereafter, and as necessary on facility emergency and disaster procedures.
2. Area weather bulletins are monitored. Methods/devices that this facility uses to be informed of impending severe weather include:
  - a. Television (local and national);
  - b. Radio;
  - c. City or municipal emergency siren (5 minute continuous siren tone);
  - d. Weather radio;
  - e. Emergency management agency alerts;
  - f. Cell phone alerts; and
  - g. Other.
3. Portable weather radios with extra batteries are kept in the emergency supplies.
4. The facility is trained and prepared for both sheltering in place and evacuation situations.
5. Measures that may be taken to plan for specific weather emergencies are suggested below.

### **Planning Considerations for Tornadoes**

1. Consult with local Emergency Management officials regarding the tornado warning system.
2. Purchase a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup. Listen for tornado watches and warnings.
3. Establish procedures to inform personnel when tornado warnings are posted. Consider the need for spotters to be responsible for looking out for approaching storms.
4. Consult with Emergency Management officials or National Weather Service office for guidance in designating shelter space.
5. Consider the amount of space you need. Adults require about six square feet of space. Nursing home and hospital residents require more.
6. The best protection in a tornado is usually an underground area. If an underground area is not available, consider:
  - a. Small interior rooms on the lowest floor without windows;
  - b. Hallways on the lowest floor away from doors and windows;

- c. Rooms constructed with reinforced concrete, brick or block with no windows and a heavy concrete floor or roof system overhead; and
- d. Protected areas away from doors and windows.

**Note: Auditoriums, cafeterias, and gymnasiums that are covered with flat, wide-span roofs are not considered safe.**

- 7. Make plans for evacuating personnel away from lightweight modular offices or mobile home-sized buildings. These structures offer no protection from tornadoes.
- 8. Conduct tornado drills.

### **Planning Considerations for Earthquakes**

- 1. Consult with \_\_\_\_\_ (local) Emergency Management officials regarding earthquake preparedness and response expectations during an earthquake.
- 2. Identify safe areas in the facility that will reduce the potential for injury. A safe place could be under a sturdy table or desk or against an interior wall away from windows and bookcases, or tall furniture that could fall on occupants.
- 3. Ensure that all furniture, appliances and other large items are properly secured in accordance with all applicable requirements to help ensure safety compliance and reduce potential damage and injury.
- 4. Develop a formal damage assessment process that utilizes a checklist to assess the facility following an earthquake. Ensure that key staff is trained on damage assessment procedures.
- 5. Keep in mind that the findings of the damage assessment will help the Incident Commander determine if the facility will be evacuated, or if occupants will shelter-in-place following the initial earthquake.
- 6. Train staff and facility residents on immediate response procedures to an earthquake including evacuation or sheltering-in-place depending on the physical condition of the facility following the earthquake and subsequent aftershocks.
- 7. Conduct regular drills to prepare staff and residents for earthquakes.
- 8. Develop a procedure to track costs associated with the damage caused by an earthquake.
- 9. Ensure that all forms of primary and back-up communications systems are identified.
- 10. Train staff that non-essential services may be suspended during an earthquake emergency.
- 11. Be prepared to address the psychological impact that an earthquake can have on residents and staff and identify resources that can assist with this matter following an adverse event.

## Planning Considerations for Floods

1. Consult with \_\_\_\_\_ (local) Emergency Management officials to determine if the facility is located in a flood plain and to review the history of flooding in the area.
2. Purchase a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup. Listen for flood watches and warnings.
3. Review the community's emergency plan. Learn the community's evacuation routes. Know where to find higher ground in case of a flood.
4. Inspect areas that may be subject to flooding. Identify records and equipment that can be moved to a higher location. Make plans to move records and equipment in case of flood.
5. Ensure the facility's insurance policy provides coverage for flooding. Evaluate the feasibility of flood proofing your facility.
6. Advance flood proofing measures include:
  - a. Filling windows, doors, or other openings with water-resistant materials such as concrete blocks or bricks. This approach assumes the structure is strong enough to withstand floodwaters.
  - b. Installing check valves to prevent water from entering where utility and sewer lines enter the facility.
  - c. Reinforcing walls to resist water pressure and sealing walls to prevent or reduce seepage.
  - d. Building watertight walls around equipment or work areas within the facility that are particularly vulnerable to flood damage.
  - e. Constructing floodwalls or levees outside the facility to keep flood waters away.
  - f. Elevating the facility on walls, columns, or compacted fill. This approach is most applicable to new construction, though many types of buildings can be elevated.
7. Contingent flood proofing measures require some additional action when flooding occurs. These measures include:
  - a. Installing watertight barriers, called flood shields, to prevent the passage of water through doors, windows, ventilation shafts, or other openings.
  - b. Installing permanent watertight doors.
  - c. Constructing movable floodwalls.
  - d. Installing permanent pumps to remove flood waters.
8. Emergency flood proofing measures are generally less expensive than those listed above, but they require substantial advance warning and do not satisfy the minimum requirements for watertight flood proofing as set forth by the National Flood Insurance Program (NFIP). They include:
  - a. Building walls with sandbags.
  - b. Constructing a double row of walls with boards and posts to create a "crib," then filling the "crib" with soil.
  - c. Constructing a single wall by stacking small beams or planks on top of each other.

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9. Evaluate the need for backup systems, such as:
  - a. Portable pumps to remove flood water.
  - b. Alternate power sources such as generators or gasoline-powered pumps.
  - c. Battery-powered emergency lighting.
  - d. Participation in community flood control projects.

### **Planning Considerations for Hurricanes and Tropical Storms**

1. Consult with \_\_\_\_\_ (local) Emergency Management Office to determine the facility's flood zone and hurricane evacuation routes. High winds from a hurricane can necessitate evacuation even if there is no threat of flooding from storm surge.
2. Purchase a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup.
3. Listen for hurricane watches and warnings.
4. Survey the facility. Make plans to protect outside equipment and structures.
5. Make plans to protect windows. Permanent storm shutters offer the best protection. Covering windows with 5/8-inch marine plywood is a second option.
6. Consider the need for backup systems:
  - a. Portable pumps to remove flood water.
  - b. Alternate power sources, such as generators or gasoline-powered pumps.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73 Emergency preparedness.; §483.73(a) Emergency plan.
<b>Survey Tag Numbers</b>	E-0001; E-0004
<b>Other References</b>	

<b>Related Documents</b>	Emergency Procedure – Flooding Emergency Procedure – Hurricanes and Tropical Storms Emergency Procedure – Take Cover/External Threat Emergency Procedure – Tornado Watch/Warning
<b>Version</b>	1.2 (H5MAPL1408)

# Rego Park Health Care

## Preparations for Severe Weather

### **Policy Statement**

This facility is prepared to respond to multiple forms of severe weather.

### **Policy Interpretation and Implementation**

1. Staff training is provided upon hire, annually thereafter, and as necessary on facility emergency and disaster procedures.
2. Area weather bulletins are monitored. Methods/devices that this facility uses to be informed of impending severe weather include:
  - a. Television (local and national);
  - b. Radio;
  - c. City or municipal emergency siren (5 minute continuous siren tone);
  - d. Weather radio;
  - e. Emergency management agency alerts;
  - f. Cell phone alerts; and
  - g. Other.
3. Portable weather radios with extra batteries are kept in the emergency supplies.
4. The facility is trained and prepared for both sheltering in place and evacuation situations.
5. Measures that may be taken to plan for specific weather emergencies are suggested below.

### **Planning Considerations for Tornadoes**

1. Consult with local Emergency Management officials regarding the tornado warning system.
2. Purchase a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup. Listen for tornado watches and warnings.
3. Establish procedures to inform personnel when tornado warnings are posted. Consider the need for spotters to be responsible for looking out for approaching storms.
4. Consult with Emergency Management officials or National Weather Service office for guidance in designating shelter space.
5. Consider the amount of space you need. Adults require about six square feet of space. Nursing home and hospital residents require more.
6. The best protection in a tornado is usually an underground area. If an underground area is not available, consider:
  - a. Small interior rooms on the lowest floor without windows;
  - b. Hallways on the lowest floor away from doors and windows;

- c. Rooms constructed with reinforced concrete, brick or block with no windows and a heavy concrete floor or roof system overhead; and
- d. Protected areas away from doors and windows.

**Note: Auditoriums, cafeterias, and gymnasiums that are covered with flat, wide-span roofs are not considered safe.**

- 7. Make plans for evacuating personnel away from lightweight modular offices or mobile home-sized buildings. These structures offer no protection from tornadoes.
- 8. Conduct tornado drills.

### Planning Considerations for Earthquakes

- 1. Consult with \_\_\_\_\_ (local) Emergency Management officials regarding earthquake preparedness and response expectations during an earthquake.
- 2. Identify safe areas in the facility that will reduce the potential for injury. A safe place could be under a sturdy table or desk or against an interior wall away from windows and bookcases, or tall furniture that could fall on occupants.
- 3. Ensure that all furniture, appliances and other large items are properly secured in accordance with all applicable requirements to help ensure safety compliance and reduce potential damage and injury.
- 4. Develop a formal damage assessment process that utilizes a checklist to assess the facility following an earthquake. Ensure that key staff is trained on damage assessment procedures.
- 5. Keep in mind that the findings of the damage assessment will help the Incident Commander determine if the facility will be evacuated, or if occupants will shelter-in-place following the initial earthquake.
- 6. Train staff and facility residents on immediate response procedures to an earthquake including evacuation or sheltering-in-place depending on the physical condition of the facility following the earthquake and subsequent aftershocks.
- 7. Conduct regular drills to prepare staff and residents for earthquakes.
- 8. Develop a procedure to track costs associated with the damage caused by an earthquake.
- 9. Ensure that all forms of primary and back-up communications systems are identified.
- 10. Train staff that non-essential services may be suspended during an earthquake emergency.
- 11. Be prepared to address the psychological impact that an earthquake can have on residents and staff and identify resources that can assist with this matter following an adverse event.

## Planning Considerations for Floods

1. Consult with \_\_\_\_\_ (local) Emergency Management officials to determine if the facility is located in a flood plain and to review the history of flooding in the area.
2. Purchase a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup. Listen for flood watches and warnings.
3. Review the community's emergency plan. Learn the community's evacuation routes. Know where to find higher ground in case of a flood.
4. Inspect areas that may be subject to flooding. Identify records and equipment that can be moved to a higher location. Make plans to move records and equipment in case of flood.
5. Ensure the facility's insurance policy provides coverage for flooding. Evaluate the feasibility of flood proofing your facility.
6. Advance flood proofing measures include:
  - a. Filling windows, doors, or other openings with water-resistant materials such as concrete blocks or bricks. This approach assumes the structure is strong enough to withstand floodwaters.
  - b. Installing check valves to prevent water from entering where utility and sewer lines enter the facility.
  - c. Reinforcing walls to resist water pressure and sealing walls to prevent or reduce seepage.
  - d. Building watertight walls around equipment or work areas within the facility that are particularly vulnerable to flood damage.
  - e. Constructing floodwalls or levees outside the facility to keep flood waters away.
  - f. Elevating the facility on walls, columns, or compacted fill. This approach is most applicable to new construction, though many types of buildings can be elevated.
7. Contingent flood proofing measures require some additional action when flooding occurs. These measures include:
  - a. Installing watertight barriers, called flood shields, to prevent the passage of water through doors, windows, ventilation shafts, or other openings.
  - b. Installing permanent watertight doors.
  - c. Constructing movable floodwalls.
  - d. Installing permanent pumps to remove flood waters.
8. Emergency flood proofing measures are generally less expensive than those listed above, but they require substantial advance warning and do not satisfy the minimum requirements for watertight flood proofing as set forth by the National Flood Insurance Program (NFIP). They include:
  - a. Building walls with sandbags.
  - b. Constructing a double row of walls with boards and posts to create a "crib," then filling the "crib" with soil.
  - c. Constructing a single wall by stacking small beams or planks on top of each other.

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9. Evaluate the need for backup systems, such as:
  - a. Portable pumps to remove flood water.
  - b. Alternate power sources such as generators or gasoline-powered pumps.
  - c. Battery-powered emergency lighting.
  - d. Participation in community flood control projects.

### **Planning Considerations for Hurricanes and Tropical Storms**

1. Consult with \_\_\_\_\_ (local) Emergency Management Office to determine the facility's flood zone and hurricane evacuation routes. High winds from a hurricane can necessitate evacuation even if there is no threat of flooding from storm surge.
2. Purchase a National Oceanic and Atmospheric Administration (NOAA) Weather Radio with a warning alarm tone and battery backup.
3. Listen for hurricane watches and warnings.
4. Survey the facility. Make plans to protect outside equipment and structures.
5. Make plans to protect windows. Permanent storm shutters offer the best protection. Covering windows with 5/8-inch marine plywood is a second option.
6. Consider the need for backup systems:
  - a. Portable pumps to remove flood water.
  - b. Alternate power sources, such as generators or gasoline-powered pumps.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73 Emergency preparedness.; §483.73(a) Emergency plan.
<b>Survey Tag Numbers</b>	E-0001; E-0004
<b>Other References</b>	

<b>Related Documents</b>	Emergency Procedure – Flooding Emergency Procedure – Hurricanes and Tropical Storms Emergency Procedure – Take Cover/External Threat Emergency Procedure – Tornado Watch/Warning
<b>Version</b>	1.2 (H5MAPL1408)

# Rego Park Health Care

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## Release of a Resident's Personal Belongings

### Policy Statement

Our facility protects the personal belongings of a resident who has been transferred or discharged from our facility.

### Policy Interpretation and Implementation

1. The personal belongings of a resident transferred or discharged from our facility will be released to the resident or authorized resident representative.
2. Personal belongings of a resident who is temporarily transferred or discharged from the facility will be inventoried and stored by the facility until the resident has returned or such items have been picked up by the resident's representative.
3. Individuals receiving the resident's personal belongings will be required to sign a release for such items.
4. Disposal or disposition of the resident's personal belongings will be filed in the resident's medical record.

References	
<b>OBRA Regulatory Reference Numbers</b>	§483.12; §483.12(b) The facility must develop and implement written policies and procedures that:
<b>Survey Tag Numbers</b>	F602; F607
<b>Other References</b>	
<b>Related Documents</b>	

**Version**

1.1 (H5MAPL0729)

## Rego Park Health Care

### Planning for Additional Staffing Needs

#### **Policy Statement**

This facility prepares and trains volunteers for emergency assistance and/or emergency staffing strategies.

#### **Policy Interpretation and Implementation**

1. As part of emergency preparedness planning, the facility recognizes the need for additional staffing resources.
2. Critical staffing shortages during an emergency may be the result of staff injury or illness; the need for regular staff to stay at home to care for family members; transportation difficulties; post-traumatic stress; etc.
3. In order to prepare for potential staffing shortages, licensed and unlicensed personnel and volunteers are recruited and trained for emergency assistance.

#### **Establishing Volunteer Resources**

1. This facility does not engage non-credentialed or untrained volunteers for direct resident care.
2. As part of emergency preparedness and planning, the human resources manager, or designee, coordinates volunteer resources through registries, including Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP).
3. During emergencies, volunteers may be accessed or recruited through credentialing agencies and organizations such as:
  - a. Public Health Services (PHS) staff;
  - b. National Disaster Medical System (NDMS) teams;
  - c. Department of Defense (DOD) Nurse Corps;
  - d. Medical Reserve Corps (MRC); and/or
  - e. Personnel identified in federally designated "health professional shortage areas" (HPSA).
4. In a highly emergent situation where the use of volunteers may be needed for non-resident care related tasks (sentry duty, clean-up and other supportive duties), the facility only utilizes volunteers that are known parties to the facility or organization.
5. Contact information (name, address and phone number) and volunteer logs are maintained for all volunteers utilized.

#### **Arrangements with other Facilities**

1. As part of the emergency preparedness planning process, the facility may establish relationships with other facilities that provide similar care in order to assess the possibility of cross-training staff from each facility. The purpose of this would be to ensure that qualified, licensed and experienced personnel could fulfill emergency staffing needs.
2. If staff from other facilities are cross-trained and selected as potential emergency staff, they will be oriented and trained on the emergency preparedness plan and their specific roles in emergency response.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73(b)6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.
<b>Survey Tag Numbers</b>	E-0024
<b>Other References</b>	
<b>Related Documents</b>	

**Version**

1.0 (H5MAPL1457)

## Rego Park Health Care

### Planning for Evacuations

#### **Policy Statement**

This facility prepares for evacuations well in advance of a crisis or disaster situation requiring partial or complete evacuation, regardless of whether the evacuation is planned or spontaneous.

#### **Policy Interpretation and Implementation**

1. Evacuations can be planned (for example, with the threat of a hurricane) or spontaneous (for example, because of a sudden catastrophic situation).
2. This facility prepares for facility evacuation well in advance of a crisis or disaster situation requiring partial or complete evacuation, regardless of whether the evacuation is planned or spontaneous.
3. The facility understands that if a community-wide and regional disaster is occurring, the facility has to be prepared to be self-sufficient, as response times of Emergency Medical Services and other transportation providers may be delayed.
4. Evacuations are coordinated to occur in two phases if possible.
  - a. Phase I transports ambulatory and lower acuity residents who can travel via buses and cars.
  - b. Phase II transports the highest acuity residents via ambulance.

#### **Established Agreements**

1. The facility has established at least two evacuation sites for relocation of residents. Relocation agreements are secured in the Administrator/Executive Director's Office or other secure location.
2. The facility has secured a contract(s) with transportation provider(s) in the event of an emergency or disaster situation requiring transportation. Relocation agreements are secured in the Administrator/Executive Director's Office or other secure location.
3. Transportation providers are trained on:
  - a. the needs of the chronic, cognitively impaired, and frail population, as well as methods to minimize transfer trauma;
  - b. methods of communication, including alternate methods; and
  - c. information regarding its relocation sites and notification process.

#### **Evacuation Routes**

1. The facility has determined the primary evacuation routes and alternate evacuation routes in advance of a crisis or disaster scenario.
2. Evacuation routes and alternate routes are designated in accordance with the local Emergency Management Plan.

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3. The following is completed and updated annually or when significant changes in regional evacuation planning occur:

<b>Evacuation to the North:</b>
Primary Route—
Alternate Route—
<b>Evacuation to the South:</b>
Primary Route—
Alternate Route—
<b>Evacuation to the East:</b>
Primary Route—
Alternate Route—
<b>Evacuation to the West:</b>
Primary Route—
Alternate Route—

4. Customized maps or diagrams depicting specific evacuation routes, driving instructions, and projected travel times to pre-designated alternate facilities (computerized mapping programs, etc.) are established and updated as needed.

### **Resident Evacuation Identification Wristbands**

1. During an evacuation, each resident wears a clear/white Resident Evacuation Identification Wristband (Resource IV-J) that includes the following information:
  - a. Resident’s full name and date of birth;
  - b. Allergies: indicate “No known allergies”(NKA); or indicate specific food/medication allergies (in red);
  - c. Medical diagnosis (critical medical information to be conveyed with an orange wristband – see below);
  - d. Facility name and contact number;
  - e. Name of physician and name of responsible parties with contact numbers for each on back or inside of band; and
  - f. Note “Do Not Resuscitate” (DNR), if applicable.

*continues on next page*

2. Residents wear an additional orange (critical medical information band) on the same wrist as the identification wristband for each resident with special needs. The orange band will include the following information:
  - a. Resident's full name;
  - b. Facility name and contact number;
  - c. Critical diagnosis or condition, and any special treatment or care needs, for example:
    - (1) for a diabetic resident, indicate either insulin dependent (IDDM) or non-insulin-dependent (NIDDM) resident;
    - (2) if resident is using a thickener product or mechanically altered diet (e.g., puree, mechanical, soft, etc.); and
    - (3) other special needs (at risk for wandering, at risk for falls, at risk for skin breakdown, etc.).
3. A staff member is designated to oversee the creation and upkeep of wristbands for all residents; and
4. The care planning team identifies and reviews wristbands during quarterly care plan meetings to confirm accuracy.

### **Resident Emergency Packets**

1. The facility maintains a Resident Emergency Packet for each resident.
2. Resident Emergency Packets are stored in \_\_\_\_\_.
3. Each packet is in a plastic bag labeled with the resident's name and "Protected Health Information (PHI)."
4. The Resident Emergency Packet is sent with the resident to the receiving facility during an evacuation.
5. If paper charts are maintained, a copy of the printed medical record (or necessary information from the medical record) is sent with the resident as back up.
6. Receiving facilities have a Business Associate Agreement signed in advance.
7. Residents and families are informed upon admission (and at least annually) that PHI will be disclosed in the event of an evacuation.
8. The emergency information packet includes:
  - a. Resident Evacuation Identification Wristband.
  - b. Resident Face Sheet/Admission Record, including:
    - (1) Contact information of responsible party/family/POA;
    - (2) Social Security number;
    - (3) Date of birth;
    - (4) Medicare/Medicaid/other insurance provider numbers;
    - (5) Allergies;
    - (6) Diagnoses/Medical conditions;
    - (7) Photograph;
    - (8) Current medication list;
    - (9) DNR status;
    - (10) Power of Attorney and/or advance directives;
    - (11) Diet and special provisions, such as thickened liquids only; and
    - (12) Mode of transfer (two-person assist, stand-by assist, etc.).

*continues on next page*

- c. Resident Emergency Packets are updated at least quarterly (during care planning) to ensure accurate information. Other triggers for an update may include:
  - (1) Significant change in resident's condition;
  - (2) Hospitalization; and/or
  - (3) Knowledge of changes in the family such as a death, illness, or relocation.
9. The facility informs upon admission (and at least annually) with the family/responsible parties, the All Hazards Emergency Preparedness and Response Plan, as well as the arrangements that have been made in the event of a planned evacuation.
10. These arrangements are documented and maintained in the residents' medical records.

### **Resident Emergency "Go Bags"**

1. The facility provides an emergency bag for each resident in preparation of an evacuation.
  - a. A handled bag is best to carry the following items for each resident:
    - (1) Personal clothing—including gowns/pajamas, shoes, slippers, socks, and underclothes for three to four days;
    - (2) Incontinence supplies;
    - (3) Personal grooming items;
    - (4) Dental supplies, dentures;
    - (5) Hearing aids, eyeglasses;
    - (6) Falls and skin breakdown preventative aids;
    - (7) Hand sanitizer;
    - (8) Preprinted labels (with name, facility name, and telephone number);
    - (9) Mask; and
    - (10) Other needed medical supplies.
  - b. All items and medical equipment are labeled.

### **Resident Evacuation Tracking Log**

1. The facility maintains a Resident Evacuation Tracking Log if residents are evacuated.
2. The following information is included:
  - a. Resident name;
  - b. Gender;
  - c. Time of departure;
  - d. Mode of transportation and provider;
  - e. Destination;
  - f. Resident Emergency Packet and Go Bag sent with resident;
  - g. Resident Evacuation Identification Wristband placed on resident;
  - h. Equipment sent with resident; and
  - i. Responsible Party/Family notified with person notified, date, and time.

*continues on next page*

## Employee Evacuation Tracking Log

1. The facility maintains an Employee Tracking Log in the event of an evacuation.
2. The following information is included:
  - a. Employee name;
  - b. Gender;
  - c. Time of departure and which alternate facility; and
  - d. Hours tracked for payroll purposes.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§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.; §483.73(b)(3) Safe evacuation from the LTC facility; §483.73(b)(4) A means to shelter in place for patients, staff, and volunteers who remain in the LTC facility.; §483.73(b)(7) The development of arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to LTC facility patients.; §483.73(b)(8) The role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.; §483.73(c)(1) Names and contact information for the following:
<b>Survey Tag Numbers</b>	E-0018; E-0020; E-0022; E-0025; E0026; E-0030
<b>Other References</b>	
<b>Related Documents</b>	Emergency Procedure – Evacuation Evacuation Routes and Directions to Alternate Facilities Sample Letter to Family/Responsible Party Regarding Evacuation Instructions Resident Evacuation Tracking Log
<b>Version</b>	1.0 (H5MAPL1458)

# Rego Park Health Care

## Planning for Shelter-in-Place Situations

### **Policy Statement**

The facility plans for sheltering-in-place well in advance of a crisis or disaster situation. The facility identifies and assesses the length of time it can realistically support SIP before a decision is made to fully evacuate.

### **Policy Interpretation and Implementation**

1. The following potential sheltering-in-place situations are identified based on the Hazards Vulnerability Assessment.
  - a. \_\_\_\_\_  
\_\_\_\_\_
  - b. \_\_\_\_\_  
\_\_\_\_\_
  - c. \_\_\_\_\_  
\_\_\_\_\_
  - d. \_\_\_\_\_  
\_\_\_\_\_
2. The following areas within the facility are identified as suitable spaces that are structurally sound and away from potential exposure areas for residents, staff, and visitors to seek shelter:
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  - d. \_\_\_\_\_
  - e. \_\_\_\_\_
3. The decision to shelter in place is determined by the administrator or designee based on the safety of the situation.
4. Safety considerations include identifying scenarios that may cause a secondary event following the initial need to shelter in place.
5. Safety considerations also include evaluating the facility's physical plant and infrastructure during and immediately following the shelter-in-place procedure to ensure the safety of occupants.
6. Planning for sheltering in place includes the review of all materials and inventory items needed to facilitate sheltering in place. This includes a review of potential scenarios, for example a contaminated or hazardous environment outside of the facility.
7. The facility determines how many individuals the facility can safely shelter (surge capacity), as the facility may have to shelter staff members, staff members' immediate family members and volunteers.
8. As part of the surge capacity review, the facility acknowledges that hospitals and/or other facilities may need to transfer patients to the facility during catastrophic events.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73(b)(4) A means to shelter in place for patients, staff, and volunteers who remain in the LTC facility.
<b>Survey Tag Numbers</b>	E-0022
<b>Other References</b>	
<b>Related Documents</b>	Emergency Procedure – Shelter-in-Place

**Version**

1.0 (H5MAPL1459)

# Rego Park Health Care

## Planning for Shelter-in-Place Situations

### **Policy Statement**

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### **Policy Interpretation and Implementation**

1. The following potential sheltering-in-place situations are identified based on the Hazards Vulnerability Assessment.
  - a. \_\_\_\_\_  
\_\_\_\_\_
  - b. \_\_\_\_\_  
\_\_\_\_\_
  - c. \_\_\_\_\_  
\_\_\_\_\_
  - d. \_\_\_\_\_  
\_\_\_\_\_
2. The following areas within the facility are identified as suitable spaces that are structurally sound and away from potential exposure areas for residents, staff, and visitors to seek shelter:
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  - d. \_\_\_\_\_
  - e. \_\_\_\_\_
3. The decision to shelter in place is determined by the administrator or designee based on the safety of the situation.
4. Safety considerations include identifying scenarios that may cause a secondary event following the initial need to shelter in place.
5. Safety considerations also include evaluating the facility's physical plant and infrastructure during and immediately following the shelter-in-place procedure to ensure the safety of occupants.
6. Planning for sheltering in place includes the review of all materials and inventory items needed to facilitate sheltering in place. This includes a review of potential scenarios, for example a contaminated or hazardous environment outside of the facility.
7. The facility determines how many individuals the facility can safely shelter (surge capacity), as the facility may have to shelter staff members, staff members' immediate family members and volunteers.
8. As part of the surge capacity review, the facility acknowledges that hospitals and/or other facilities may need to transfer patients to the facility during catastrophic events.

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73(b)(4) A means to shelter in place for patients, staff, and volunteers who remain in the LTC facility.
<b>Survey Tag Numbers</b>	E-0022
<b>Other References</b>	
<b>Related Documents</b>	Emergency Procedure – Shelter-in-Place

**Version**

1.0 (H5MAPL1459)

# Rego Park Health Care

## Preparing for Mass Casualties

### Policy Statement

This facility has planned for the potential of deceased residents, staff and visitors following a crisis or disaster situation in which the support of local emergency responders or other community resources is not available.

### Policy Interpretation and Implementation

1. In the case of an event that impacts hospitals, funeral homes, mortuaries and morgues to the point where the volume of deaths is overwhelming and/or public service assistance is not immediately available, this facility has made provisions to temporarily handle and hold the remains of deceased individuals.
2. In planning for handling, processing and storing human remains on a temporary basis, the following has been identified:
  - a. The facility's normal capacity, if any, to store deceased residents/occupants;
  - b. Any refrigeration capacity that may be available to store human remains safely separated from emergency food supply;
  - c. Suitable areas on the periphery of the facility to store human remains without refrigeration;
  - d. Any equipment (ice making machines, etc.) or materials/supplies needed (storage bags for ice, deodorizers, body bags, heavy duty plastic wrap, tarps, pallets, etc.) to provide temporary storage of human remains; and
  - e. Ways to isolate temporary morgue provisions from healthy facility occupants (residents, staff and visitors).

<b>References</b>	
<b>OBRA Regulatory Reference Numbers</b>	§483.73 Emergency preparedness. §483.73(b)(6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.
<b>Survey Tag Numbers</b>	E-0001; E-0004; E-0024
<b>Other References</b>	
<b>Related Documents</b>	

**Version**

1.2 (PEMAPL0002)

# REGO PARK HEALTH CARE

## POLICY and PROCEDURE

Page No.: 1 of 2  
Four addendums

**Title: Emergency Preparedness:  
Strategies for optimizing the supply of Personal Protective Equipment (PPE) during surge capacity**

**Issued By: Rego Park Health Care**

**Effective Date: 3/25/20**

**Last Review Date: 3/25/20**

**Supersedes: New**

**Distribution: All Departments**

### **OBJECTIVE:**

- 1) To be able to optimize supplies of PPE when there is limited supply due to a surge capacity.
- 2) To understand the different levels of surge capacity and be able to prioritize measures to conserve PPE or to establish alternative strategies if indicated.

### **DEFINITIONS:**

**Surge Capacity** – The ability to manage a sudden, unexpected increase in patient volume that would otherwise be severely challenged or exceed the present capacity of the facility.

**Conventional Capacity**- Measures consist of providing resident care without any change in daily contemporary practice. The measures consisting of engineering, administrative, personal protective equipment controls should already be implemented in general infection prevention and control plans in the facility.

**Contingency capacity**- Measures may change daily standard practices but may not have any significant impact on the care delivered to the resident or safety of the healthcare provider. These practices may be used temporarily during periods of expected PPE shortages.

**Crisis capacity**- Strategies that are not commensurate with standard U.S. standards of care. These measures, or combination of measures, may need to be considered during periods of known PPE shortages.

### **POLICY:**

It is the policy of this facility that during emergency situations, that impact or limit the availability of PPE, the facility may adopt a series of strategies or options to optimize supplies of PPE.

See addendums for specific measures that may be utilized when there is a shortage of

*Isolation Gowns*  
*Facemasks*

**Addendum 1**  
**Addendum 3**

*Eye Protection*  
*N95 Respirators*

**Addendum 2**  
**Addendum 4**

**Addendum 1**  
**Emergency Preparedness:**  
**Strategies for optimizing the supply of ISOLATION GOWNS during surge capacity:**

Daily, during the ongoing emergency, the facility Nursing and Administrative team will meet to assess the facility's surge capacity and establish strategies on how best to optimize the supply of isolation gowns. If indicated, alternative plans may need to be implemented. The following measures or combination of measures may be taken for each surge capacity. The decision will be made by the team, based on the evolving clinical conditions of the residents' and availability of isolation gowns.

1. During **conventional capacity**, when there are no expected or known shortages of isolation gowns, staff will follow the established facility P&P for Infection Prevention and Control, using the appropriate personal protective equipment/ isolation gowns as indicated. Use of isolation gown alternatives that offer equal or higher protection may be used in place of isolation gowns if need be. i.e. surgical gowns or coveralls.
2. During **contingency capacity**, when isolation gowns are expected to be in shortage, alternative strategies may be implemented:
  - a. Selectively waive the need to wear a gown under certain conditions.
  - b. Shift to cloth, washable, isolation gowns. If implemented, gowns will be routinely inspected, maintained and replaced when they are thin or ripped. Inspections will be conducted daily by designated nursing staff, prior to issuing items for staff to use.
  - c. Shift to coveralls. Only staff that have been trained and have practiced in their use will be able to use them for resident care.
  - d. Use expired gowns beyond the manufacturer designated shelf life.
3. During **crisis capacity**, when there are known shortages of isolation gowns alternative strategies may be implemented:
  - a. Implement *extended* use of isolation gowns, cloth or disposable. The same gown can be worn by the same HCP/Staff when interacting with more than one patient known to be infected with the same infectious disease when these residents are housed in the same location. (i.e. COVID-19 residents residing in an isolation cohort). This should only be done if there are no additional co-infectious diagnoses transmitted by contact among residents i.e. C-Diff. If gown becomes visibly soiled, it must be removed.
  - b. Implement *re-using* of gowns. Both cloth and disposable can be re-used. Disposable gowns should only be re-used if they remain intact and the tie fasteners were not damaged during the doffing process. Any gown that becomes visibly soiled during patient care should be disposed of or cleaned if it's a cloth gown.

(In situations where gowns are being used as part of standard precautions to protect HCP/Staff from splash, the risk of re-using a non-visibly soiled isolation gown may be lower. However, for care of resident with suspect or confirmed COVID-19 or other infectious diseases, the risk for re-using gowns with single HCP/Staff caring for multiple residents using one gown or multiple HCP/staff sharing one gown is unclear. The goal of this strategy is to minimize exposure to the HCP/staff and not necessarily prevent transmission between residents.)

**Addendum 2**  
**Emergency Preparedness:**  
***Strategies for optimizing the supply of EYE PROTECTION during surge capacity:***

Daily, during the ongoing emergency, the facility Nursing and Administrative team will meet to assess the facility's surge capacity and establish strategies on how best to optimize the supply of isolation gowns. If indicated, alternative plans may need to be implemented. The following measures or combination of measures may be taken for each surge capacity. The decision will be made by the team, based on the evolving clinical conditions of the residents' and availability of isolation gowns.

1. During **conventional capacity**, when there are no expected or known shortages of eye protection, staff will follow the established facility P&P for Infection Prevention and Control, using the appropriate personal protective equipment/eye protection as indicated. Use eye protection according to product labeling and local, state and federal requirements.
2. During **contingency capacity**, when eye protection equipment is expected to be in shortage, alternative strategies may be implemented:
  - a. Shift eye protection supplies from disposable to re-usable devices (i.e., goggles and reusable face shields). Ensure appropriate cleaning and disinfection between users if goggles or re-usable face shields are used. See below for procedures for reprocessing eye protection.
  - b. Implement *extended* use of eye protection: Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several residents, without removing eye protection between resident encounters. Extended use of eye protection can be applied to both disposable and reusable devices.
    - i. Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through. See below, for procedures for reprocessing eye protection.
    - ii. If a disposable face shield/eye protection is being reprocessed it should be dedicated to one HCP/Staff. Face shield/eye protection must be reprocessed whenever it is visibly soiled or after removing the item prior to putting it back on.
    - iii. Eye protections should be discarded if damaged (e.g., face shield no longer can be fastened securely to the HCP/staff, if visibility is obscured and reprocessing does not restore visibility.)
    - iv. HCP/Staff should not touch their eye protection. If they touch or adjust their eye protection, they must immediately wash their hands.
    - v. HCP/Staff should leave resident care area if they need to remove their eye protection.
3. During **Crisis Capacity** when there are known shortages of protective eye protection alternative strategies may be implemented, including but not limited to:
  - a. Use eye protection devices beyond the manufacturer-designated shelf life during resident care. If there is no date available on the eye protection device label or packaging, the user should visually inspect the product prior to use, and, if there are concerns discard the product.
  - b. Prioritize eye protection for selected activities such as:
    - i. During care where splashes and sprays are anticipated, which typically includes aerosol generating procedures (e.g. nebulizer treatments)

### **Addendum 3**

#### **Emergency preparedness:**

#### **Strategies for optimizing the supply of FACEMASKS during surge capacity:**

Daily, during the ongoing emergency, the facility Nursing and Administrative team will meet to assess the facility's surge capacity and establish strategies on how best to optimize the supply of facemasks. If indicated, alternative plans may need to be implemented. The following measures or combination of measures may be taken for each surge capacity. The decision will be made by the team, based on the evolving clinical conditions of the residents and availability of facemasks.

1. During **conventional capacity**, when there are no expected or known shortages of facemasks, staff will follow the established facility P&P for Infection Prevention and Control, using the appropriate personal protective equipment/ facemasks as indicated.
  - FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated.
  - Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.
2. During **contingency capacity**, when facemasks are expected to be in shortage, alternative strategies may be implemented:
  - a. Remove facemasks for visitors in public areas
  - b. Implement extended use of facemasks
    - i. Remove and discard if soiled, damaged, or hard to breathe through.
    - ii. Be sure not to touch facemask. If the facemask is touched, hand hygiene must be performed immediately.
    - iii. Health Care Provider should leave patient area if they need to remove facemask.
  - c. Restrict facemasks to use by Health Care Provider, rather than residents for source control.
3. During **crisis capacity**, when there are known shortages of facemasks, alternative strategies may be implemented:
  - i. Use facemasks beyond the manufacturer-designated shelf life during patient care activities. The user should visually inspect the facemask prior to use and, if there are concerns, discard the product.
  - ii. Implement limited re-use of facemasks
    1. The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
    2. Not all facemasks can be re-used. Facemasks that fasten to the provider via ties may only be re-used if the ties are intact and can be retied safely. Otherwise consider facemasks with elastic ear hooks as they may be more suitable for extended use.
    3. Health Care Provider should leave patient care area if they need to remove the facemask.
    4. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The

#### **Addendum 4**

##### **Emergency preparedness:**

##### **Strategies for optimizing the supply of N95 RESPIRATORS during surge capacity:**

Daily, during the ongoing emergency, the facility Nursing and Administrative team will meet to assess the facility's surge capacity and establish strategies on how best to optimize the supply of N95 respirators. If indicated, alternative plans may need to be implemented. The following measures or combination of measures may be taken for each surge capacity. The decision will be made by the team, based on the evolving clinical conditions of the residents and availability of N95 respirators.

1. During **conventional capacity**, when there are no expected or known shortages of N95 respirators, staff will follow the established facility P&P for Infection Prevention and Control, using the appropriate personal protective equipment/ N95 respirators as indicated.
  - a. *Engineering controls* – Reduces exposures for health care workers by placing a barrier between the hazard and the health care provider.
    - If facility has an airborne infection isolation room, isolate suspected/confirmed infectious resident in that room.
    - If facility does not have an airborne infection isolation room, place resident in a room using physical barriers such as privacy screens or curtains placed between residents in shared areas. Use curtains between residents in shared areas for airways suction for intubated residents.
  - b. *Administrative Controls* – Employer dictated work practices that reduce or prevent hazardous exposures.
    - Limit number of residents going to the hospital or outpatient settings.
    - Exclude all Health Care Providers not directly involved in patient care.
    - Limit face-to-face Health care providers encounters with resident.
    - Exclude visitors to resident with known or suspected infection. Subject to change as per government regulations.
    - Identify and assess resident who may be ill or exposed to an infectious illness.
    - Cohorting residents with the same infections.
    - Cohorting health care providers.
    - Telemedicine.
    - Training on indications for use of N95 Respirators. Cross reference P & P “N95 Respirator Indication, Training and Use”
  - c. *Protecting PPE*- Provision for cleaning, disinfecting, inspecting, repairing, storing the respiratory equipment for employees.
    - Surgical N95 Respirators are recommended for use by health care providers who need protection from both airborne and fluid hazards.
    - Standard N95 Respirators can be used by health care providers who have no risk for exposure to high velocity sprays, splashes or splatters of blood or body fluid.
    - If there is no Surgical N95 Respirator and there is a risk for splashes, sprays or splatters of blood/body fluid, then a health care provider should wear a face shield over a standard N95 Respirator.

- Discard N95 respirators following close contact with any patient co-infected with an infectious disease requiring contact precautions.
- Use a cleanable face shield (preferred) or a surgical mask over an N95 respirator and/or other steps (e.g., masking residents, use of engineering controls), when feasible to reduce surface contamination of the respirator.
- Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly.
- Clean hands with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary, for comfort or to maintain fit).
- Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, perform hand hygiene as described above.
- Use a pair of clean (non-sterile) gloves when donning a used N95 respirator and performing a user seal check. Discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.

3. During **crisis capacity**, when there are known shortages of N95 respirators, alternative strategies may be implemented.

- a. Use N95 respirators beyond the manufacturer-designated shelf life.
- b. Use N95 respirators approved under standards used in other countries that are similar to NIOSH-approved N95 respirators but may not necessarily be NIOSH-approved. See chart from CDC. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/crisis-alternate-strategies.html>
- c. Implement limited re-use of N95 respirators for residents with COVID-19, measles, and varicella
- d. Use additional respirators, as identified by the CDC as NOT performing adequately for healthcare delivery beyond the manufacturer-designated shelf life.
- e. Prioritize the use of N95 respirators by activity type
  - (i) If the Health Care Provider will remain at greater than 6 feet from symptomatic patient, no facemask or N95 respirators needed.
  - (ii) If the Health Care Provider will be within 3-6 feet of symptomatic resident and entering the resident care area, a facemask or N95 respirators is needed. If not entering the resident care area, then no facemask or N95 respirators needed.
  - (iii) If the Health Care Provider will be within 3 feet of symptomatic patient an N95 respirators (or similar alternative) is needed.
  - (iv) If the Health Care Provider will be present in the room during aerosol generating procedures an N95 respirators (or alternative) is needed.

4. During **Crisis Capacity When No N95 Respirators Are Available** alternative strategies may be implemented:

- a. *Administrative Controls* –

# Rego Park Health Care

9

ENVIRONMENT OF CARE

TITLE: PPE CONSERVATION GUIDANCE AND STRATEGIES

POLICY # EC DIS 700

EFFECTIVE DATE: 3/2020

SUPERSEDES:

## POLICY

During the COVID-19 outbreak, PPE (Personal Protective Equipment) is necessary and scarce. The CDC has released an updated guidance for conservation and use strategies. When implementing alternate PPE strategies, the facility must ensure that it is systematic, and the staff are educated to ensure consistent practices to minimize the transmission of infection. The Infection Preventionist nurse and clinical staff oversee the use of alternate PPE strategies.

Based on CDC Recommendations as of 3/17/2020

(<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>)

## PROCEDURE

### For MASKS:

- Implement extended use of facemasks, which allows the wearer to use the same facemask for repeated close-contact encounters with several different patients, without removing the facemask between patient encounters.
- Restrict face masks to use by health care personnel (HCP), rather than patients, for source control. Have patients with symptoms of respiratory infections use tissues or other barriers to cover their mouth and nose.
- Implement limited re-use of facemasks, which is the practice of using the same facemask by one HCP for multiple encounters with different patients but removing and discarding after each encounter if soiled, damaged, or hard to breathe through.
- Prioritize facemasks for selected activities, such as for provision of essential surgeries and procedures, during care activities where splashes and sprays are anticipated, during activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable, and for performing aerosol-generating procedures.

### For GOWNS:

- Shift gown use toward cloth isolation gowns.
- Consider the use of coveralls. Other options include: disposable laboratory coats, reusable (washable) patient gowns, reusable (washable) laboratory coats, disposable aprons, and combinations of pieces of clothing.
- Extended use of isolation gowns (disposable or cloth), such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort).
- This can only be considered if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridium difficile*) among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices.
- Re-use of cloth isolation gowns among multiple patients in a patient cohort area without

## Rego Park Health Care

ENVIRONMENT OF CARE

TITLE: PPE CONSERVATION GUIDANCE AND STRATEGIES

POLICY # EC DIS 700

EFFECTIVE DATE: 3/2020

SUPERSEDES:

laundering in between.

- Prioritization of gowns for the following activities: during care activities where splashes and sprays are anticipated, which typically include aerosol-generating procedures, during the high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCPs, such as: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care.
- When no gowns are available, consider pieces of clothing as a last resort, preferably with long sleeves and closures (snaps, buttons) that can be fastened and secured, particularly for care of COVID-19 patients as single-use.

### For EYE PROTECTION:

- Implement extended use of eye protection, which is the practice of wearing the same eye protection dedicated to one HCP for repeated close-contact encounters with several different patients, without removing eye protection between patient encounters. This applies to disposable and reusable devices.
- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
- If HCP touches or adjusts their eye protection, they must immediately perform hand hygiene.
- Prioritize eye protection for selected activities such as: during care activities where splashes and sprays are anticipated, which typically include aerosol-generating procedures or when prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.
- Consider using safety glasses (for example, trauma glasses) that have extensions to cover the side of the eyes.
- Consider designated convalescent HCP for provision of care to known or suspected COVID-19 patients.