Checklist for Nursing Homes and other Long-Term Care Settings

DOGWOOD HEALTH TRUST

Coronavirus Disease 2019 (COVID-19) Preparedness

Nursing homes and other long-term care facilities can take steps to assess and improve their preparedness for responding to coronavirus disease 2019 (COVID-19).

1. **Structure for planning and decision making**
   a. COVID-19 has been incorporated into emergency management planning for the facility.
   b. A multidisciplinary planning committee or team has been created to specifically address COVID-19 preparedness planning.
   c. Members of the planning committee include the following: (Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist.)

      Facility administration
      i. Medical director
      ii. Director of Nursing
      iii. Infection control
      iv. Occupational health
      v. Staff training and orientation
      vi. Engineering/maintenance services
      vii. Environmental (housekeeping) services
      viii. Dietary (food) services
      ix. Pharmacy services
      x. Occupational/rehabilitation/physical therapy services
      xi. Transportation services
      xii. Purchasing agent
      xiii. Facility staff representative
      xiv. Other member(s) as appropriate (e.g., clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff including consultant services, union representatives)
   d. The facility's COVID-19 response coordinator has contacted local or regional planning groups to obtain information on coordinating the facility's plan with other COVID-19 plans.

2. **Development of written COVID-19 plan**
   a. A copy of the COVID-19 preparedness plan is available at the facility and accessible by staff.
   b. Relevant sections of federal, state, regional, or local plans for COVID-19 or pandemic influenza are reviewed for incorporation into the facility's plan.
   c. The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.

3. **Elements of a COVID-19 plan**
   a. The facility has a system to monitor for, and internally review, development of COVID-19 among residents and healthcare personnel (HCP) in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting).
   b. The facility has infection control policies that outline the recommended Transmission- Based Precautions that should be used when caring for residents with respiratory infection. (In general, for undiagnosed respiratory infection, Standard, Contact, and Droplet Precautions with eye protection are recommended unless the suspected diagnosis requires Airborne Precautions)
   c. The facility periodically reviews specific IPC guidance for healthcare facilities . caring for residents with suspected or confirmed COVID-19.

Facility Communications:

a. Key public health points of contact during a COVID-19 outbreak have been identified.
b. A person has been assigned responsibility for communications with public health authorities during a COVID-19 outbreak.
c. A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of COVID-19 in the facility. (Having one voice that speaks for the facility during an outbreak will help ensure the delivery of timely and accurate information).
d. Contact information for family members or guardians of facility residents is up to date.
e. Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., consultants, sales and delivery people) about the status of COVID-19 in the facility.
f. A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals and hospital emergency medical services, relevant community organizations—including those involved with disaster preparedness) with whom it will be necessary to maintain communication during an outbreak. Attach a copy of the contact list.
g. A facility representative(s) has been involved in the discussion of local plans for interfacility communication during an outbreak.

Supplies and resources:

The facility provides supplies necessary to adhere to recommended IPC practices including:

a. Alcohol-based hand sanitizer for hand hygiene is available in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
b. Sinks are well-stocked with soap and paper towels for hand washing.
c. Signs are posted immediately outside of resident rooms indicating appropriate IPC precautions and required personal protective equipment (PPE).
d. Facility provides tissues and facemasks for coughing people near entrances and in common areas with no-touch receptacles for disposal.
e. Necessary PPE is available immediately outside of the resident room and in other areas where resident care is provided.
f. Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).
g. Trash disposal bins should be positioned near the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another resident in the same room.
h. Facility ensures HCP has access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
i. The facility has a process to monitor supply levels.
j. The facility has a contingency plan, that includes engaging their health department and healthcare coalition when they experience (or anticipate experiencing) supply shortages.

Identification and Management of Ill Residents:

a. The facility has a process to identify and manage residents with symptoms of respiratory infection (e.g. cough, fever, sore throat) upon admission and daily during their stay in the facility, which include implementation of appropriate Transmission-Based Precautions.
b. The facility has criteria and a protocol for initiating active surveillance for respiratory infection among residents and healthcare personnel.
c. Plans developed on how to immediately notify the health department for clusters of respiratory infections, severe respiratory infections, or suspected COVID-19.
d. The facility has criteria and a protocol for: limiting symptomatic and exposed residents to their room, halting group activities and communal dining, and closing units or the entire facility to new admissions.
e. The facility has criteria and a process for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units.

Considerations about Visitors:

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

Facility Communications:

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

Education and Training:

a. The facility has plans to provide education and training to HCP, residents, and family members of residents to help them understand the implications of, and basic prevention and control measures for, COVID-19. Consultant HCP should be included in education and training activities.
b. A person has been designated with responsibility for coordinating education and training on COVID-19 (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance).
c. Language and reading-level appropriate materials have been identified to supplement and support education and training programs to HCP, residents, and family members of residents (e.g., available through state and federal public health agencies such and through professional organizations), and a plan is in place for obtaining these materials.
d. Plans and material developed for education and job-specific training of HCP which includes information on recommended infection control measures to prevent the spread of COVID-19, including:
    i. Signs and symptoms of respiratory illness, including COVID-19.
    ii. How to monitor residents for signs and symptoms of respiratory illness.
    iii. How to keep residents, visitors, and HCP safe by using correct infection control practices including proper hand hygiene and selection and use of PPE. Training should include return demonstrations to document competency.

iv. Staying home when ill.

v. HCP sick leave policies and recommended actions for unprotected exposures (e.g., not using recommended PPE, an unrecognized infectious patient contact).

e. The facility has a plan for expediting the credentialing and training of non-facility HCP brought in from other locations to provide resident care when the facility reaches a staffing crisis.

f. Informational materials (e.g., brochures, posters) on COVID-19 and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic.

Surge Capacity:
Staffing

a. A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.

b. A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during a COVID-19 outbreak.

c. Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law.

d. The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.

Consumables and durable medical equipment and supplies

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

Postmortem care:

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

Information obtained from the Centers for Disease Control (cdc.gov/coronavirus/2019-ncov/healthcare-facilities). Please reference that site for updates.