New Jersey DOH – LTCF Collaboration for Long-Term Care Resilience

Staffing and Cohorting

Cooper University Health Care

NJDOH-LTCF Collaboration For Long-Term Resilience

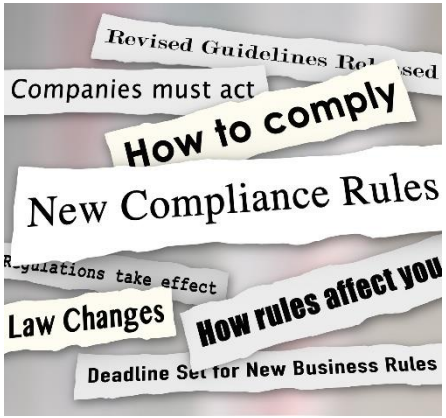
Overview

- General Staffing Philosophy
- State Guidelines
- Proactive Steps
- Cohorting
- CDC Return to Work Guidelines
  - Covid positive Staff
- Alternative Staffing Pool
- Questions?

General Philosophy

- Follow CDC and State Guidelines
- Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift). Ensure HCP practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break)
- If cannot maintain distancing in break rooms – seek alternatives
- Suggest establishing a hotline for symptomatic staff
  - Provides a method for consistent staff direction
- Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
- Counsel all residents to restrict themselves to their room to the extent possible.
- Develop a plan for alternative staffing – engage non clinical workers to help design

State Guidelines



- Comply with State Guidelines for staffing ratios
- Must have outbreak plan
  - Addresses contact with resident families weekly
    - Virtual visitation coordinator
  - Strategies for securing more staff
  - Posted on website by 10/30/2020
- Also plan for reduction of social isolation for residents
  - Instead of family visits outside of the facility, the DOH recommends visitation outdoors,or possibly indoors in facilities that meet the requirements for indoor visitationin accordance with DOH Executive Directive 20-0261. Increased virtual communications in lieu of visitation should be used by facilitiesduring the holidays.

Proactive Steps

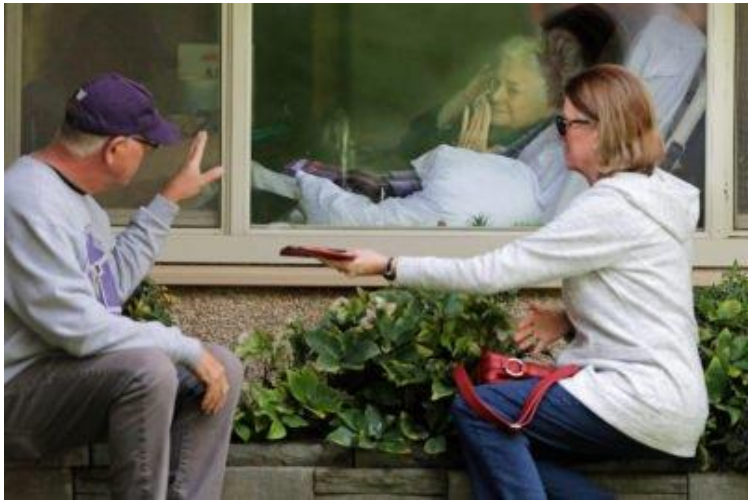
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
- Identify area to create a COVID unit
  - Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19. Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms.
- Establish a Non Clinical Alternative Staffing Pool
  - Provides administrative staff the opportunity to assist with indirect resident care

Proactive Steps

- Assign dedicated HCP's to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents.
- HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
- To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit. Assign environmental services [EVS] staff to work only on the unit.
- Bundle care activities to minimize the number of HCP entries into a room

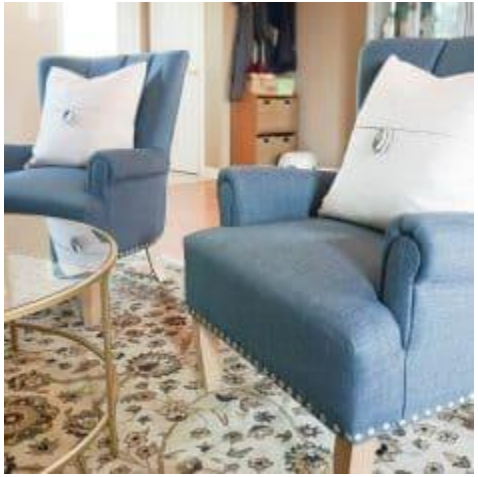
Proactive Steps – Visitation

- Alternatives to Resident Visits - In lieu of visits, the Department of Health strongly suggests facilities continue:
  - a)Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.)
  - b)Creating/increasing listserv communication to update resident on outdoor visitation availability
  - c)Assigning staff as primary contact to the resident's visitors for inbound calls and conducting regular outbound calls to keep them informed
  - d)Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits



Cohorting

- Exposure
  - Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.
  - If severe staffing shortages - Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
- Holiday Visitation
  - Require all individuals who leave the facility for holiday gatherings/visits to quarantine for 14 days upon return to the facility.
  - Estimate how many residents can be cohorted, dependent on the facility's available space, for a 14-day quarantine period based on current census and projected census from Nov. 25 through Dec.31,2020,as well as available PPE and staff.



CDC Recommendations on Return to Work

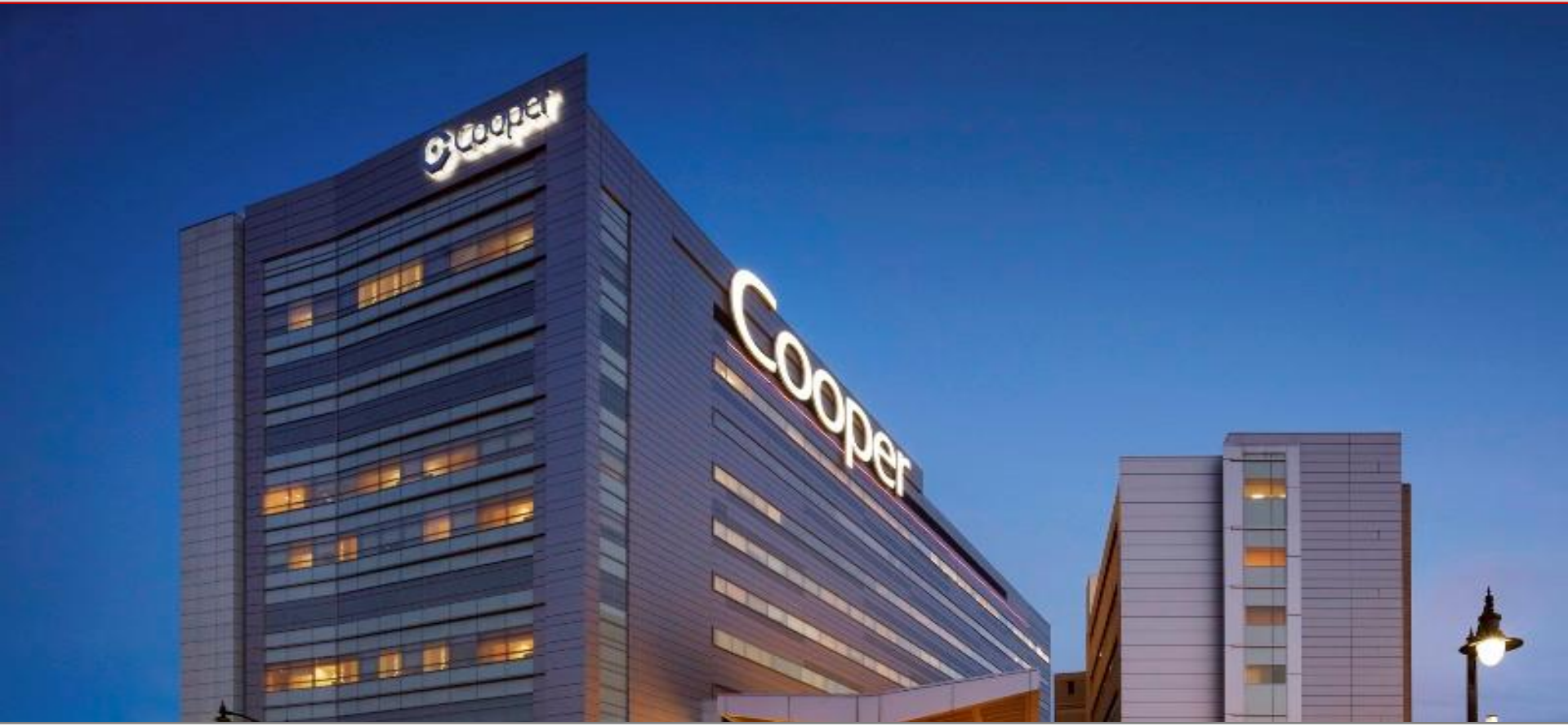
- ***A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious***.
- **Symptom-based strategy for determining when HCP can return to work.**
- *HCP with mild to moderate illness who are not severely immunocompromised:*
- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- **Note**: HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.
- **After returning to work, HCP should:**
- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
    - A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed SARS-CoV-2 infection.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen.

Suspected or Covid Positive Staff

- If staffing shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are well enough and willing to work but have not met all Return to Work Criteria to work. If HCP are allowed to work before meeting all criteria, they should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order: If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
- Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
- Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.
- As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients *without* suspected or confirmed COVID-19.

Alternative Staffing Pool

- Determine numbers of non clinical personnel that could augment clinical staff in crisis
- Define roles that could be assistive to clinical staff
- Develop just-in-time training for non-clinical staff
- Ask for volunteers for 4 hour shifts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