Lessons Learned from the Response to and Experience with COVID-19

1. We need coordination and cooperation of all departments to execute a comprehensive COVID response.

2. Train-the-trainer was an effective method to more rapidly disseminate information to a large number of staff.

3. We need to have at all times a stockpile of personal protective equipment ("PPE") per cohort group.

4. In a rapidly changing situation, we need to be vigilant of ever-shifting CDC guidelines.

5. We need to post signs on appropriate PPE, correct donning and doffing of PPE, hand hygiene, physical distancing.

6. It is important to notify all re the facility's website, to communicate with residents and family.

Communication with Staff, Residents, Families or Guardians

1. We have a website, woodlandbehavioral.com, where we post cumulative as well as current updates and other information.

2. In addition, by 5 P.M. the next calendar day following the subsequent occurrence of either the identification of a single confirmed infection of COVID-19, or the occurrence of new-onset of respiratory symptoms in three or more residents or staff with within 72 hours of each other:

   a. Residents' families or representatives (legally responsible persons) as well as staff will be notified via Robocalls (automated phone calls that deliver a recorded message) conveying a Coronavirus update -- whether a confirmed infection of COVID-19 has been identified or there is a new-onset of respiratory symptoms in three or more residents or staff within 72 hours of each other -- and providing a telephone number to call in case of questions. *(10/23/2020)*

   b. If there is a change of resident's medical condition, whether the resident is exposed, symptomatic or has tested positive for COVID-19, Nursing Department shall inform the resident and call the attending physician as well

as family or guardian of the resident regarding resident's change of condition or test results, if any;

3. Mitigating actions to prevent or reduce the risk of transmission include the following: *NOTE: (a) to (e) below is per Regulatory & Clinical Consultant Gail Rader (who was in contact with Marcella of NJ DOH), as emailed by ID Consultant Dr. Cindy Schiller on November 23, 2020.*

   a. No non-essential personnel should enter the building. All individuals who enter the building outside of regular staff that routinely tests need to be rapid antigen tested in the Reception area before they enter;

   b. EMS transporters taking patients for appointments, dialysis, etc., must be rapid antigen tested in the Reception area before they can take the resident until further notice;

   c. 911 responders and EMS personnel in an emergency situation do not need to be tested to enter the building;

   d. Residents are strongly discouraged from leaving for an out-of-the-facility visit:

      i. If they insist, whoever is picking them up must be rapid antigen tested in the Reception area before they take the resident;

      ii. If the family member tests positive, they cannot take the resident;

      iii. Upon return to the building from the visit, resident will be observed in the yellow unit for 14 days. If there is no yellow bed available, the family has to keep the resident until we have a bed;

      iv. We need an "informed consent" form signed by family, detailing the above;

   e. Staff and any other person allowed entry will be screened daily;

   f. Resident wings will be on lockdown and residents will be in quarantine;

   g. Communal activities such as dining and recreation shall be stopped;

   h. Visitation will be restricted;

   i. Each resident wing will be provided with a cellphone for phone calls from or to family members;

   j. Cohort wings will be implemented;

   k. For any COVID-positive residents, a true COVID unit will be used.

i. The unit is totally isolated and has its own entrance and exit for staff;

ii. Resident(s) on the isolation unit will be cared for by dedicated staff who will not be assigned to work on any other wing,

l. There will be dedicated equipment on yellow and red units;

m. Disposable food trays, plates, and utensils will be utilized on yellow and red units;

n. Physical barriers such as privacy curtains will be utilized at all times within yellow and red units;

o. Vital signs of residents will be monitored daily or every shift as may be indicated;

p. Signage on PPE, hand hygiene, and physical distancing will be posted throughout the building. Signage on PPE shall include the following information:

i. Green wing – surgical mask and face shield or eye protection;

ii. Yellow wing – N95 mask if available -- KN95 mask if N95 is not available, face shield or eye protection, and while in the resident room, isolation gown and gloves;

iii. Red wing – N95 mask, face shield or eye protection, and while in the resident room, isolation gown and gloves.

q. Universal source control via masking will be strictly enforced at all times. Surgical masks shall be used, unless on a yellow or red unit where N95 masks, or KN95 if N95 masks are not available, shall be donned. Cloth masks are not permitted;

r. In addition to source control and other infection prevention and control measures, universal eye protection shall be required for all staff and for compassionate care or essential caregiver visitors unable to maintain social distancing when the NJDOH CALI Level is Very High/High or Moderate; (Updates to NJ DOH Executive Directive No. 20-026 [amended January 6, 2021])

s. Active surveillance of staff and residents via testing will be conducted; and

t. Staff will have to stay home if not feeling well.

4. To notify residents, their families or guardians, and staff about any infectious disease outbreaks, mitigations taken, and available modes of virtual communication in case of restricted visitation, the facility will communicate at a minimum on a weekly basis in the following manner:

   a. The facility will post on the website cumulative and daily updates, if any, as well as a summary of the mitigating actions being taken;

   b. A communication board will be posted by the time clocks and will provide data including number of positive or PUI cases and COVID-19/cohort status (red and/or yellow unit(s)), as needed;

   c. The facility will in-service and re-educate staff as needed.

Virtual Communication between Residents and Families/ Representatives

POLICY: The facility shall provide a cellphone for each wing for virtual communication between residents and their families or representatives in the event of visitation restrictions due to an outbreak of infectious disease or in the event of an emergency.

STAFF INVOLVED: Security staff, Social Services Assistant

PROCEDURE:

1. **Hours - Cellphone family calls will be at 10:00 A.M. – 8:00 P.M.**

2. **Custody –** During the hours designated for cellphone family calls, Security staff will have custody of the cellphone for resident use as follows: (updated 01/14/2021)
   a. South 2 – Security staff on the unit has custody of a cellphone designated for the exclusive use of the residents on the isolation unit, South 2;
   b. 2nd Floor – Security staff has custody of two (2) cellphones for use by residents on West 2, North 2, and East 2;
   c. 3rd Floor – Security staff has custody of two (2) cellphones for use by the residents on the 3rd Floor;
   d. North 1 – Security staff has custody of one (1) cellphone designated for residents on the observation unit, North 1; and
   e. East 1 – Security staff has custody of one (1) cellphone for residents on East 1.

3. **Answering phone call** – Unless assisting with a resident behavior situation, Security staff shall answer any incoming phone call and take the cellphone to the resident. If resident is asleep or in no condition to receive the call, staff shall politely inform the caller that the resident is unable to take the call and ask the family member or representative to call back -- or note the name of caller, phone number, and name of the resident being called, and call back when possible.

4. **Voicemail check; return call** – Security staff must check for messages on the voicemail, assist with returning the call of the family member or representative and take the phone to the resident.

5. **Protocol on charging, safekeeping, and distribution of cellphones:**

    a. Every day at 10:00 P.M., evening Security Supervisor will collect all cellphones and chargers, disinfect them and bring the cellphones to the Lobby to be charged overnight and locked in the office formerly known as former Admissions Director Adele Primiano's office.

    b. Receptionist on evening shift will lock said office before leaving.

    c. At 7 A.M., Receptionist will unlock the office and Security Supervisor will distribute the cellphones to the designated staff.

6. **Phone load/credit –** Social Services Assistant will obtain funds from Corporate Accounts Payable to purchase pre-paid phone cards good for thirty (30) days.

7. If for any reason, a cell phone and/or charger is missing, please communicate with Management as soon as possible.

SANITIZING THE CELLPHONE - PROCEDURE:

1. Perform hand hygiene.

2. Before using the cellphone for a call for resident, wipe down the phone with disinfectant wipes. Be careful as to not get wet the Micro-USB-B or Micro-USB-AB receptacle where the Micro-USB connector part of the charger is plugged.

3. Immediately after use of the cellphone, wipe down the cellphone with a disinfectant wipe.
4. Dispose of the disinfectant wipe in resident trash cans after use of said wipes to prevent carrying infectious materials from room to room.
5. Follow product cleaning instructions and allow product to remain on the surface for the recommended time period or until dry.
6. Perform hand hygiene.

Crisis Capacity Strategies to Mitigate Staffing Shortages

From CDC – last reviewed April 13, 2020; updated 04/17/2020; 08/27/2020

When staffing shortages are occurring, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care.

As part of crisis capacity strategy to mitigate staffing shortage and thus continue to provide resident care, the Facility will take the following steps:

1. Utilize staffing agency under contract to augment the work force in the building, if available;
2. Offer bonuses and increased pay to get our staff to cover shifts;
3. Convert 8-hour work shifts to 12-hour work shifts to extend wing coverage by nurses in the building;
4. Pull office licensed nurse staff out of the office and deploy to work on the floor;
5. Reapportion CNA assignments to cover more residents;
6. Bundle duties/assignments to limit exposures and optimize the supply of PPE; and
7. Cross-train staff to conserve resources and/or to enable to continue providing necessary services. For instance, Security and Maintenance staff will cross-train and help perform non-direct care services such as cleaning and other housekeeping functions.

When there are no longer enough staff to provide safe patient care:

1. Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing.
2. If not already done, allow asymptomatic healthcare personnel ("HCP") who have had an unprotected exposure to the virus that causes COVID-19 to continue to work.
    a. These HCP should still report temperature and absence of symptoms each day before starting work.
    b. These HCP should wear a surgical facemask (for source control). A surgical facemask instead of a cloth face covering should be used by these HCP for source control.
    c. HCP shall refer to the facility policy regarding *universal source control* during the pandemic.
        i. A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed COVID-19.
        ii. Of note, N95 or other respirators with an exhaust valve might not provide source control.
3. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.

If shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are well enough 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:

1. 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.
2. Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.

3. Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.

4. ***As a last resort***, allow HCP with confirmed COVID-19 to provide direct care for patients *without* suspected or confirmed COVID-19.

If HCP are permitted to return to work before meeting all ***Return to Work Criteria,*** they should still adhere to all ***Return to Work Practices and Work Restrictions*** recommendations described in that guidance. These include:

1. Wear a facemask for source control at all times while in the healthcare facility.
    a. A surgical facemask instead of a cloth face covering should be used by these HCP for source control.
    b. HCP should refer to the facility policy regarding ***universal source control*** during the pandemic, in addition to universal eye protection where social distancing is not possible.
2. A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
3. Of note, N95 or other respirators with an exhaust valve might not provide source control.
4. They should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
5. Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
6. If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others.
7. Being restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until the full ***Return to Work Criteria*** have been met.
8. Self-monitoring for symptoms and seeking re-evaluation from occupational health if respiratory symptoms recur or worsen.