Kirkhaven
Transitional & Long-Term Care

PANDEMIC EMERGENCY PLAN (PEP)

BACKGROUND

Definitions:

Emerging Infectious Diseases (EIDs)

Infectious diseases, whose incidence in humans has increased in the past two decades or threatens to increase in the near future, have been defined as "emerging." These diseases, which respect no national boundaries, include:

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

For an emerging disease to become established at least two events must occur:

(1) the infectious agent has to be introduced into a vulnerable population and

(2) the agent has to be able to spread readily from person-to-person and cause disease.

The infection also has to be able to sustain itself within the population; that is, more and more people continue to become infected.

Pandemic

A sudden infectious disease outbreak that becomes very widespread and affects a whole region, continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

Isolation

Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease.

Quarantine

Separation and restriction of the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.

Cohorting

Imposed grouping of two or more residents exposed to, or infected with, the same infectious disease that are separated physically from other residents who have not been exposed to, or infected with, that infectious disease.

Cohort Staffing

The practice of assigning specific staff to care only for residents known to be exposed to or infected with the same infectious disease. Such staff "does not" participate in the care of residents who have not been exposed or infected with that infectious disease.

PURPOSE

The purpose of this Pandemic Emergency Plan (PEP) is to contain an outbreak of disease caused by an infectious agent or biological toxin or to respond to other infectious disease emergencies as defined above. This is consistent with the facility's mission to protect the residents and staff from illness and/or death.

Activities that may be implemented during an Infectious Disease Response include:

- Coordination with other healthcare facilities, local, regional, state and federal agencies and other organizations responding to a public health emergency.
- Development and dissemination of information and guidance for the residents, families and staff within our community.
- Containment measures such as infection control, mass prophylaxis, isolation and quarantine, or restriction and clearance.
- Activities such as surveillance, investigation, and lab testing.

SCOPE

An infectious disease emergency occurs when urgent and possibly extensive public health and medical interventions are needed to respond to and contain an infectious disease outbreak that has the potential for significant morbidity and mortality in a given area.

This plan is a functional response guide for the facility Leadership Team and Department Managers. The plan is to be used in conjunction with the facility's Emergency Management Plan and Infection Prevention and Control Plan.

This plan will be posted on the facility website and will be updated and submitted for review on an annual basis.

ASSUMPTIONS

The PEP integrates the key elements of communicable disease control and prevention with emergency management concepts. The Incident Command System (ICS) organizational structure will be used to scale the response as needed to effectively manage and meet the incident objectives of the infectious disease emergency response.

The PEP assumes that individuals occupying leadership positions have completed ICS training. The PEP further acknowledges that there could be a limited number of personnel within the facility with the knowledge and training in infectious diseases, epidemiology, public health, and emergency preparedness.

The plan assumes each incident will require tailored activation and use of the Pandemic Emerging Infectious Disease Response Plan. This plan can be adjusted to address scenarios varying by infectious diseases, size and/or overall severity.

This PEP also assumes that all confidential data regarding individual cases will not be shared outside of those who need to know, or in order to fulfill legally mandated public health reporting and information sharing.

The facility leaders will form an Emerging Infectious Disease Support Team during a pandemic or infectious disease event to include administrative, clinical and internal and external support team members to ensure proper response to the infectious disease.

GENERAL ACTIONS APPLICABLE TO ALL STAFF

As healthcare providers we must always be prepared to protect people within our buildings and to protect our residents, families, and staff from harm resulting from exposure to an emerging infectious disease while they are in the facility.

Every disease is different. The local, state, and federal health authorities (CDC, CMS, OSHA, NY State DOH, etc.) are the sources of the latest information and provide the most up-to-date guidance on prevention, case definition, surveillance, treatment, and clinical response related to a specific disease threat.

Incidents involving an emerging infectious disease, or a suspected case, require referencing the organization's written Infection Prevention and Control Plan and direct consultation of the Director of Nursing/ Infection Prevention Nurse, the facility Medical Director, local DOH epidemiologist and/or other physicians and providers.

GENERAL PREPAREDNESS FOR EMERGING INFECTIOUS DISEASES (EIDS)

The facility's Infection Control Plan will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza and Coronavirus, COVID-19. This plan will:

- Include administrative controls (screening, isolation, visitor policies, including restrictions as necessary, and employee absentee plans)
- Address environmental controls (cohorting, isolation areas/rooms, plastic barriers, sanitation stations, and special areas for contaminated waste)
- A plan for readmission of residents to the facility after hospitalization for the pandemic infectious disease.
- Address human resource issues such as employee leave, staffing, and emergency credentialing

As part of the Emergency Management Plan (EMP), the facility will maintain, or have readily accessible, a two (2) month supply of personal protective equipment (PPE) including moisture-barrier gowns, face shields/eye protection, surgical masks, N95 respirators or other appropriate respiratory barrier devices, and gloves. As well as sanitizer and disinfectants in accordance with current EPA Guidance.

When determining PPE supply needs during a pandemic episode, the facility will base such need on State and Federal guidance and regulations; in the absence of such guidance, the facility will consult utilize the CDC PPE burn rate calculator.

The facility will develop plans with their vendors for resupply of food, medications, medical supplies, sanitizing agents, and PPE in the event of a disruption to the normal supply chain including an EID outbreak.

The facility will follow its customary admission and readmission policy and procedures in accordance with State and Federal laws and regulations. Specific to COVID 19 and in compliance with Executive Order 202.30, the facility must certify that it is able to properly care for such patient and the hospital shall not discharge such patient without first performing a diagnostic test for COVID-19 and obtaining a negative result.

In an effort to further reduce virus transmission, upon admission or readmission, residents will be placed on droplet precautions and full PPE (gown, gloves, surgical mask, protective eyewear) will be utilized for 14 days and until a second, negative COVID-19 test result is obtained.

In the event a resident tests positive for COVID-19, the resident will be relocated to a secure designated area on the 5th household where there is no sharing of bathrooms with residents outside the cohort. The regional and local DOH will be notified if the facility cannot set up a cohort area or can no longer sustain cohorting efforts.

During periods of quarantine and/or restricted visitation the facility has implemented a method for residents to keep in touch with families or responsible parties daily, such as providing no cost access to teleconferencing services (FaceTime, ZOOM, Skype, cellphones and landlines). These required communications must be by electronic means or other method selected by each authorized individual.

The facility will provide orientation and in-service training to all staff on the Infection Prevention and Control Plan, including the Pandemic Emergency Plan - Emerging Infectious Diseases response plan periodically and at least on an annual basis.

The facility will follow applicable OSHA requirements, including OSHA's Bloodborne Pathogens (29 CFR 1910.1030), Personal Protective Equipment (29 CFR 1910.132), and Respiratory Protection (29 CFR 1910.134) standards.

PLAN ACTIVATION

Only authorized staff may direct the activation/deactivation of the Pandemic Emergency Plan. The activation and notification process should be used in accordance with the facility Emergency Management Plan. Staff authorized to initiate activation/deactivation include the:

- Administrator/Executive Director
- Director of Nursing
- Leadership Team member (as defined by Emergency Operations Plan)

The need to notify department managers/supervisors and external partners of the activation of the Pandemic Emergency Plan (PEP) will be determined by the circumstances of the event including: the suspected disease, the anticipated scope of the response, and the size of the impacted populations.

The PEP assumes that all incident communications and requests will follow Incident Command System guidelines. Any communications that changes the scope of the operations, the objectives, or strategies must be approved by the Administrator/Incident Commander.

ADMINISTRATION / LEADERSHIP CONSIDERATIONS

The leadership team will consider recommendations and requirements from the CDC, OSHA, Center for Medicare and Medicaid (CMS), NYS DOH, state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA), and other state or federal laws in determining the precautions it will take to protect its residents, visitors, and staff members.

Once notified by the public health authorities at either the federal, state, and/or local level that the EID is likely to, or already has spread to the facility's community, the facility will activate specific surveillance and screening as instructed by local/state Department of Health, the Centers for Disease Control and Prevention (CDC), or the local public health authorities.

COMMUNICATIONS

A communications plan helps facilities maintain situational awareness throughout the duration of an incident and enables facilities to share information effectively across the organization, as well as with external stakeholders and any partners who may be supporting the response.

Resident Communication: Upon admission, annually, and prior to any recognized threat, the facility will educate residents and responsible parties on the EMP efforts. Resident communications are included in the admission packet / resident handbook, resident and family council meeting(s)/ minutes, email and US mail correspondence.

During and after an incident, the Administrator will establish a regular location and frequency for delivering information to staff, residents, and resident emergency contacts/ responsible parties, recognizing that message accuracy is a key component influencing resident trust in the facility and in perceptions of the response and recovery efforts.

Communication will be adapted, as needed, to meet population-specific needs, including memory-care residents, individuals with vision and/or hearing impairments, and individuals with other access and functional needs.

External Communications: Under no circumstances will protected health information be released over publicly-accessible communications or media outlets. All communications with external entities shall be in plain language, without the use of codes or ambiguous language.

Authorized Family and Guardians: As part of the medical record, the facility maintains contact information of authorized family member's and guardian's (responsible parties') to include phone numbers and email addresses. Such individuals will receive information about the facility's preparedness efforts upon admission.

The initial notification message to residents and their primary point of contact (e.g., relative) will include the following information.

- Nature of the incident;
- Status of resident;
- Restrictions on visitation; and
- Estimated duration of protective actions

During an incident, the facility will notify responsible parties about the incident, status of the resident, and status of the facility by phone and email or US Mail. If the authorized individual does not have email or access to the internet, the primary means of communication will be a verbal (telephone call) and written updates via US Mail. Additional updates will be provided on at least a weekly basis to keep residents relatives/responsible parties apprised of the incident and the facility's response.

- Updates will be provided to the authorized individuals of residents infected with the pandemic infectious disease at least once per day and upon a change in the resident's condition.
- Updates will be provided to residents and authorized individuals of residents once per week on the number of infections and number of deaths at the facility.

When incident conditions do not allow the facility to contact residents' relatives/responsible parties in a timely manner, or if primary methods of communication are unavailable, the facility will utilize local or state health officials, the facility website, and/or a recorded outgoing message on voicemail, direct phone calls among other methods, to provide information to families on the status and location of residents.