MANUAL: **NURSING - COVID19 plan**
FACILITY: **Greenwood House**
DATE: Revised May, 2020 Revised 12/4/20
POLICY: **Addressing Staffing Shortage When There Are No Longer Enough Staff to Provide Safe Patient Care- CRISIS**

POLICY

It is the policy of Greenwood House to maintain appropriate staffing to provide care to our residents, even in a time of crisis or staffing shortage.

PURPOSE

To maintain appropriate staffing to ensure a safe living environment for our residents. This policy will assist in creating a contingency plan for possible staffing shortages due to medical emergencies (pandemic/epidemic) and other times of crisis.

PROCEDURE:

A. Implement regional plans to transfer residents to designated facilities with adequate staffing
B. If not already done, allow asymptomatic health care providers who have had an unprotected exposure to the virus that causes COVID-19 to continue to work
    a. These health care providers should still report temperature and absence of symptoms each day before starting work. These HCP should wear a facemask (for source control) while at work for 14 days after the exposure event. 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.
        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.
        iii. 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.
        iv. 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:
C. If health care provider is permitted to return to work before meeting all criteria, they should adhere to the following criteria:

a. Wear a facemask for source control while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
b. A facemask for source control does not replace the need to wear a KN95 or higher when indicated, including when caring for patients with suspected or confirmed COVID-19
c. They should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
d. Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
e. Whenever possible, restrict their contact with severely immunocompromised residents until the full return to work criteria has been met.

Update: If staffing is at critical levels, quarantine guidelines can be used below. Before implementing the guidelines below, the ICP and the QAPI committee will meet to discuss to ensure that staff and residents remain in the safest environment possible.

Local public health authorities determine and establish the quarantine options for their jurisdictions. CDC currently recommends a quarantine period of 14 days. However, based on local circumstances and resources, the following options to shorten quarantine are acceptable alternatives.

- Quarantine can end after Day 10 without testing and if no symptoms have been reported during daily monitoring.
    - With this strategy, residual post-quarantine transmission risk is estimated to be about 1% with an upper limit of about 10%.
- *When diagnostic testing resources are sufficient and available,* then quarantine can end after Day 7 if a diagnostic specimen tests negative and if no symptoms were reported during daily monitoring. The specimen may be collected and tested within 48 hours before the time of planned quarantine discontinuation (e.g., in anticipation of testing delays), but quarantine cannot be discontinued earlier than after Day 7.
    - With this strategy, the residual post-quarantine transmission risk is estimated to be about 5% with an upper limit of about 12%.

In both cases, additional criteria (e.g., continued symptom monitoring and masking through Day 14) must be met.