



## ***Reducing COVID-19 Mortality in Contra Costa County's Congregate Living Facilities***

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[cchealth.org/covid19/clf](https://cchealth.org/covid19/clf)



## PURPOSE: WHY TO USE THIS PLAYBOOK

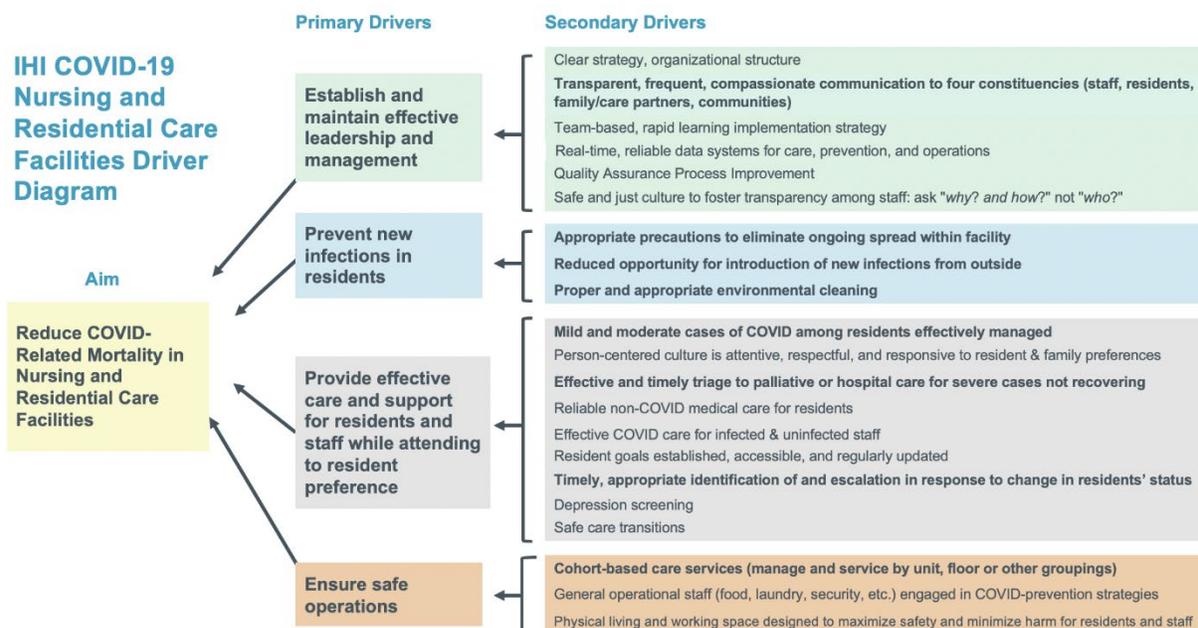


The purpose of this playbook is to support congregate living facilities in Contra Costa County to reduce mortality due to COVID-19. Governments, public health departments, and health care organizations have generated an abundance of guidance for care teams to manage this new disease. This playbook aims to distill current guidance into clear actions to be taken by leaders, staff, residents, and their families. These actions are required to reduce mortality due to COVID-19 among residents of congregate living facilities. As knowledge of the disease evolves and public health policies shift to reflect the new realities, the playbook content may also need updating.

This playbook was produced by the Contra Costa County COVID-19 Congregate Care Team, in collaboration with Contra Costa Health Services and the Institute for Healthcare Improvement (IHI). We would like to acknowledge the Contra Costa Regional Health Foundation and the Silicon Valley Community Foundation for their generous support for the development of this playbook.

## FROM THEORY TO PRACTICE

The driver diagram below outlines IHI’s theory of change for reducing COVID-related mortality in nursing homes and related facilities. This theory of change served as the foundation for development of a playbook for Contra Costa County. Secondary drivers in bold were selected by experts within Contra Costa County to be the focus of this effort.



Based on the eight prioritized secondary drivers, the following plays were developed (see visualization below).

#### 8 Prioritized Secondary Drivers for Contra Costa Playbook

Transparent, frequent, compassionate communication to four constituencies (staff, residents, family/care partners, communities)

Appropriate precautions to eliminate ongoing spread within facility

Reduced opportunity for introduction of new infections from outside

Proper and appropriate environmental cleaning

Mild and moderate cases of COVID among residents effectively managed

Effective and timely triage to palliative or hospital care for severe cases not recovering

Timely, appropriate identification of and escalation in response to change in residents' status

Cohort-based care services (manage and service by unit, floor or other groupings)

#### 8 Prioritized Plays

1. Huddles with Staff

2. Consistent Communications with Family and Care Partners

3. Implement infection prevention practices

4. Implement effective testing practices

5. Implement effective cleaning practices

6. Develop a robust visitation plan for families and care partners

7. Implement care transition practices

8. Implement care zones to group residents by COVID status

While designing an effective care delivery system to mitigate the effects of the disease requires the reliable implementation of all eight plays, IHI and Contra Costa Health Services encourage congregate living facilities to begin by implementing one or two of these plays. The plays are mutually reinforcing and interconnected; implementing one play may lead you to begin to improve processes in another. Start anywhere: you may consider where staff teams are struggling the most or build on in-house capabilities.



## IMPLEMENTATION: HOW TO USE THIS PLAYBOOK

The playbook includes this introduction, eight plays, a glossary, and acknowledgments.

Each play begins with the “play strategy,” including the purpose of the play and questions it seeks to answer. Then each play covers how to run the play, with clear descriptions of actions and indication of who should accomplish them; general tips and tricks to support implementation; special considerations for people with dementia and/or in memory care units; and additional resources with links to policies and tools.

Consider reading the short glossary first to familiarize yourself with terms.

## A NOTE ON DEMENTIA AND RELATED CONDITIONS

COVID-19 poses unique challenges and risks to people with dementia and/or living in memory care units. Cognitive deficits stemming from dementia pose challenges for infection prevention practices related to COVID-19. People living with dementia are likely to be unable to understand mask-wearing (by themselves or others) and incapable of performing physical distancing or isolating in their rooms. Quality of life may decline due to changes in routines and physical surroundings, isolation from family and friends, and a lack of stimulating activities. All of this can lead to increased agitation and confusion for those living with dementia.

Leaders should ensure that facility staff is reminded of these cognitive processing limitations and their implications during the pandemic. For care teams, a solid foundation in effective dementia care practices is imperative during this challenging time. The importance of calm, loving attention cannot be overstated: staff may pause at the patient’s door to momentarily remove their mask with a warm hello, help residents to pass the time with a favorite radio station, incorporate gentle touch, and connect to the past with photos or physical objects.

Many of the plays include a section titled, “Special Considerations for People Living with Dementia and/or in Memory Care Units.” These sections include specific implementation guidance for interacting with residents who exhibit these cognitive limitations.



## A NOTE ON QUALITY IMPROVEMENT PRINCIPLES

While this playbook attempts to provide clear, detailed guidance, no two congregate living facilities are exactly alike. Because of this, most plays will require some customization by each facility. To both save lives and save time, where possible, people implementing these plays should attempt to first test a strategy with a small group before implementing it facility-wide.

As an example, before sending an email to families of residents to notify them of updates from your facility, you might test the email with 1-2 family members to get their feedback and refine the email to better meet their needs. Strategies such as huddles and cleaning checklists will also benefit from testing with as small a group as feasible before implementing facility-wide.

Similarly, as you implement these plays, you will likely find ways to improve upon them. Ongoing conversations with staff and residents about what is and isn't working can help you to identify areas in need of improvement and to develop ideas that might result in improvement. Huddles and other ongoing communications strategies are a great venue to lift up challenges and develop potential solutions.

## A NOTE ON ROLES AND TITLES USED IN THE PLAYS

These plays attempt to use generic or widely used titles for the various roles within congregate living facilities. Before implementing a play, to help reduce confusion, consider replacing the generic titles/roles in the play with the specific titles used by your facility.



## GLOSSARY OF TERMS



**Advance care directives** – Legal documents that allow a resident/patient/client to articulate in writing their decisions about end-of-life care.

**Care partners** – Individuals (friends, unmarried partners, etc.) who provide care to residents but are not technically family members.

**CDC** – U.S. Centers for Disease Control and Prevention

**CMS** – U.S. Centers for Medicaid and Medicare Services

**Cohort** – A group of residents/patients/clients who are grouped together (generally due to similar characteristics). For this playbook, “cohort” refers to people who are COVID+, COVID-negative, or who have been exposed to COVID-19 and their status is unknown.

**Congregate living facilities** – A broad term for a range of facilities in which people live at or stay at a facility in which they are provided with care. Congregate living facilities in Contra Costa County include, but are not limited to: skilled nursing facilities (SNF), adult residential facilities (ARF), adult residential facilities for persons with special health needs (ARFPSHN), enhanced behavioral supports homes, group homes, hospice care, intermediate care facilities (ICF), residential care facilities for the elderly (RCFE), social rehabilitation facilities, and short-term residential treatment programs (STRTP).

**COVID+** – Refers to people who have tested positive for COVID-19 (with or without symptoms) and who have not (yet) cleared their current infection.

**EMS** – Emergency Medical Services

**EPA** – U.S. Environmental Protection Agency

**Family and resident councils** – Formal or informal groups of family members of people living in congregate living facilities (in the case of family councils); groups of residents (in the case of resident councils); or groups of family members and residents (in the case of family and resident councils). These councils generally provide a way for families and/or residents to keep up to date on what’s happening in the facility and offer a mechanism to advocate for improvements in the quality of care. Not all congregate living facilities have family and/or resident councils.

**Infection preventionist** – A designated professional within a congregate living facility who ensures that staff and residents/patients/clients are adhering to all requirements and guidelines to prevent infections.

**Isolation carts** – Generally mobile carts with PPE and related equipment to help prevent the spread of infections.



**Memory care units** – Units within a congregate living facility that provide intensive, specialized care for people with dementia or other memory issues.

**POLST (Physician Orders for Life-Sustaining Treatment)** – Refers to Portable Medical Orders. POLST may refer to a process, a conversation, and/or a form:

- **A process** – a part of advance care planning, which helps residents/patients/clients live their best life possible and have their medical wishes carried out.
- **A conversation** between a provider and resident/patient/client to understand and make decisions about medical conditions, treatment options, and resident wishes.
- **A medical order form** that travels with a resident/patient/client (called a POLST form).

**PPE** – Personal protective equipment is equipment worn to minimize exposure to hazards that cause injuries and illnesses. In this playbook, PPE refers to equipment used to prevent exposure to COVID-19.

**Shift supervisor** – A generic name for the head nurse, administrator, or similar position during a specific time of day (e.g., morning supervisor, night supervisor, etc.). Different congregate living facilities will have different names for these roles.

**SNFs** – Skilled nursing facilities

**Vitals** - Measurements of the body's most basic functions. The four main vital signs are body temperature, pulse rate, respiration rate and blood pressure.

**Zones (red, yellow, green)** – In this playbook, zones are areas for residents/patients/clients, demarcated in the following way:

- **Red zone:** area for residents who are COVID+ and have not cleared their infection.
- **Yellow zone:** area for residents who have been exposed, residents with unknown exposure (PUI: patient under investigation), and exposed residents who have tested negative. Isolation rooms are included in the yellow zone.
- **Green zone:** area for residents who are COVID-negative and have no known exposure AND residents who were previously COVID+ and have since cleared their infection.



## ACKNOWLEDGMENTS

This playbook was developed by the Institute for Healthcare Improvement (IHI) in collaboration with Contra Costa Health Services and the [Contra Costa County COVID-19 Congregate Care Team](#), a coalition of local residential care facilities, skilled nursing facilities, and hospital, community and advocacy groups. Thank you to everyone who contributed.



We would also like to thank the Contra Costa Regional Health Foundation and the Silicon Valley Community Foundation for their generous support for the development of this playbook.





12/3/2020

## GOAL: Develop Specific Methods to Clearly Communicate with all Staff Teams



### PLAY STRATEGY

COVID-19 is a new disease, and information about community spread, mitigation strategies, and treatment approaches are evolving. Congregate living facilities serve people who are highly vulnerable to the disease's most catastrophic outcomes, and staff members report to work with their own vulnerabilities. This ongoing crisis demands effective leadership with a strong foundation in consistent, open, and ongoing communication with staff, residents, families, and community.

How will leaders clearly communicate a series of policy adjustments? How can leaders cultivate open and trusting relationships with staff members across the congregate living facility?



### HOW TO RUN THE PLAY

#### **Senior leaders:**

- Are onsite daily and hold virtual all-staff huddles at least weekly to answer questions, hear concerns, acknowledge fears, and assess the evolving situation in-house and in the community. Leadership ensures that the COVID-19 huddle is clearly communicated as such in advance and that, after the huddle, a summary is emailed to all staff the same day. Also communicate the various types of support available to staff at all levels, including senior leaders, staff supervisors, infection preventionists, and human resources managers.
- Solicit volunteers to work in the "red zone," where COVID+ residents stay, and these leaders hold open discussions regarding staff members' concerns about working in the red zone.



### **Shift supervisors:**

- Huddle with care team staff at the start of each shift to clearly communicate infection control practices, including how to implement and problem-solve around cleaning practices, and share any updates.
- Consistently solicit questions and concerns from staff members.
- Provide one-on-one guidance to care team staff around PPE use and other infection control practices.

**Care team:** participate in huddles at the start of each shift to express concerns, practice infection control, and keep up to date on conditions within the facility and community.

**All facility staff:** participate in senior leadership huddles to keep abreast of COVID-related policies, discuss the implementation of such policies, give and receive emotional support, and navigate the challenges posed by the disease.



## **TIPS AND TRICKS**

- Establish a dedicated email address for staff questions on COVID to frame weekly Q & A huddle led by senior leaders.
- Use a video meeting platform for all-staff huddles, and send out connection information as soon as the meeting is scheduled, and again within 15 minutes of the start of the call.
- Shift supervisors incorporate COVID-related topics into existing staff huddles, specifically noting any changes in policy or COVID status.
- Care team huddles are facilitated discussions framed by questions and concerns posed by staff, and typically last 10-20 minutes.
- Leadership maintains up-to-date understanding of federal, state, and local policy developments (e.g., CMS, CDC, public health department) and COVID activity in the local environment.



## **ADDITIONAL RESOURCES**

Leadership huddle agenda: Q & A conversation and listening session; COVID status of facility and local community with related data; internal policy and practice updates (including infection control and visitation); updates from CDC and local public health department.

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## PLAY 2 Consistent Communications with Family & Care Partners

12/3/2020

**GOAL: Communicate with Residents' Families & Care Partners Openly, Compassionately & Supportively**



### PLAY STRATEGY

COVID-19 and its mitigation strategies pose a double threat to congregate living facility residents: the possibility of contracting the disease, and the well-being challenges posed by broken routines, cancelled activities, and isolation from family and friends. Residents and families are suffering as the global pandemic upends daily life for an uncertain and prolonged period of time. Compassionate communication is essential to supporting residents and families. How will congregate living facility leadership develop and maintain clear messages as the local context changes? How can leaders foster ongoing and open dialogue with families and care partners?



### HOW TO RUN THE PLAY

#### **A. Senior leaders develop multiple direct, open communication channels with families.**

- Leaders send families/care partners written communication by email at least weekly (see B below) and/or record automated phone call updates.
- Senior leaders attend meetings of the facility's family and resident councils as requested.
- Leaders hold individual conversations about safety measures with families/care partners, especially in case of quarantine.

#### **B. Senior leaders reach out directly to families/care partners at least weekly with updates by email and/or robocalls.**

- Communication template includes: facility and community conditions, patient well-being, specific and clear information around opportunities for family visits, reasons for any visitation restrictions, and the role of families in implementing current safety measures (e.g., quarantine, mask-wearing, social distancing, hand hygiene, testing).
- When there is an outbreak in the facility, leaders develop a plan for one-on-one contact with each resident's family or designated care partner, at least including residents of the unit experiencing the outbreak. Leaders and the care team divide the resident list, each contacting a



small number of people. Short, proactive conversations will stem the flow of calls and emails, ultimately saving staff time.

- When one-on-one calls to family and care partners are not possible due to time constraints, leaders ensure that a combination of mass emails and robocalls are sent to families and care partners.

**C. Senior leaders designate a staff member to serve as liaison to family/care partners.**

- Liaison is directly overseen by a senior leader to ensure that s/he is empowered to quickly make some decisions related to family and care partners' concerns.
- Liaison holds individual conversations about safety measures with families/care partners.
- Liaison gathers questions and concerns from families/care partners, through direct solicitations by email, and maintains a policy of responding to family and care partners within 24 hours.
- Liaison elevates family/care partner concerns to senior leader, who then communicates directly with affected families on that topic, includes topic in next senior leader email communication to families/care partners, and suggests the topic for inclusion in upcoming meetings of resident and family councils.

**D. Senior leaders, working with local public health and in-house resident and family councils, develop and communicate a robust visitation policy.**

- See more on this in Play 5, *Develop a robust family visitation plan*.

**E. Senior leaders and care team communicate with family and care partners the importance of having an updated advance care directive for each resident.**

- Leaders support staff to frame a family's conversation about care directives, including POLST (physician orders for life-sustaining treatment) form, to document resident's treatment preferences as medical orders.
- Senior leaders ensure that staff teams are confident using POLST forms and advanced care directives, offering training as needed.
- Care teams work with each family/care partner to keep advance care directives updated to reflect the possibilities presented by COVID.
- Leaders identify simple advance care directive resources to support families to have conversations about end-of-life care, and care teams share such resources with families and care partners for their review with, or on behalf of, the resident.
- Senior leaders ensure on a monthly basis that all residents' advance care directives are up to date.





## TIPS AND TRICKS

- One-on-one conversations with family and care partners around visitation policy and safety measures are a good time investment when starting to reopen the facility to visitors and new residents after an outbreak. When it is not possible, a combination of thorough, clear emails and robocalls is an acceptable alternative.
- Schedule regular outgoing communication with families and care partners, and use templates to frame emails in a streamlined way. Consider developing email templates for different circumstances: 1. COVID outbreak at facility; 2. No COVID cases at facility; 3. Community spread. Include in each template: regular updates on staffing, infection control practices, de-identified aggregate summary of resident health, current visitation policy, and infection control practices.
- Designate a hotline for family and care partners; disseminate a set of answers to frequently asked questions (FAQs) to be included in weekly outgoing emails and posted on the website; develop a pathway to prioritize incoming communication for follow-up.



## SPECIAL CONSIDERATIONS FOR PEOPLE WITH DEMENTIA AND/OR IN MEMORY CARE UNITS

Families and care partners of residents with dementia or in memory care units (MCUs) have unique concerns stemming from the pandemic, related to restrictions on communal life, changes in visitation policies, and requests for residents to participate in infection control practices.

Leaders reflect those concerns in communications to families and care partners and share the ways that the facility is ensuring safety while accommodating the behaviors that result from the cognitive deficits of dementia.

Leaders discuss in COVID huddles the special considerations for supporting families and care partners of residents with dementia or in MCUs, soliciting ideas, surfacing bright spots, and brainstorming solutions to challenges that arise during the pandemic.



## ADDITIONAL RESOURCES

- [Advance care directive fillable form](https://bit.ly/3obHyE6) (bit.ly/3obHyE6)
- [Advance care planning training presentation for congregate living facility staff](https://bit.ly/3fVWrHA) (bit.ly/3fVWrHA)
- [A mass communication system](https://bit.ly/2VnKCAz) (bit.ly/2VnKCAz)
- [Contra Costa County health care coalition](https://bit.ly/33Q1hSf) (bit.ly/33Q1hSf)



## PLAY 2.A EMAIL EXAMPLES FOR FAMILIES

### EMAIL EXAMPLE: No outbreak in facility and limited community spread

[Date]

#### Most Recent Update

- Over the past 24-hours there have not been any material changes within the community. There are no residents or staff that have tested positive for COVID-19.
- A reminder: Assisted living family visitors are not permitted back into the community after completing their outdoor visits. Screen, visit, leave. Please!
- *Please be aware that the community discourages window visits. These can be disruptive to other residents, pulls staff away from their assignments, and, is potentially dangerous given the location and access to resident room windows.*
- **If temperatures outdoors exceed 80 degrees, Assisted Living visitors will be directed to an indoor location for their visit.**

#### General Visitation and Screening Process

All visitors, employees and healthcare personnel are screened at our front entrance between 4:30 AM and 11:30 PM. Anyone entering after 11:30 PM will be screened by a nursing supervisor at the front entrance. Individuals permitted to enter the building must sanitize their hands at the check-point station, don a mask and wear a gown. *There are no exceptions.* Personnel arriving from another community, e.g. Hospice, etc., must wear clean scrubs upon entering.

Under Phase 2 we will permit one-adult visitor per day for compassionate/end of life care visits. While the visitor may stay as long as he/she likes, we do request that you visit during normal business hours in order for the staff to be able to sanitize the apartment or room after you leave. Please reach out to your respective nurse manager for additional details.

Scheduled outdoor family visits - one adult visitor only - with residents residing in Assisted Living and Memory Care are now permitted.

In order to schedule a visit, please follow the instructions below:

1. **Schedule and confirm a time. The new number to call-in to reserve times is # and is specifically for visits.** You'll receive updated instructions under separate cover.
2. Arrive 5 – 10 minutes before your scheduled appointment. Visiting hours are limited to 10 AM – 11:45 AM; 2 PM – 4:45 PM; and, 6 PM – 7 PM.
3. Proceed to the main entranceway and screening table in the main lobby. You must have a mask on before entering the building. Any of these type masks are acceptable: Cloth masks must be 3-ply; surgical masks must be certified; N-95 masks must be properly fitted.



4. After screening, sanitize hands and move back outside. Once back outside make a left and another left toward the Main Dining Room patio area.
5. Please remain at least 10-feet from your loved-one and refrain from hugging, touching, kissing, etc. The chairs and/or tables will be in the correct distance for visits. Please do not move these.
6. You will be permitted to visit for 45 minutes; a caregiver will be present should you need assistance or your visit is shorter than the allotted time.
7. Following the visit, please leave the area to allow staff time to sanitize the surfaces and prepare for the next visitor; You may not re-enter the building for any reason.
8. Since it can be quite warm here, please bring your own water to remain hydrated; staff will provide water for residents.

If you have any questions, please reach out to (name) at (number) for assistance.

### Employee COVID-19 Testing

Baseline testing for employees resumes [DATE] for on-going monthly testing.

- On-going monthly testing is required for all employees. CCCDPH has made this a ‘condition of employment.’
- Contra Costa County drive-up site testing for employees is easy: Call (844) 421-0804 to schedule an appointment (make sure to tell them you are a health care worker), drive to the site and get tested while remaining in your vehicle the entire time, and receive results in 24-48 hours. You don’t need a doctor’s order to get tested. There is no up-front cost for testing. You do not need medical insurance to get tested, however, if you have health insurance, your insurance will be billed. You will not be asked about your immigration status.
- While we encourage all individuals to get tested regularly – residents, employees, families – we will not collect or track results of family members. We expect that if you test positive, you will not enter the community and follow your care provider’s and CDC guidance for quarantine and/or hospitalization.

### Masks

Employees are required to wear *surgical* masks at all times based upon the recommendations issued by the CDC. All employees and visitors *must* wear a face covering upon entering the building.

### Social Distancing

Social Distancing reminder: Resident groups may expand to a maximum of 10 total (residents and staff) per group as long as they are able to maintain standing/sitting at least 6-feet apart. Please wear your masks at all times when leaving your apartment, and, when caregivers enter your apartment.



## **EMAIL EXAMPLE: Outbreak in the Facility**

[Date]

To our Residents, Families and Employees

During this pandemic crisis, as you know, we have taken proactive measures to protect our residents as much as we can. Unfortunately, since [DATE] our SNF unit has been placed in COVID-19 Outbreak status by Contra Costa Health Services (CCHS) due to one positive case in the SNF unit.

At this time, there are no additional cases to report. Regardless, to limit the spread of COVID-19 within our community, CCHS has requested the following:

- The SNF unit is closed for new admissions
- Communal dining and group activities are closed
- All SNF employees and associated, including ancillary departments staff (Dining Services, HSKP/Laundry, Maintenance, Life Enrichment, Rehab) as well as all SNF residents will be tested weekly until all results negative for at least 2 consecutive weeks.
- Essential visitors only (internally)
- Outdoor Visitation is opened for SNF residents with no known exposures: at this time, some of the SNF residents have been placed on a 14-days quarantine (just a preventive measures) and can't have visitors

Please review the included Visitation Guidance for Facilities While in an Outbreak/Being Monitored by Public Health after Positive Case Identified

- Visitors must be informed of the COVID-19 status of the facility
- Visitors must be screened for COVID-19 symptoms and fever
- Visitors to complete a Visitor Screen Form after being screened
- After screening, visitors are asked to sanitize hands and move to assigned locations: Main Dining Room patio – AL/MC; SNF patio – SNF.
  - At this time, visitation takes place outside only, and be in a location that allows 6 feet or more distancing and includes no hand shaking, hugs, etc.
- Visitors and residents should wear masks during the visits
- Following the visit, visitors are asked to leave the area to allow staff time to sanitize the surfaces and prepare for a next visitor
- Visitors may not re-enter the building for any reason
- No pets allowed during the outdoor visit.



This is a fluid time with circumstances changing daily. We will continue to communicate with you on a regular basis when updates are available.

Again, with the assistance of our residents, family members and valued staff, [facility name] is committed to keeping our seniors safe, healthy, and comfortable. We are grateful for your partnership on this journey.

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12/3/2020

## GOAL: Implement a Range of Practices to Prevent the Spread Of COVID-19



### PLAY STRATEGY

A communicable disease poses grave challenges to congregate living facilities, especially in the case of COVID-19, a new disease that is still only partially understood. Preventing the spread of infection is crucial to protecting the health and safety of residents, staff, and their families. How can congregate living facilities limit the spread of COVID-19 within the facility? What supports do care teams need to enable them to consistently use infection prevention techniques? How can the role of the infection preventionist be leveraged to best effect?



### HOW TO RUN THE PLAY

- A. All congregate care facility staff consistently use infection prevention techniques in each shift, including appropriate use of personal protective equipment (PPE), physical distancing from coworkers, and adherence to cohort-based care team designation (i.e., staff in each zone provide care only in that zone, with some fluidity permitted between yellow and green zones given proper use of PPE).**
- All leaders and supervisors ensure that the purpose of infection prevention practices is consistently communicated: “We are keeping each other and our families safe.”
  - Leaders ask staff to elect colleagues to audit adherence to infection prevention protocols.
  - Shift supervisor and elected colleagues monitor PPE use, hand hygiene, and social distancing of the staff team in each shift, including in break rooms and staff-only spaces.
  - Shift supervisor coaches staff team in key infection control practices (including proper use of PPE, hand hygiene, social distancing) in daily huddles and in real time when observing mistakes.
  - Supervisors provide ongoing supervision around the proper use of PPE, with particular attention to common challenges, including guidance on when and where masks can be removed, on eliminating the mistaken behavior of removing and replacing an N95 mask



throughout the day, and on the importance of the annual N95 fit test (to ensure that all staff wear correctly sized masks).

**B. Senior leaders ensure that all facility staff (including certified nursing assistants, bath aides, kitchen, facility manager, custodial staff) are trained and receive ongoing supervision in infection control practices.**

- Training in basic preparedness in infection control includes HOW to implement infection control practices (PPE with specifics on donning, doffing, and disposing or disinfecting used items; implementing patient care zones (see Play 8); cleaning practices (see Play 5)) and WHY all staff must implement these practices (facts on virus pathways and limiting spread, safety of all staff and their families). Offer levity and humor, especially in reviewing ways that infection prevention practices collapse, and encourage staff to identify other pitfalls and suggest solutions.
- Training is offered in all languages used by staff.
- Colorful posters illustrating infection prevention practices and habits are posted in break rooms and gathering spaces to promote continuance of infection control measures in staff-only spaces.

**C. Leadership ensures that infection prevention methods are easy for staff to implement.**

- Leadership introduces and implements a simple cue system to prompt all workers to participate in site-wide cleaning at intervals throughout shifts. See Play 5: *Cleaning and disinfecting practices*.
- Leaders designate infection preventionist to surveil physical placement of infection control and care materials (see D).
- Leadership tracks and maintains adequate PPE supplies and requests back-up supplies from county health department when needed.
- Leadership develops a contingency plan for PPE use in the event that adequate PPE is unavailable, as well as related communication plans to share this information with staff, residents, families, and care partners.

**D. Leadership identifies, trains, and supervises at least one full-time registered nurse as the *designated infection preventionist*.**

- Infection preventionist ensures strategic physical placement of infection control and care materials to support staff's ability to develop the required infection control practices as habits — e.g., entering patient room only once with all necessary items. The infection preventionist takes responsibility for the following activities:
  - Place a large garbage receptacle in each patient room for staff to doff gown and PPE before exiting room.



- Place isolation cart in front of patient room, or alternatively, a few per hallway in highly visible locations.
- Position hand sanitizer inside and outside patient rooms.
- Ensure that windows are open in all shared spaces, weather permitting.

**E. Infection preventionist monitors cleaning and specifies cleaning protocols to be completed by all staff, assigning additional cleaning or monitoring as appropriate. The following measures can facilitate this work:**

- Check that staff participate in site-wide cleaning when auditory cue sounds.
- Post colorful signs with fun print about PPE and infection control precautions in languages that staff are comfortable using (e.g., Tagalog, Mandarin, Spanish).

**F. Leadership clearly communicates and implements policy around isolation and quarantine for exposed staff.**

- Care team staff immediately inform supervisor about any contacts they have had with COVID+ people outside of work and of contacts with residents outside of their assigned zone.
- All staff working in any role stay home if they have COVID symptoms, and report their symptoms to supervisor.
- Supervisor elevates information about a patient under investigation (PUI) or symptomatic staff to infection preventionist and leadership.
- Leadership ensures that all patients that had been working with any staff member who tested COVID+ are assigned or reassigned to the yellow zone.
- Leadership ensures that staff are reassigned to administrative duties during 14-day quarantine period; if administrative work is unavailable, leaders will ensure that staff sick time policy allows staff to quarantine at home.
- Leadership determines patient assignment tracking method, such as a sign-in sheet on each resident's door or a shift-wide sign-in sheet listing patient assignments for each staff member.
- Shift supervisor ensures that all staff document patient assignments in each shift.
- Leadership maintains and shares with staff information about various resources to support them during the pandemic, including information about leave of absence rights, hotel accommodation for health care workers, and mental health support lines.



**G. Leaders implement policies that limit non-essential entry to facility by professionals seeking to visit the facility on business.**

- Leadership ensures that non-essential professional visits are disallowed until further notice, designating an outdoor space to receive deliveries and requiring virtual vendor visits.
- Infection preventionist ensures that allowed visitors (e.g., ombudsman, legal counsel) are screened for COVID-19 (see Additional Resources for screening items handout) and made aware of required infection prevention practices, including sanitizing hands upon building entry and exit, mask-wearing at all times, and use of appropriate PPE.
- Infection preventionist ensures that colorful signs are placed at all entries, near elevators, and throughout site about PPE and infection control precautions.

**H. Leaders ensure that families and care partners are screened for COVID-19 and made aware of infection prevention practices. For details, see Play 6: *Develop a robust visitation plan for families and care partners.***

**I. Leaders maintain use of red/yellow/green patient care zones and ensure that staff work within a single zone in each shift. For details, see Play 8: *Implement care zones to group residents by COVID infection status.***

**J. Leadership ensures that effective testing and cleaning practices are followed. For details, see Play 4: *Testing practices* and Play 5: *Cleaning and disinfecting practices.***



## TIPS AND TRICKS

- Institute a buddy system to doff large gown (to reduce the risk of, for example, touching the face while doffing).
- Place mirrors in staff room to check for correct PPE placement.
- Ensure that staff are aware of protecting their airway by removing mask last.
- Use a PPE [“burn rate” calculator](https://bit.ly/3fTI8Vi) (bit.ly/3fTI8Vi) to calculate needed PPE supplies, and document the contingency plan if PPE supplies are not available.
- Consider partnering with community groups to develop culturally grounded messages about infection prevention for inclusion in training modules, posters, and printed materials supporting infection prevention practices.
- Leaders and care teams consider how the facility can reconfigure shared spaces to physically prompt social distancing (e.g., great distance between chairs).





## SPECIAL CONSIDERATIONS FOR PEOPLE WITH DEMENTIA AND/OR IN MEMORY CARE UNITS

- Staff recognize that people with dementia and/or in memory care units may not be able to process, understand, or retain information around wearing masks, physical distancing, refraining from wandering, and other safety measures.
- The facilities should work to develop customized strategies that work for each resident and keep others safe. For example, a person with dementia may not be able to wear (or continue wearing) a mask without becoming agitated. The facility can work to keep others safe by ensuring that others engage in infection prevention behaviors (mask-wearing, physical distancing, etc.) as the resident moves throughout the facility.
- Staff should check to see if individual residents can hear, understand, and retain this information. In cases where the resident cannot understand or retain this information, the care team should develop a customized plan to provide appropriate care to the resident while keeping other residents and staff safe.



## ADDITIONAL RESOURCES

- [CDC recommendations for infection prevention and control for healthcare workers](https://bit.ly/3lr0M72) (bit.ly/3lr0M72)
- [CMS guidance for visitation](https://go.cms.gov/2Vn8fZY) (go.cms.gov/2Vn8fZY)
- [CMS guidance on duration of isolation for adults with COVID](https://bit.ly/3oe2j1R) (bit.ly/3oe2j1R)
- [CDC guidance on using PPE](https://bit.ly/39tSAR3) (bit.ly/39tSAR3)
- [CDC "PPE lessons" mini-webinar \(scroll to the bottom of the page\)](https://bit.ly/3oiOH5H) (bit.ly/3oiOH5H)
- [CDC "hand washing" mini-webinar \(scroll to the bottom of the page\)](https://bit.ly/37wjx46) (bit.ly/37wjx46)
- [CDC PPE burn rate calculator](https://bit.ly/3fTI8Vi) (bit.ly/3fTI8Vi)
- [Contra Costa Health Services outbreak checklist](https://bit.ly/37rzQ20) (bit.ly/37rzQ20)
- [Contra Costa Health Services Instructions to healthcare workers who are close contacts to a COVID-19 case](https://bit.ly/3qtlIxY) (bit.ly/3qtlIxY)



## PLAY 3.A - COVID-19 SCREENING CHECKLIST

All visitors should go through a COVID-19 screening, including temperature checks and responding to the questions below. A temperature above 100 degrees (Fahrenheit) and/or a “yes” answer to any of these questions will preclude a prospective visitor from entering the facility. They will be asked to leave, and the area where they were asked these questions will be thoroughly cleaned and disinfected.

1. Do you have any of these symptoms that are not caused by another condition?
  - Fever or chills
  - Cough
  - Shortness of breath or difficulty breathing
  - Fatigue
  - Muscle or body aches
  - Headache
  - Recent loss of taste or smell
  - Sore throat
  - Congestion
  - Nausea
  - Vomiting
  - Diarrhea
2. Within the past 14 days, have you had contact with anyone that you know had COVID-19 or COVID-like symptoms? Contact entails being within 6 feet (2 meters) or closer for more than 15 minutes of a person, or having direct contact with fluids from a person (for example, being coughed or sneezed on).
3. Have you had a positive COVID-19 test for active virus in the past 10 days?
4. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

*This playbook, available at [cchealth.org/covid19/clf](https://cchealth.org/covid19/clf), was developed by the Institute for Healthcare Improvement (IHI), Contra Costa Health Services and the Contra Costa County COVID-19 Congregate Care Team, with generous support from the Contra Costa Regional Health Foundation and the Silicon Valley Community Foundation.*





## PLAY 4 Implement Effective Testing Practices

12/3/2020

**GOAL: Implement Effective & Efficient Testing Practices that Adhere to Federal, State, and County Guidelines**



### PLAY STRATEGY

Congregate living facilities must minimize the risk that residents and staff will contract COVID-19. In the event that any do test positive, the facilities must be able to immediately intervene. Therefore, facilities must develop and implement effective testing plans for staff, residents, and visitors.

See the section below titled “Special Considerations for People with Dementia and/or in Memory Care Units” for additional guidance on this sub-population of residents.



### HOW TO RUN THE PLAY

#### A. Testing of New Residents and Re-admitted residents

- The designated infection preventionist should ensure that **new residents and re-admitted residents** are tested in accordance with the guidance in the [California Department of Public Health All Facilities Letter \(AFL\) 20-53.3](#) ([bit.ly/37sGmFt](http://bit.ly/37sGmFt)).
- If testing is not available, follow [the guidance in the absence of available testing](#) ([bit.ly/3oc6JX8](http://bit.ly/3oc6JX8)) issued by the California Department of Social Services.

#### B. Ongoing Testing of Residents and Staff

- Each day senior leaders review any new testing data to determine whether their congregate living facility has an active case of COVID-19 among staff and/or residents and then proceeds with ongoing testing based on this.
- The infection preventionist regularly check (at least twice weekly) for any new guidance from the U.S. Government, State government, County and/or any licensing body. Some guidance may be more restrictive than the guidance in this play.
- Staff or residents who have symptoms of COVID-19 should be tested as quickly as feasible.
- If a **Skilled Nursing Facility** has **no active cases and the county in which the facility is located has less than a 10% positivity rate**, the designated infection preventionist should



develop and implement a plan to conduct surveillance testing of **100 percent of all staff every seven days.**

- If a **Skilled Nursing Facility has no active cases but the county in which the facility is located has a 10% or higher positivity rate**, the designated infection preventionist should develop and implement a plan to conduct surveillance testing of **100 percent of all staff two times per week.**
- If a congregate living facility (other than a Skilled Nursing Facility) has **no active cases**, the designated infection preventionist should develop and implement a plan to conduct surveillance testing of **25 percent of all staff every seven days.**
  - The infection preventionist should choose different staff to test every seven days.
  - If testing is not available, follow [the guidance in the absence of available testing](https://bit.ly/33Qqdcj) (bit.ly/33Qqdcj) issued by the California Department of Social Services.
- If the congregate living facility has **one or more active cases** among staff or residents, the infection preventionist should **test or retest all (100 percent) of congregate living facility staff and residents.**
  - The initial tests/retests should all be conducted within 12 hours for all staff working that day and residents who are currently at the facility.
  - Staff who are not working that day should be tested at the beginning of their next shift.
  - Newly admitted residents or returning residents should be tested as they enter/re-enter the facility.
  - The retests of all staff and residents should be performed at least every seven days, until no new cases are identified in two sequential rounds of testing.
  - If testing for all staff and residents is not available, follow [the guidance in the absence of available testing](https://bit.ly/33Qqdcj) (bit.ly/33Qqdcj) issued by the California Department of Social Services.

### C. Testing Visitors

- Federal and California guidance does not suggest routine testing of visitors but does require that each congregate living facility conducts initial screening for any/all individuals entering congregate living facility. For more information on visitors, see Play 6: *A robust visitation plan for families and care partners.*



## D. Conducting Tests

- The test used should be an authorized nucleic acid or antigen detection assay for the SARS-CoV-2 virus, used as recommended for testing in nursing homes by the CDC, with results obtained within 48 hours.
- Skilled nursing facilities (SNFs) may use the [Point of Care \(POC\) antigen testing](https://bit.ly/3muael4) (bit.ly/3muael4) instruments distributed by the Department of Health and Human Services. POC antigen test should be used on symptomatic staff or residents as guided by the manufacturer instructions. As appropriate, testing in SNFs using POC antigen test may be used in accordance with [California Department of Public Health guidance](https://bit.ly/3fVCJvL) (bit.ly/3fVCJvL).



### TIPS AND TRICKS

- Federal, state, and/or county guidance may be updated frequently, so it is critical to have the designated infection preventionist check for updates at least weekly.
- If your facility allows one family member/care partner to be designated as a part of the resident's care team, test that person as staff is tested.



### SPECIAL CONSIDERATIONS FOR PEOPLE WITH DEMENTIA AND/OR IN MEMORY CARE UNITS

- If the resident has a care partner with power of attorney, the facility needs to get permission from that person before testing.
- For instances where the person with power of attorney declines having the resident tested:
  - If there are no cases within the facility, continue as usual.
  - If there are cases in the facility, monitor the patient closely.
  - If they begin showing symptoms, begin treatment (in consultation with a medical professional).





## ADDITIONAL RESOURCES

- [California Department of Public Health AFL 20-53.3](https://bit.ly/39Bla1J) (bit.ly/39Bla1J)
- [California Department of Public Health Guidance on the Use of Antigen Tests for Diagnosis of Acute COVID-19](https://bit.ly/3g0D3JB) (bit.ly/3g0D3JB)
- [California Department of Social Services – PIN 20-38-ASC](https://bit.ly/3myEoda) (bit.ly/3myEoda)
- [Center for Medicare and Medicaid Services, HHS - Title 42 CFR 483.80\(h\)](https://bit.ly/3qiSfXn) (bit.ly/3qiSfXn)
- [CDC Guidance on Antigen Testing in Nursing Homes](https://bit.ly/33zj7J3) (bit.ly/33zj7J3)
- [California Coronavirus testing task force](https://testing.covid19.ca.gov) (testing.covid19.ca.gov)

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12/3/2020

## GOAL: Implement Effective & Efficient Cleaning & Disinfecting Practices to Prevent Spread of COVID-19



### PLAY STRATEGY

Communicable diseases pose a grave threat to congregate living facilities, especially in the case of COVID-19. Preventing the spread of infection is crucial to protecting the health and safety of residents, staff, and their families. Regular cleaning and disinfecting using approved disinfectants and equipment is a key component of every facility's plan. What should facilities clean? How should they clean? How often? Who should be responsible for cleaning?



### HOW TO RUN THE PLAY

#### A. DEVELOP A PLAN

- **Ensure that all staff have a role in cleaning and disinfecting**
  - Leadership identifies, trains, and supervises at least one full-time registered nurse as the **designated infection preventionist**.
  - Shift supervisors are responsible for the implementation of the cleaning and disinfecting plan for their shifts.
    - Walkarounds help shift supervisors to understand how cleaning fits into the workflow of the facility, the time required for cleaning, and any barriers to completing effective and efficient cleaning.
    - Shift supervisors shadow staff as they clean, and monitor to ensure that staff have completed cleaning in accordance with the facility's policies.
  - Leadership gives all staff specific cleaning and disinfecting assignments that are based on their roles and that, in many cases, can be embedded into existing workflows.
  - All staff are trained on their specific roles and responsibilities and how to carry them out (see below: "Identify who will be responsible for cleaning and disinfecting")



- The infection preventionist will make lists detailing what to clean, how, when (how often), and by whom (specific roles/positions within the facility). These lists are described in more detail below.
- **Determine what needs to be cleaned and disinfected**
  - The designated infection preventionist, or their designee, makes a full and complete list of all surfaces, tools, and equipment that will need to be cleaned and disinfected.
  - These should be divided into two categories:
    1. Hard and non-porous materials (e.g., glass, metal, plastic)
    2. Soft and porous materials (e.g., carpets, rugs, material in seating areas)
  - Areas unoccupied for seven or more days need only routine cleaning.
  - Maintain existing cleaning practices for outdoor areas.
  - Focus on high-touch and high-risk surfaces such as door handles, light switches, chairs, etc. that should be cleaned and disinfected at least two times per day.
  - Focus on high-touch and high-risk tools/equipment such as stethoscopes, keyboards, walkers, etc. that should be cleaned and disinfected before and after each use.
  - Consult [CDC's Decision Tool](https://www.cdc.gov/decision-tool) (bit.ly/3ltQJ15) for additional information.
- **Determine how areas/surfaces will be cleaned and disinfected**
  - The infection preventionist or their designee will detail how each area/surface within the facility will be cleaned.
  - Consider the type of surface and how often the surface is touched.
  - For hard and non-porous materials like glass, metal, or plastic:
    - Make sure to use the [EPA list of approved disinfectants](#).
    - For each hard and non-porous surface item, list the EPA-approved disinfectant(s) and equipment (e.g., gloves, mop, etc.) available at your facility.
    - Provide instructions on how to apply/use each product:
      - Clean the surface first.
        - Generally go from cleaner areas on the surface to dirtier areas.
        - Generally go from top of the surface to bottom.
        - Clean dirty surfaces with soap and water prior to disinfection.



- Then apply the disinfectant, always following the instructions on the label for the product.
    - Know how long the disinfectant needs to remain on the surface to be effective (contact time) and follow this guidance.
  - For soft and porous materials like carpet, rugs, or material in seating areas:
    - Remove soft and porous materials in high-traffic areas, when feasible.
    - For each soft and porous material item, list the appropriate way of cleaning and disinfecting the material (e.g., laundering, use of disinfectant approved for that material, etc.) and the equipment used (e.g., spray, washer, etc.).
    - Thoroughly clean or launder materials.
    - Disinfect materials if appropriate [EPA-approved products](https://www.epa.gov/3mofwqx) (bit.ly/3moFwQx) are available.
- **Identify who will be responsible for cleaning and disinfecting**
  - Leadership identifies, trains, and supervises at least one full-time registered nurse as the **designated infection preventionist**. The infection preventionist will work with other staff to develop, implement, and improve upon the plan, including keeping abreast of any updates to federal, state, or county guidance.
  - The **infection preventionist** or their designee will match each role/position at the facility with cleaning and disinfecting assignments.
  - **Each staff member** will work to embed their cleaning and disinfecting assignments into existing workflow (where feasible).
  - **Shift supervisors** track and monitor cleaning and disinfecting for their shift.
- **Put it all together to make it easy to remember and track**
  - The infection preventionist or their designee will turn the what, how, when, and by whom (from above) into checklists (see the Using Cleaning and Disinfecting Checklists Mini-Play for more information).
  - Make cleaning and disinfecting easy to remember (and hard to forget).
    - Train staff on the plan (in the primary languages of each staff member).
      - Detail what, how, when (how often), and by whom.
      - Consider making a video so that staff can watch on their own time.
      - Update and revise the training and plan as needed.
    - Work elements of the plan into ongoing staff huddles and communications.



- Provide demonstrations on cleaning and disinfecting specific items/materials.
- Solicit questions and concerns about cleaning and disinfecting.
- Provide updates to guidance and/or the plan.
- Use posters, automated audio reminders, mini-checklists (e.g., in the area to be cleaned and disinfected) and other visualizations throughout the facility.
- Make more detailed instructions (e.g., this play) easily accessible.

## **B. IMPLEMENT THE PLAN**

- Consider using checklists to guide and track cleaning and disinfecting.
- Use huddles to:
  - Provide ongoing training/re-training
  - Identify challenges, questions, concerns and new ideas
  - Decide which new ideas to test
  - Provide updates on the results of new ideas tested
  - Provide updated guidance, roles, checklists (including successful tests that have been incorporated into the guidance)
- The infection preventionist or their designee ensures that the following are readily available to staff:
  - Clearly marked supplies and equipment needed for cleaning and disinfecting
  - This play (including the links to additional resources)
  - Checklists by role/position:
    - In a language understandable to the person in the role
    - For each shift (for tracking and monitoring)
  - A method for staff to anonymously report challenges and issues
- Shift supervisors or their designees track and ensure that cleaning and disinfecting protocols and procedures are being followed:
  - Consider using daily, simple checklists for each staff member to help them remember their assignments and track completion of them.
  - Consider the use of a performance improvement process device (e.g., adenosine triphosphate (ATP) or fluorescent light testing) to ensure that cleaning is being done adequately.



### C. MAINTAIN AND REVISE THE PLAN

- Infection preventionist checks for updated guidance at least weekly from:
  - Federal sources (CDC, EPA, etc.)
  - California Department of Public Health and California Department of Social Services
  - Contra Costa Health Services
- Infection preventionist maintains contact with other facilities to work on common challenges together and implement bright spots from other facilities.
- Shift supervisors and facility leadership use huddles to discuss the plan, and staff communication contains regular reminders about policies and procedures for cleaning and disinfecting.
- All staff use huddles to identify questions, concerns, and challenges, and to present new ideas.
- All staff use anonymous method to report concerns as needed.
- New ideas are tested (using small tests of change) and are incorporated into the overall guidance and checklist(s) should they prove successful.
- Infection preventionist updates the checklists for role/positions as the guidance changes and/or as staff develop more effective and efficient approaches to following this guidance.



### TIPS AND TRICKS

- While time-intensive in the beginning, checklists for each role/position for each day make it easier and more efficient for all staff to complete their assignments.
- Encourage staff to find new ways to incorporate their cleaning and disinfecting assignments into their existing workflow (and to report back on what they find so it can be formally incorporated into the plan).
- Encourage staff to come up with new ideas to test to make cleaning and disinfecting more effective and efficient.
- Celebrate the work of staff for adhering to the guidance on cleaning and disinfecting.
- Learn from other facilities their best practices and consider adapting them for use at your facility.





## ADDITIONAL RESOURCES

- [CDC Detailed Guidance for Cleaning and Disinfecting](https://bit.ly/33BBOM1) (bit.ly/33BBOM1)
- [CDC Decision Tool for Cleaning and Disinfecting](https://bit.ly/3o6mSgO) (bit.ly/3o6mSgO)
- [CDC Cleaning and Disinfecting Your Facility – Everyday Steps](https://bit.ly/36qk6Nq) (bit.ly/36qk6Nq)
- [EPA List of Approved Disinfectants](https://bit.ly/33Bu9NT) (bit.ly/33Bu9NT)
- [CDC: Sparkling Surfaces Webinar](https://bit.ly/39xOZBt) (scroll down to bottom of page) (bit.ly/39xOZBt)

## PLAY 5.A – USING CLEANING AND DISENFECTING CHECKLISTS MINI-PLAYIST

- To help ensure regular and adequate cleaning and disinfecting at the facility, consider develop a series of checklists that include the following:
  - The item (e.g., area, equipment, etc.) to be cleaned
  - How each item on the list is to be cleaned (e.g., disinfectant wipes (name specific approved disinfectant), vacuuming, from top to bottom, etc.)
  - How often each item is to be cleaned (e.g., per shift, per use, once per day, etc.)
  - Who is responsible for cleaning each item (e.g., nurse, housekeeping, health aide, person using the equipment, etc.)
  - The resources and equipment to be used to clean each item
  - How the cleaning can be incorporated into existing workflows (where feasible)
  - A mechanism for tracking and monitoring that the assignment(s) have been completed as prescribed
- Consider making the following checklists:
  - **Infection Preventionist Cleaning and Disinfecting Checklist** for use by the infection preventionist
    - Tracking the work by shifts and the work of shift supervisors in monitoring the work of their shifts
    - Identifying challenges, questions, and concerns
    - Answering and disseminating answers to challenges, questions, and concerns
    - Reminders to check for updated federal, state, or county guidance



- **Shift Cleaning and Disinfecting Checklist** for use by shift supervisors (AM, PM, etc.)
  - Tracking the work done by role/position for their shifts
  - Ongoing training, problem-solving via huddles, etc.
  - Verifying that the required cleaning and disinfecting for their shift has been carried out
- **Facility Role/Position Cleaning and Disinfecting Checklists**
  - Each role/position within the facility has a customized checklist outlining their specific roles and responsibilities (e.g., list for nurses, list for housekeeping, etc.)
  - Each checklist includes:
    - What to clean
    - How to clean it
    - When (how often) to clean it
    - Tracking and documenting their cleaning (for each shift they work)
    - Tracking and documenting supplies, equipment, and orders for new supplies/equipment (applicable only to certain roles)

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## PLAY 6 Develop a Robust Visitation Plan for Family & Care Partners

12/3/2020

**GOAL: Develop a Clear and Robust Visitation Policy Ensuring Residents have Access to the Highest Possible Level of Family and Care Partner Support**



### PLAY STRATEGY

Mitigation strategies for COVID-19 pose a threat to congregate living facility residents in the form of severe well-being challenges. Disconnection from family, broken routines, and cancelled activities may lead to isolation, anxiety, depression, and physical and cognitive deterioration. Residents and their families are suffering as the global pandemic upends daily activities in an ongoing way for an uncertain duration of time. Families and care partners are essential to residents’ well-being, advocating for their needs, assisting with activities of daily living (ADLs), and providing needed connection and continuity.

How can facilities attend to residents’ needs for social interaction and familial care while upholding their dignity and autonomy? How can residents, families, care partners, and care teams co-create holistic care plans, identifying interactions and care activities that residents may prefer to be accomplished by families and care partners? How can infection control practices allow facilities to leverage family members’ efforts to support residents?



### HOW TO RUN THE PLAY

- A. Senior leaders develop and clearly communicate a robust visitation policy allowing for maximum possible family contact in accordance with public health guidelines (see [All Facilities Letter 20-22.5](#) ([bit.ly/37xH3gX](http://bit.ly/37xH3gX))). The policy outlines an array of visitation modalities, including outdoor, indoor in shared space, in-room, and virtual. The policy offers guidelines for visitors’ movement and behavior in the facility, including screening and infection control measures at entry; designating a specific path to the resident’s room or meeting place; and engaging in consistent infection prevention practices.**



- Leaders prioritize outdoor visits for residents who are able to comfortably leave their rooms and be outside. Designate a staff member to manage the scheduling of visits in outdoor space. Identify outdoor areas that can accommodate multiple simultaneous visits and arrange the space to promote social distancing. Consider sheltering the outdoor space from sun, wind, cold, and light rain.
- Ensure that visits can occur in indoor communal areas when outdoor visits are not possible. Space must be large enough to allow 6-foot distancing (e.g., lobby, cafeteria, activity room) with physical barriers to allow simultaneous visits for multiple residents when possible.
- Facilities may allow in-room visits if the facility is not currently in an outbreak investigation and is not located in a county with widespread community infection (e.g., purple tier). Families and care partners visiting in resident rooms are required to engage in infection control measures, including wearing masks and observing 6 feet of physical distancing. For residents with roommates, the infection preventionist arranges the indoor visit in a different indoor space or without the roommate present in the shared room.
- Facilities that are in outbreak status may allow indoor visits in communal spaces only for residents in the “green zone” (i.e., tested negative and no known exposure). Procure technological equipment to allow virtual visits when other options are not possible. Consider designating a member of the care team to serve as a connector who facilitates virtual visits between residents and families. When other visits are not possible, the care team facilitates virtual visits at least twice per week or as requested by resident or family/care partner.

**B. Leaders and infection preventionist develop an array of supports to ensure that families and care partners practice infection prevention.**

- Leaders establish system to ensure that each visitor is screened for COVID-19 symptoms and fever upon entry and that all sign in a visitor log including date, time, and contact information.
- Leaders provide information about local testing sites and encourage family members to seek routine testing.
- Infection preventionist ensures that physical space enables and promotes social distancing in any potential visit location: outdoors, communal area, or in-room.
- Infection preventionist ensures that colorful posters are visible (at entries, in communal areas, in hallways, and near elevators) to communicate infection prevention practices (hand hygiene, physical distancing, mask wearing). Include details on designated visitor restrooms and the required path to each visit location.
- Infection preventionist ensures that hand sanitizer is available throughout common spaces, visitation areas, and in resident rooms.



- All visitors use hand sanitizer upon entering both the facility and location of resident visit, wear mask at all times in facility, refrain from touching others, and limit their movement within the facility to the designated visit space, in addition to submitting to screening for COVID-19 symptoms and fever, and signing their name and contact information, upon entry.

**C. Leaders clearly define compassionate care visits to support residents’ emotional well-being, and leaders communicate that residents’ emotional well-being is central to the individual care plan. Compassionate care visits are those that, among other things, will improve the resident’s quality of life, ease suffering, boost morale, aid with ADLs, support nourishment, or provide comfort.**

- Leaders co-create with family advisory board a policy indicating a broad scope of compassionate care visits. Policy outlines general parameters of compassionate care visits, including reasons for need for compassionate care and the need for leaders to review needs on a case-by-case basis. The guiding principle of compassionate care visits is the potential impact on a resident’s quality of life and physical or emotional well-being, and determinations take into consideration both the potential positive impacts of visits and negative impacts of isolation.
- Leaders recognize that residents will likely need compassionate care visits to recur over time, and case-by-case determinations should establish at least an initial set of allowed visits, to be reviewed at least monthly.
- Leaders ensure that the policy indicates that some compassionate care visitors may be required to comply with social distancing, while others may be granted permission to physically touch the resident. The leaders’ case-by-case determination will take into account not only end-of-life circumstances but also needed assistance around ADLs and other considerations (e.g., dementia, cognitive impairment, agitation, depression).
- In a case where the visitor is granted permission to touch the resident, facility leaders or infection preventionist will ensure that the visitor submits to testing at least weekly for COVID-19 in addition to upholding infection prevention practices, including mask-wearing, frequent hand sanitization (including at entrances to facility and to visit location), and screening for COVID-19 symptoms at entry. As with other visitors, infection preventionist will ensure that compassionate care visitors move directly to the visit location (resident room or designated visit area) on a designated path.
- Leaders designate a member of each care team to manage compassionate care visits, including scheduling in advance for a specified period of time.



**D. Designate a family member or care partner as part of the congregate living facility’s essential care team.**

- Leaders create a document naming the designated care partner, to be included in the resident’s file, indicating that the designated care partner has the same authorization to share space with the identified resident as a care team member. Document specifies frequency of visits, up to daily, and maximum visit duration.
- If a resident who has dementia or is living in a memory care unit (MCU) tests COVID+, the designated care partner’s authorization to visit does not change, provided that the designated care partner uses the same facility entrance, restroom, and enhanced PPE as do staff working in the “red zone.” See Play 8 for more detail.
- Leaders designate a care team member for every resident to learn the resident’s preferences for a designated care partner.
- This care team member elicits resident’s preferences, either directly or through the resident’s spokesperson, and reaches out to potential designated care partner to determine interest, availability, and preferences for time and frequency of visits.
- Resident or spokesperson shares updated preferences on designated care partner to care team on an as-needed basis, and care team assesses with resident or spokesperson at least monthly how the current plan is serving resident.
- Infection preventionist meets with each designated care partner to educate and coach the care partner in infection prevention practices, including hand hygiene, wearing masks and other appropriate PPE, and social distancing. Infection preventionist shares with designated care partner the same recommendations for off-site behavior that staff receive.
- Leaders ensure that shift supervisor and elected colleagues monitor PPE use, hand hygiene, and social distancing of essential family and care partners in each shift as an element of supervision of the care team.
- Designated care partner is not required to practice social distancing with the resident, on the condition that s/he wears PPE and engages in enhanced infection prevention practices, including weekly COVID-19 testing and social distancing from all others onsite.
- Designated care partner acts with heightened awareness of COVID-19 risks when off-site.
- Designated family care partner logs brief visit notes of essential care activities at each visit.





## GENERAL TIPS AND TRICKS

- Facilities can use up to \$3000 of Civil Money Penalty to purchase plastic dividers, tents, or communication devices to support connection to families and care partners.
- Consider logistics including restroom availability for visitors.



## SPECIAL CONSIDERATIONS FOR PEOPLE WITH DEMENTIA AND/OR IN MEMORY CARE UNITS

- Consider prioritizing the needs of residents with dementia and/or in memory care units in developing and implementing visitation policies. Recognize that some residents will need customized visitation plans and ensure that the policy is flexible enough to allow visitation for these residents. Consider how visit venue will affect the individual resident. Will moving outdoors be overstimulating or disorienting to the resident? Will a shared indoor space be too noisy or distracting?
- Wherever possible, offer in-room visits to residents with dementia and/or living in MCUs.
- If a resident with dementia or living in an MCU is COVID+, the designated care partner may continue to provide needed support to resident onsite, following the enhanced infection prevention measures in place in the “red zone.”



## ADDITIONAL RESOURCES

- [California Department of Public Health All Facilities Letter 20-22.5](https://bit.ly/37xH3gX) (bit.ly/37xH3gX)
- [CMS guidance on visitation](https://go.cms.gov/3lFmrbs) (go.cms.gov/3lFmrbs)
- [Contra Costa Health Services visitation guidance for facilities while in outbreak](https://bit.ly/36ESDI1) (bit.ly/36ESDI1)

*This playbook, available at [cchealth.org/covid19/clf](https://cchealth.org/covid19/clf), was developed by the Institute for Healthcare Improvement (IHI), Contra Costa Health Services and the Contra Costa County COVID-19 Congregate Care Team, with generous support from the Contra Costa Regional Health Foundation and the Silicon Valley Community Foundation.*





12/3/2020

**GOAL:**

**Develop Practices that Allow for Safe Care Transitions**



**PLAY STRATEGY**

COVID-19 poses a significant transmission risk at congregate living facilities, for residents, staff, and visitors. How can congregate living facilities minimize transmission risk when transitioning residents to and from hospitals or other residences? How can “resident care zones” support the safe intake of new residents who are COVID+ or PUI (patient under investigation)?



**HOW TO RUN THE PLAY**

**A. Leadership establishes a clear policy on how to transfer COVID+ residents to hospital. The policy should include the following provisions:**

- Care team ensures that each resident’s advance care directives are up to date and are clearly communicated to the EMS team and the receiving hospital at time of transfer.
- Congregate living facility staff consistently report the facility’s outbreak status and the resident’s COVID+ status when requesting EMS transfer, in advance of EMS team’s arrival to the facility.
- Care team ensures that resident is wearing face mask, if they are able to do so, prior to EMS arrival. When a resident’s cognitive state precludes mask-wearing (e.g., not understanding the request, becoming agitated, and/or repeatedly removing mask), care team communicates to the EMS team that the resident is COVID+ and unable to wear a mask. For more on this scenario, see “Special Considerations for People with Dementia and/or in Memory Care Units” below.
- Leadership ensures that residents are never transferred to hospital (or other residence) by rideshare, taxi, or public transport.

**B. Care team consistently assesses residents’ vital signs to quickly observe and respond to any degradation in status.**

- Leadership updates policy on assessing vital signs in response to COVID-19. Policy includes:  
1. Frequency of vital sign assessment across the different resident care zones (e.g., every X hours in green zone, every Y hours in red and yellow zones); 2. Indication of when the care



team is required to administer fluids to support hydration; 3. Guidance specific to COVID regarding the clinical decision to transfer resident to hospital.

- Care teams use vital sign checks to prompt swift transfer of residents in declining health when needed in accordance with their advance care plan and when onsite care options have been exhausted.

**C. Leadership establishes clear policies on admitting new residents (across all COVID statuses) and strictly adhering to resident care zones. See Play 8 for detail on implementing resident care zones.**

- Leadership allows admittance of new residents who are PUI in private rooms in yellow zone.
- Leadership allows admittance of new residents who are COVID+ into red zone, preferably in private rooms.
- Leadership determines required isolation period to include days resident spent in isolation in hospital, instead of restarting isolation clock on day of admittance to congregate living facility.

**D. Leadership establishes open lines of communication between congregate living facility and local hospital acute care units.**

- Care team member (e.g., shift supervisor, infection preventionist) or designated staff liaison to hospital speaks directly with hospital leadership to learn about each patient transferring to the congregate living facility, including duration of isolation, testing dates, patient notes, and symptoms or lack thereof.



## TIPS AND TRICKS

Leader or another staff member skilled in strategic partnership develops a relationship with a few key staff members at local hospitals (e.g., those who work in acute care unit or on discharge) who can serve as ongoing liaisons to the congregate living facility staff.





## SPECIAL CONSIDERATIONS FOR PEOPLE WITH DEMENTIA AND/OR IN MEMORY CARE UNITS

- Care team develops individualized care plans for residents for whom vital signs assessments are difficult (e.g., confusing, alarming, uncomfortable, agitating), determining the minimum frequency necessary.
- Staff recognize that people with dementia and/or in memory care units (MCUs) may not be able to process, understand, or retain information around wearing masks, physical distancing, and other safety measures.
- Facilities should develop customized strategies that work for each resident with dementia and/or in an MCU and keep others safe. For example, a person with dementia may not be able to wear (or continue wearing) a mask without becoming agitated. The facility can work to keep others safe by ensuring that others engage in infection prevention behaviors (mask-wearing, physical distancing, etc.) as the resident moves throughout the facility.
- Staff should check to see if individual residents can hear, understand, and retain this information. In cases where the resident cannot understand or retain this information, the care team develops a customized plan to provide appropriate care to the resident while keeping other residents and staff safe.



## ADDITIONAL RESOURCES

- [Contra Costa Health Services facility outbreak checklist](https://bit.ly/33CpQSu) (bit.ly/33CpQSu)
- [CDC COVID-19 Guidance for shared or congregate housing](https://bit.ly/2JAhBPH) (bit.ly/2JAhBPH)
- [Contra Costa Health Services Guidance on movement of patients between hospitals and long-term care facilities](https://bit.ly/3mum4BY) (bit.ly/3mum4BY)

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## PLAY 8 Implement Care Zones to Group Residents by COVID-19 status

12/3/2020

### GOAL: Implement “Resident Care Zones” to Limit the Spread of COVID-19



#### PLAY STRATEGY

To reduce the spread of infection, it is crucial to limit contact between residents who are COVID+, or have been exposed to the virus, and all others. A rigorous “cohort” strategy will minimize infection risk across the facility and limit the number of staff interacting with COVID+ residents. How can facilities minimize the risk of a broader outbreak when a resident contracts COVID-19? How can the facility be reconfigured to limit the chances of transmission? What supports do facility staff, from the kitchen staff to nursing teams, need to effectively implement zoning?

#### DEFINITIONS:

- **Red zone:** area for residents who are COVID+ and have not cleared their infection.
- **Yellow zone:** area for residents who have been exposed, residents with unknown exposure (PUI: patient under investigation), and exposed residents who have tested negative. Isolation rooms are included in the yellow zone.
- **Green zone:** area for residents who are COVID-negative and have no known exposure and for residents who were COVID+ and have cleared their infection.



#### HOW TO RUN THE PLAY

##### A. Leaders, with infection preventionist, implement red/yellow/green zoning based on COVID status to limit interactions among staff and residents.

- Leaders redraw facility map to outline the parameters of red, yellow, and green zones to include exits, break rooms, restrooms, and staff care spaces. Leaders revise the map as required by the changing number of possible or confirmed cases of COVID.
- Leaders delineate the allowed path of items, such as food trays, through the facility. Like people, items will circulate only within a zone, not crossing zones.
- Leaders communicate the PPE requirements for each resident care zone when entering patient rooms and for all patient care.



- Red and yellow zones: full PPE to include N95 mask, face shield, gloves, and gown.
  - Green zone: surgical mask when entering patient/resident room; face shields for any patient care or if staff are within six feet of the resident/patient; PPE: (gown, gloves, surgical mask, and face shield) for care activities with body fluids or risk of splash or spray. Also in green zone, staff should wear a N95 mask, and use gown, gloves, and face shield when doing aerosol-generating procedures.
- Infection preventionist or shift supervisor monitors PPE use on each shift.

**B. Leaders assign staff members to care for only the green, yellow, or red cohort.**

- Leaders consider incentives for staff working in the red zone, soliciting volunteers if possible. Leaders arrange for frequent COVID testing for staff working in red zone and those with whom they live. Leaders ensure that staff at high risk of severe illness with COVID-19 are assigned to green zone.
- Leaders, shift supervisors, and infection preventionist ensure that staff are not working across cohorts. If necessary, leaders can authorize staff to cross between yellow and green zones if PPE is used correctly in yellow zone.
- Care team staff adhere rigorously to working and spending break time in their assigned zone.
- Facilities staff (kitchen, janitorial, etc.) adhere to zone requirements, including working in strict zone assignment in delivering items within that zone.

**C. Facility leaders maintain private rooms to the extent possible.**

- Facility leaders prioritize private rooms for the 14-day observation period of new admissions, the remaining observation period needed for residents returning from the hospital, and exposed asymptomatic individuals who test negative.
- If possible, facility leaders allow for COVID-negative patients to be placed in private rooms.
- When grouping COVID+ residents together, facility leaders and infection preventionist attend to non-COVID infections among COVID+ residents using a sick/sicker coding to minimize transmission risk of non-COVID infections. In this way, residents with other infectious illnesses will not be placed in shared rooms, and COVID+ residents will not be at increased risk of contracting other illnesses.



**D. Residents follow infection control practices when leaving their room, if they are capable of such practices (see “Special Considerations” section below for alternatives). These practices include:**

- Wearing face mask
- Performing hand hygiene (washing hands with soap and water or using an alcohol-based hand sanitizer)
- Limiting movement within the facility
- Performing social distancing (staying at least six feet from others).



### **TIPS AND TRICKS**

- All facility staff must be trained in implementing the red/yellow/green cohort facility map. Training includes definition of “resident care zones,” reasons for zones, explanations of where staff can and cannot go and why. Example scenarios involving staff movement, food and supply delivery, and PPE practices will be instructive in helping staff understand how to implement zoning appropriately.
- Develop a system to arrange to drop off items, including meals, to help ensure that zones are not crossed by people or items.
- If needed, staff care spaces and exits can be shared between yellow and green zones, as long as PPE is worn correctly in the yellow zone.
- If private rooms are unavailable, leaders may consider other placement options, such as grouping together COVID-negative residents, and grouping exposed residents who had the very same exposure.
- When exposed residents are grouped together, facility leaders ensure distancing measures (at least six feet of separation, a physical barrier (e.g., curtain) between residents). Staff must change PPE after caring for each exposed resident.
- In facilities where residents have private rooms, facility leaders ensure that rooms are clearly marked as green, yellow, or red and that PPE use accords with resident status.
- Residents in the green zone participate as desired in communal dining, activities and outings, as long as leaders ensure continued adherence to infection prevention practices.





## SPECIAL CONSIDERATIONS FOR PEOPLE WITH DEMENTIA AND/OR IN MEMORY CARE UNITS

- Where feasible, consider having isolation areas (rather than rooms) for residents with dementia and/or in memory care units to allow for some movement and stimulating activity.
- Where isolation areas are not possible:
  - Staff practice caution, correctly use PPE, and understand that residents with dementia and/or in memory care units may not be able to stay in their rooms.
  - Staff perform enhanced cleaning after a resident has left their room, with careful attention to surfaces resident has touched.
  - Care team finds individualized ways to provide stimulating company and comfort at various times during the day (e.g. taking residents for walks outdoors, engaging with residents in preferred activities or exercises, visiting residents to help them pass the time, playing music).
- Staff recognize that people with dementia and/or in memory care units may not be able to process, understand, or retain information around wearing masks, physical distancing, refraining from wandering, and other safety measures.
- The facilities should develop customized strategies that work for each resident and keep others safe. For example, a person with dementia may not be able to wear (or continue wearing) a mask without becoming agitated. The facility can work to keep others safe by ensuring that others engage in infection prevention behaviors (mask-wearing, physical distancing, etc.) as the resident moves through the resident care zone.



## ADDITIONAL RESOURCES

- [CDC COVID-19 Guidance for Shared or Congregate Housing](https://bit.ly/2JxmLf9) (bit.ly/2JxmLf9)
- [CDC infection prevention control recommendations for healthcare workers](https://bit.ly/33AeY7p) (bit.ly/33AeY7p)
- [Contra Costa Health Services outbreak checklist](https://bit.ly/3lsUiEK) (bit.ly/3lsUiEK)

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## CONTRA COSTA COUNTY COVID-19 CONGREGATE CARE TEAM

**Contra Costa County COVID-19 Congregate Care Team** is dedicated to protecting highly vulnerable seniors from COVID-19 infections and deaths. Skilled nursing facilities and residential care facilities have accounted for nearly two-thirds of the county's COVID-19 deaths. This has prompted a powerful coalition in Contra Costa County to kick start a rapid infection-control curriculum and learning community for the skilled nursing facilities. Through partnerships with local hospitals, community, advocacy groups, and local facilities we have developed custom training and tailored best practices to help local operators care for community elders in sensitive facilities on the front line of the pandemic.

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