Answer Sheets

Case 1: Is it Measles? Managing Risk in the ED

1. **What are the potential risks in this situation, even if we don't know the germ?**
   - Crowded areas and unmasked individuals with fever, cough, rash, and conjunctivitis suggest airborne transmission risk.
   - Misusing isolation rooms and N95s on patients unlikely to have measles means real cases might be missed due to resource exhaustion.

2. **What clues show how germs could spread here?**
   - Germs spread when there are people, surfaces, and air involved in transmission and how to control them early.
   - Multiple symptomatic persons in waiting and hallway spaces, without symptom screening or masking protocols.
   - A mix of protected & unprotected staff enter and exit shared areas across different patients.
   - Protocol confusion allows potentially infectious patients to roam freely, risking further transmission.

3. **What steps can help interrupt the chain of transmission?**
   - Use an evidence-based triage checklist (fever + "3 C's" + rash + risk factors) to accurately identify actual measles cases.
   - Reserve isolation rooms and N95s for patients who meet criteria (confirmed or suspected) and use mask + private room for others.
   - Educate staff on proper PPE use and infection control procedures.

4. **What coaching or support could you offer the facility right now?**
   - Acknowledge the stress: "You're doing the right thing by being cautious."
   - **Use PPE Strategically:**
     - Staff should use standard precautions for all patients
     - Add respiratory protection (e.g., N95) when risk of airborne germs is suspected
   - **Communicate Clearly:**
     - Train triage staff on what to look for: measles symptoms, exposure, travel
     - Provide simple guidance: *"If you're not sure–mask the patient, assess away from others."*
   - Share Project Firstline's *Risk Recognition* video or visuals and measles Micro-Learn
   - Offer a 15-minute triage huddle or debrief training for staff

5. **Where do you see uncertainty or mixed messages that could create confusion?**
   - Some staff place all symptomatic patients in isolation, often unnecessarily.
   - Other staff let mildly ill patients stay in public spaces without masking.
   - No shared, easy-to-follow guideline exists, so staff revert to fear-based decision-making.

6. **How can we simplify this situation to focus on risk, not fear or assumptions?**
   - Use a straightforward decision tool posted in triage: *"Fever + rash + at least one of: cough, runny nose, red eyes, travel/no MMR → mask & isolate; staff use N95."*
   - Simplify the environmental guidance: AIIR → private room with mask if AIIR unavailable → clear the room for 2 hours after departure.
   - Reinforce: action equals risk recognition—not panic.

Answer Sheets

Case 2: We're Short Staffed and Supplied- Managing Diarrhea in Long Term Care

1. **What are the potential risks—even without knowing the germ?**
   - Sudden diarrhea suggests possible GI pathogens like norovirus, which spreads rapidly through stool, surfaces, hands, and aerosolized vomitus or droplets (> 50% outbreaks in LTCs)
   - Germs can move through people, hands, and surfaces — especially when environmental cleaning and disinfection or hand hygiene isn't consistent
   - One sick staff member could unknowingly spread germs before they report illness
2. **What clues show how germs might spread here?**
   - Multiple cases in different wings and shared communal spaces—common contamination points.
   - Improper cleaning, missing PPE, and staff working while sick spread risks.
3. **What do we notice about the space and the people?**
   - Residents are in shared rooms and shared dining/living spaces
   - Staff may be working while ill
   - PPE and cleaning supplies are limited
   - The environment includes carpets, shared bathrooms, and hallway traffic
   - Staff aren't all following the same routine — some are cleaning, some aren't, and no one's sure how serious the situation is
4. **What steps help interrupt the transmission chain?**
   - Activate contact precautions: use gloves and gowns for symptomatic residents
   - If there's not enough PPE, prioritize its use for staff providing direct care or handling laundry/soiled items.
   - Clean with EPA-registered norovirus disinfectant (e.g., bleach 1,000–5,000 ppm).
5. **Leadership & Communication:**
   - Talk to staff about symptoms, reporting, and safety — create a consistent plan
   - Use huddles or daily check-ins to share what's happening and what actions to take
   - Make space for staff to express challenges (shortage of supplies, time pressure)
6. **What coaching or support could LHD offer right now?**
   - Affirm the supervisor's instincts: "You're right to be alert — this is the moment to act."
   - Offer to help them create a clear checklist of actions (e.g., clean, notify, monitor, protect)
   - Reinforce Project Firstline's idea: *"You don't need to wait for a confirmed diagnosis to interrupt transmission."*
   - Help them prioritize environmental cleaning and disinfection, staff exclusion if symptomatic, and consistent PPE use
   - Suggest quick daily team check-ins: "What are we seeing today?" "What's our response?"
   - Share Project Firstline visuals or Micro-Learns about diarrhea, surfaces, environmental risk
   - Ask: "Where are the germs likely going?" → "How do we stop them?"

Answer Sheets

Case 3: Blood Spill at Dialysis Station

1. **What are the potential risks in this situation, even if we don't know the germ?**
   - Bloodborne pathogen exposure, potentially from HBV, HCV, or HIV.
   - Environmental contamination of frequently touched surfaces like chairs and touchscreens.
   - Cross-contamination risk as gloved hands move between areas without PPE change.

2. **What clues can help you assess how germs might spread here?**
   - The absence of disinfectant use on visibly soiled surfaces.
   - Contaminated gloves used beyond the spill site, transferring blood to machines and furniture.
   - Lack of PPE beyond gloves, risking splashes to eyes or clothing.
   - No dedicated spill-response tools or spaces present.

3. **What steps can help interrupt the chain of transmission?**
   - Use full protective gear: gloves, gown, and eye/face shields for splash protection.
   - Contain and clean properly: Absorb spilled blood, perform detergent cleaning, then disinfect with an EPA-registered intermediate-level cleaner (e.g., tuberculocidal or HBV/HIV effective)
   - Remove gloves safely and wash hands
   - Equip each station with spill kits and ensure proper sharps and biohazard disposal.

4. **What coaching or support could you offer the facility right now?**
   - Acknowledge awareness: "You recognized the risk"
   - Provide CDC materials: spill-response checklists and station-level job aids
   - Demonstrate correct PPE donning, cleanup, and glove removal steps.
   - Encourage daily huddles to reinforce cleanup protocols.

5. **Where do you see uncertainty or mixed messages that could create confusion?**
   - Unawareness and lack of clarity around PPE, cleaning and disinfection procedures
   - Equipment and station cleaning responsibilities are not defined in staff workflows.

6. **How can we simplify this situation to focus on risk—not fear or assumptions?**
   - Encourage a quick team huddle: *"Where are we prepping? What's our routine?"*
   - Introduce clear signage to report spills and residue and checklist at or around stations on how to appropriately clean and what PPE to wear.

Answer Sheets

Case 4: Do Visitors Really Need Gowns? Managing Perception and Risk

1. **What are the potential risks—even if we don't know the exact germ?**
   - MRSA colonization in the wound and nose means the patient can shed bacteria onto hands, dressings, or surfaces.
   - Visitors hugging or sitting on furniture can inadvertently pick up and carry MRSA on their clothing or hands.
   - Inconsistent PPE use and unclear messaging increases the risk of unintentional spread to the community or other patients.

2. **What clues show how germs might spread here?**

   The germs could be on the patient, on his wound dressing, on nearby surfaces — or even on the hands of those coming in and out. Even if we can't see germs move, they travel when people move and touch things.

3. **What's happening in the environment?**
   - Visitors are in close contact with the patient
   - Touchpoints include linens, chairs, handrails, and elevators
   - PPE is inconsistently offered or used
   - There is confusion — which increases the risk of unintentional spread and staff frustration

4. **Recognize Where Germs Might Spread:**
   - Germs spread when people touch, when items are shared, and when surfaces aren't cleaned
   - Visitors hugging or assisting patients create opportunities for germs to move

5. **What steps can help interrupt transmission?**
   - If PPE is required for visitors, that should be clearly explained, posted, and reinforced
   - If visitors aren't doing direct care, facilities may choose education over enforcement — but they must make a clear, informed choice

6. **Hand Hygiene Always Matters:**
   - Regardless of PPE, visitors should always perform hand hygiene before and after visits
   - Make it easy — place sanitizer and signage where they're visible and accessible

7. **Create a Consistent Message:**
   - Whether it's posters, scripts, or staff talking points, consistency builds confidence
   - Use huddles to reinforce: *"Here's how we're handling visitor precautions this week."*

8. **What coaching or support could you offer right now?**
   - Start with empathy: "This is a common challenge — and you're not alone in navigating it."

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- Offer to review their current visitor messaging together
- Reinforce that precautions are only effective when consistently applied
- Ask: “What does your team need to feel confident explaining your approach?”
- Share Project Firstline’s message: *“Infection prevention works best when everyone knows what to do and why.”*
- Support simple interventions like:
    - A sign explaining hand hygiene expectations for visitors
    - A brief script: *“To help keep everyone safe, we ask visitors to sanitize their hands before and after every visit.”*
    - A team check-in to align around a shared approach