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COVID-19: How to Prepare for a Second Wave

By Caralyn Davis, Staff Writer - June 16, 2020

The first wave of SARS-CoV-2, the virus that causes COVID-19, is diminishing in many of the states that were hit first (e.g., New York) but growing in other states that initially escaped the worst of the outbreak (e.g., Arkansas) and in some states that are moving to reopen quickly (e.g., Georgia). COVID-19 remains an unpredictable virus, says **Alice Bonner**, PhD, APRN, GNP, senior advisor for aging at the Institute for Healthcare Improvement in Boston, MA, and a member of the board of directors at AMDA – The Society for Post-Acute and Long-Term Care Medicine.

"We can take our best experience and expertise and be logical and thoughtful, but we still don't know what will happen next," explains Bonner. "For example, as states move through the three phases of reopening, some states have seen an uptick in COVID-19 cases, and we don't know if those upticks will flatten out or if those states will see new peaks in an extended first wave. Consequently, it's important to think ahead, plan, and be strategic in planning for another outbreak."

No matter what happens with the ongoing first wave, most infectious disease specialists predict that a second wave will occur sometime this fall or winter, adds **Laura Hofmann**, MSN, RN, director of clinical and nursing facility regulatory services for LeadingAge Washington in Tacoma, WA. To prepare for another surge in COVID-19 cases, many providers are focused on establishing a testing program. However, nursing homes also can take the following steps:

Plan how to implement safe visitations

Later phases of the reopening plan for nursing homes allow residents to have visitors "with screening and additional precautions including ensuring social distancing and hand hygiene (e.g., use alcohol-based hand rub upon entry). All visitors must wear a cloth face covering or facemask for the duration of their visit," according to the Centers for Medicare & Medicaid Services' (CMS) Quality, Safety, and Oversight (QSO) memo QSO-20-30-NH.

"Families really want to visit, so you need to stay tuned into how you can allow them to visit safely when your state moves to later phases," says Bonner. "How can you structure those visits with social distancing, masks, and gloves? Do staff members need to supervise? Have a process in place that minimizes the risk of an outbreak while allowing those visits to occur."

Do an after-action report

Once providers that have had an outbreak have no positives in the building, they should conduct an after-action report, suggests Hofmann. "Count it as one of your emergency preparedness trainings, and do an after-action report where you list out everything that went well and everything that didn't. You don't want to wait until after the federal public health emergency has ended. Instead, do it now so that you don't lose sight of everything that has been happening in your facility, and you can make necessary changes to prepare for a fall/winter surge."

This after-action report should include input from residents and families, says Hofmann. "Ask them, 'What do you think we did well, and what do you think we should have done better?' Put those suggestions in the after-action report, and let residents and families review the report. Let them see the good, the bad, and the ugly so that line of communication stays open."

Note: CMS offers the Health Care Provider Voluntary After Action Report/Improvement Plan Template and Instructions (ZIP) at the QSO Group's Emergency Preparedness Templates & Checklists page.

Review the facility assessment and update the risk assessment

"Reviewing your facility assessment—and making sure it is up-to-date—will tell you which of your residents have multiple comorbidities," says Hofmann. "For example, residents who are immunocompromised, are on dialysis, or have diabetes with poor blood sugar control appear to be at higher risk for more severe COVID-19 illness, according to the Centers for Disease Control and Prevention (CDC). Knowing who has those significant underlying conditions will help you understand who you need to monitor more closely during an outbreak and can help you update your risk assessment."

Note: As of May 30, hospitalizations were six times higher and deaths were 12 times higher for COVID-19 patients with cardiovascular disease, diabetes, and chronic lung disease than for patients who had no reported comorbidities, according to "Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020" in the June 15 *Morbidity and Mortality Weekly Report*.

Look for PIP opportunities

"Are there any performance improvement plans (PIPs) that you can run in your quality assurance and performance improvement (QAPI) program from this?" asks Hofmann. "For example, one facility did not have clear guidelines of movement for residents who were suspected to have COVID-19. As a result, they were moved into the COVID-19 unit and then returned to the regular unit when their tests came back negative, but they had been exposed during their time in the COVID unit and took the virus back with them to the uninfected residents. Providers that had this type of problem may want to do a PIP for their cohorting plan and guidelines of movement."

Note: Resources on cohorting include the April 22 video "SNF COVID 19 Unit First Experiences: What Have We Learned?" from the Washington State Society for Post-Acute and Long-Term Care Medicine and the June 11 webinar "Cohorting: Effective Management of Residents and Staff" from the Quality Improvement Organization (QIO) Program.

Update policies and plans

"Having policies and plans in place and ready to go is hugely beneficial," says Hofmann. "You want to continue to pull out and review your core documents to make sure they remain consistent with the most recent guidance from CMS and the CDC. Plans you want to keep reviewing include, but are not limited to, isolation/cohorting plans, pneumonia and flu plans, infection prevention and control policies, visitation and screening plans, communication plans, telehealth plans, and media plans."

Polish your emergency staffing plan

"Many providers across the country have been surprised that the COVID-19 Focused Infection Control Surveys require them to have an emergency staffing plan in place," notes Hofmann. However, nursing homes should be prepared to include emergency staffing strategies as part of their Emergency Preparedness Policy and Procedure that must be provided to surveyors immediately upon entrance to

the facility, according to the COVID-19 Entrance Conference Worksheet. Further, emergency staffing is step 9 in the COVID-19 Focused Survey for Nursing Homes

9. Emergency Preparedness – Staffing in Emergencies
„ **Policy development**: Does the facility have a policy and procedure for ensuring staffing to meet the needs of the residents when needed during an emergency, such as COVID-19 outbreak?
„ **Policy implementation**: In an emergency, did the facility implement its planned strategy for ensuring staffing to meet the needs of the residents? (N/A if an emergency staff was not needed).

9. Did the facility develop and implement policies and procedures for staffing strategies during an emergency?
Yes No **E0024** N/A

"Staffing needs to be part of your pandemic plan, and your pandemic plan should be an ongoing living document that you continue to keep updated so that you aren't caught off-guard when a pandemic actually hits," says Hofmann.

All-too-often during the first wave of the pandemic, nursing homes have been calling their state Department of Health or Department of Aging at, for example, 9 p.m. on a Friday night saying, "We don't have enough staff to cover the night shift," adds Bonner. "You want to have that emergency staffing plan in place and closely monitor your staffing so that you can speak up sooner rather than later when staff get sick. You don't want to be in a position where you are scrambling for staff."

Run a scenario for a COVID-positive resident

After completing the after-action report and updating policies and procedures, providers should do a dry run to see how staff handle a resident who tested positive for COVID-19, suggests Hofmann. "For example, at one facility here in Washington, the director of nursing called the night-shift nurse at 4 a.m. and said, 'You have a COVID-positive resident. I will be there at 8. You need to get everything in place.' By the time he got there at 8, staff had their COVID-19 unit done. Maintenance had put up their zip walls, and all designated staff and supplies were in the unit."

Nursing homes should use this dry run as a tabletop exercise or a live drill in their emergency preparedness preparations, says Hofmann. "Look for what you should have prepared for that you didn't prepare for. For example, the COVID-19 unit prepared by that night shift didn't have an independent printer, so they had no way to print documents."

Note: Learn about tabletop exercise and live drill requirements in Appendix Z, "Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance," of the *State Operations Manual*.

Establish a respiratory protection program

"As the first wave of the pandemic initially spread in U.S. nursing homes, CMS told surveyors not to worry about when facilities did the last fit-test for N95 respirators," says Hofmann. However, on May 19,

the CDC included implementing a respiratory protection program as a component of one of 11 core practices that nursing homes should have in place even when they resume normal activities. The following excerpt explains:

Core Practice: Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices

- Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.

"Consequently, you should go ahead and do your fit-testing for N95 respirators before COVID-19 comes to your community," recommends Hofmann.

Assess current and projected PPE levels

"We are concerned about PPE supply. Right now, we still have healthcare organizations all over the country that are struggling to make sure they have appropriate PPE," says **Connie Steed**, MSN, RN, CIC, FAPIC, 2020 president of the Association for Professionals in Infection Control and Epidemiology (APIC) and director of infection prevention at Prisma Health in South Carolina. "A dedicated infection preventionist can help nursing homes establish appropriate crisis standards of care in preparation for a new surge."

Providers also should determine whether they need to work with suppliers or their state coalitions to try to find PPE now to stockpile for fall, adds Hofmann.

Note: The CDC has developed a PPE Burn Rate Calculator Tutorial video to help providers use its PPE Burn Rate Calculator. Both are available here.

Target hand hygiene and PPE use

Having a designated infection preventionist is not only a requirement under 42 *Code of Federal Regulations* (*CFR*) 483.80, it is a critical step in ensuring that nursing home staff perform hand hygiene appropriately and don and doff personal protective equipment (PPE) safely every time they provide care to residents, says Steed. "Staff fatigue is a real concern," she explains. "Front-line staff need someone who can coach them, mentor them, communicate about opportunities, and improve their compliance with basic practices—and that is a key component of what an infection preventionist should do."

It does take time to monitor these behaviors and provide education, adds Steed. "The infection preventionist, who should be a subject matter expert, needs to do an initial risk assessment of how compliant staff are and look at their competency. However, they also should monitor compliance on an ongoing basis. For example, the infection preventionist may want to schedule specific time frames each month to monitor hand hygiene and PPE compliance when staff are providing actual clinical care for residents. Best practice would be to include monitoring for off shifts and intermittent time frames."

In addition, residents should be educated about hand hygiene and other infection prevention practices, including universal masking, says Steed. "It's not just about the staff. It's also about the residents. What things do residents need to do to help reduce risk and protect themselves?"

Continue to monitor environmental cleaning

Environmental cleaning and disinfection is a core infection prevention strategy to reduce disease, says Steed. "The infection preventionist also should be routinely monitoring whether staff are cleaning the environment properly."

Note: For information about key issues related to COVID-19, review the June 5 webinar "Environmental Cleaning and Infection Prevention" from the National Emerging Special Pathogen Training and Education Center (NETEC).

Begin a flu immunization campaign now

Providers want to avoid being hit with the double whammy of an influenza outbreak at the same time as a COVD-19 outbreak, says Steed. "In addition to offering flu vaccines to residents, providers should make a strong push to get staff vaccinated and should even consider making it a requirement. COVID-19 symptoms are very similar to influenza symptoms, and you may not be able to tell the difference between the two. Consequently, flu vaccination programs will be imperative with this likely next COVID-19 wave if it hits in the fall and the winter."

Note: The CDC has developed two free resources: *Influenza Vaccination Information for Healthcare Workers* and *A Toolkit for Long-Term Care Employers: Increasing Influenza Vaccination Among Health Care Personnel in Long-term Care Settings*.

Continue to develop a relationship with your local health department

"Before COVID-19, many nursing homes had never really worked closely with their local health jurisdictions," says Hofmann. "However, they will dictate your admissions during a COVID-19 outbreak. You want to continue those meetings with your local health jurisdictions so that you can strengthen those relationships that were built under stress and duress."

In addition, the local Board of Health, as well as the state Department of Health and the state Quality Improvement Network QIO (QIN-QIO), can offer educational resources and training that providers that lack an extensive corporate structure may want to tap into, suggests Bonner. "Sometimes even the emergency management organization in your state can provide guidance."

Stay focused on advance care planning

Advance care planning is an important part of preparing for a second wave of COVID-19, but providers should focus on how advance care planning helps develop resident-centered care instead of a dire prognosis, says Hofmann. "One hospital system told nursing homes that they should explain to residents that they only had a 6 percent survival rate on a ventilator, so they needed to be treated in place," she notes. "However, that's approaching advance care planning from a very negative place. The way to talk to residents and their families is to point out that the nursing home can treat in place with supportive

therapy (e.g., IVs and oxygen), allowing residents to stay with staff members who are like family to them, if that fits their values and wishes."

Providers should use Skype or other videoconferencing tools to ensure that the family is involved in advance care planning discussions, says Hofmann. "They may not be there physically, but they can have that discussion with you so that you are not doing it in a silo of you and the resident."

Provide aftercare for both staff and residents

The COVID-19 pandemic has been a trauma, stresses Hofmann. "Facilities need to provide trauma-informed care. Acknowledge it, talk about it, and listen to learn how you can help residents and staff deal with the trauma of this pandemic."