



TO: Facility Administrators

FROM: State Director Mary Poole

SUBJECT: Refine COVID-19 Protocols & Reinforce Thorough Execution

DATE: July 23, 2020

I have complete confidence in each Facility Administrator's understanding of the COVID-19 protocols set forth to protect and care for our residents and staff. However, our challenge is having all 1600 full and part-time staff in our five Regional Centers execute these protocols fully 24 hours a day, seven days a week. Absent a repetitive, energetic approach to maintain awareness of all COVID-19 protocols and systematic "on-the-floor" inspections, protocols tend to dilute or morph over time. It takes great effort to maintain high infection control standards for 1600 staff, particularly under our current stressful conditions addressing active COVID-19 infections with residents and staff.

Based on national experience and our recent experiences, it is clear that once a COVID-19 infection enters a congregate care facility, it carries the risk of a match to dry brush. Our emphasis has to be on stopping COVID-19 from entering the Regional Centers' perimeter and our immediate actions once identified to snuff it after getting inside. This is truly "*an ounce of prevention is worth a pound of cure.*"

Since our planning in March/April, we have been tested with significant COVID-19 infections at three centers. Based on some lessons learned and reinforcing the COVID-19 fundamentals, below are points of emphasis I need each of you to personally ensure are fully being executed in each Regional Center.

1. Daily screening checklist and temperatures required for all personnel and visitors, to include:
 - a. Continuing the twice a shift screening/temperature checks for employees.
 - b. Every shift check for residents. *Stress with staff to closely monitor for signs and symptoms even after screenings are done as good practice –they know our folks the best!*
 - c. During an active outbreak with residents, these checks will be increased to maintain optimal health and safety of the residence.
 - d. All visitors to go through the screening process – **no exceptions**.
2. During an outbreak on campus, all staff with direct resident contact are required to wear:
 - a. N95 mask and face shield/goggles if caring for a COVID-19 resident in their building.
 - b. A surgical mask is required for all other buildings with residents. This exceeds current national standard when not housing an active case, which is washable/reusable cloth masks and use of a face shield when completing tasks that may result in splatter/spray (e.g., breathing treatments, teeth brushing, dining).
 - c. The above requirements may appear excessive, but are needed at this time due to the surge in the rate of COVID-19 infections in SC's general population this summer, an estimated 45% of infections are asymptomatic, and the highly contagious nature of the virus.
3. All staff without direct contact with residents must:
 - a. Maintain social distancing.
 - b. Use a surgical mask if within six feet of another person.
 - c. DDSN will monitor over time to see if there is a point when we may use cloth masks; but for now, the standard is surgical masks.
4. If a staff has symptoms consistent with COVID-19, they should:
 - a. **Not** report to work.
 - b. Be tested as soon as possible.
 - c. Report results to their supervisor and designated Regional Center COVID-19 tracking POC.

5. If a staff or resident has symptoms consistent with COVID-19:
 - a. When resident tests positive, all other residents and staff in the building will be tested.
 - b. When staff has COVID-19 symptoms, all residents require testing and judgement exercised for logical staff tested (e.g., shift staff working with suspected infected staff).
 - c. Prior to testing and after testing, continue to treat all residents and staff as if they are infectious and maintain hand hygiene, social distancing, and masking.
6. If staff have no symptoms and tested by Regional Center or off-campus, staff are still required to continue to work inasmuch as they have no symptoms nor a positive test.
7. If a staff or resident has symptoms consistent with COVID-19:
 - a. The building must be placed on “modified” quarantine until the test result comes back. Modified quarantine means precautions taken to limit staff and nurses from other areas into this dorm.
 - b. Initiate the use of extended shifts and mandatory overtime to reduce the amount of pulled staff.
 - c. Once the staff has been pulled into coverage in a positive dorm, they will be utilized in the positive dorms for the remainder of the 14 day exposure window.
 - d. Do not pull staff from the “modified quarantine” building for other buildings as well as the reverse.
 - e. Signage must be placed in all logical places in a modified quarantine building.
 - f. Staff removed from building and later confirmed positive still requires modified quarantine to continue for a full 14 days.
8. If a resident tests positive, the resident should be moved to separate building set up for positive cases when possible. If this separate quarantine capacity is exhausted or infections become wide-spread, then residents are quarantined in place and the following needs to be available:
 - a. The resident’s room/door covered in plastic and a portable air filtration or air conditioner with exhaust out the window, if available, deployed as soon as possible. Rufus & Andrew are working on this procurement for the centers.
 - b. We know that even though this is best practice, in some situations such as behavioral versus medically fragile consumers, other factors will need to be considered to maintain an individual’s health and overall safety.
9. The AOD station will have a large visible list (e.g., a white board) of each building’s status as quarantine, modified quarantined, or clear to support the following protocols:
 - a. Staff from a quarantine or modified quarantined building will not be used in clear buildings and vice versa.
 - b. If health and safety requirements mandate the need to violate this rule, the Residential Director must personally approve exceptions to this rule.
 - c. AODs must understand that they may be asked to be in coverage.
10. Store all levels of PPE in each building’s nursing station to be available upon demand by staff. However, if management or a nurse observes a pattern of an individual staff’s wastefulness, instructions should be given as to better discerning how to maximize PPE’s useful life and adjust this staff’s request as needed to be more practical.
11. A disinfecting checklist must be kept in each building and initialed every four hours by staff as completed. Attached to this sheet will be specific protocols. Protocols varying from day to night shifts must be clearly specified.
12. QIPDs will be located physically in each building along with the following protocols:
 - a. QIPDs are responsible for continuous monitoring of all 21 weekly shifts and adjust their buildings’ staff so each shift starts with adequate staffing evenly distributed between all shifts throughout the week, to include weekends.
 - b. This becomes even more critical as staff go out during a COVID-19 outbreak.
 - c. QIPDs must understand that they may be asked to be in coverage.
13. During COVID-19 when Day Programs are not operating or operating on a limited capacity:
 - a. Day Program staff will be directly available to QIPDs for assignment. Consideration should be given to Day Program staff seniority to permit normal Monday-Friday 1st shifts, but it is not required.
 - b. All personnel considerations will be factored into the schedule to the extent possible, yet these adjustments must not impinge on the mission requirement of even staffing throughout the week.

14. Nurses, QIPDs, AODs, FAs, and peers have an affirmative duty to address all staff not wearing PPE properly or operating a residence with less than expected infection control practices. Staff should be encourage “buddy checking” each other’s PPE use.
15. Next person up: If a manager is out ill, or even on extended annual leave, appoint an “Acting” manager designated to cover this manager’s duties to ensure continuity of operations and a complete chain of command from the front line to the Facility Administrator. This is critical during a pandemic to ensure there is no hesitation or ambiguity as to who is responsible to act.
16. Central Office will be purchasing industrial strength dis-infecting cleaning machines for buildings to add a quick response to an infection outbreak.
17. The infection control checklist should be handed out to all team leaders to ensure compliance. This includes observations on second and third shift.
18. Facility Administrator Quality Controls:
 - a. Each day the Facility Administrator, or their designee, will personally look at prior day’s shift staffing and address with the respective QIPD(s) inadequate staffing at the beginning of a shift or a pattern of abnormal callouts. Better planning and coordination by QIPDs stops the negative impacts on campus-wide staff caused by abnormal “pulls” or “forced OT.”
 - b. FA, or designee (e.g., Residential Director, DON), complete the infection control checklist by daily walking all residential buildings inspecting proper use of PPE; infection control; unit leadership command of unit activity for the day; and solicit issue/feedback from front-line staff. Any exceptions require same day follow-up.
19. Until further notice, the Facility Administer will meet weekly with QIPDs and one direct care staff from each unit in a town hall meeting forum to ensure communication lines are open, which will include Nancy, Rufus attending via Skype as well as either Mary or Pat attending via Skype. ***Please work with Deborah or Sandra to get that schedule up and running.***
20. A standardized, simple daily report will be establish shortly to ease the communication overload we are all under, as well as simplify FA and chain of command focusing on abnormal variances requiring attention. The report will organize basic information an administrative staff can coordinate from existing Regional Center data, to include prior day’s shift TSL%; new COVID-19 cases; status of residents (staff) in hospitals; and the prior day executive personally inspecting each building and issues identified for follow-up.
21. Projects to be launched when events calm down:
 - a. Develop a standard approach to scheduling in all regional centers with emphasis on establishing a single “Master Scheduler.”
 - b. Examine the roles, responsibilities, and span of control for each building’s leadership team (QIPD; supervisors; team leaders) to properly balance and compensate to support a high accountable and continuous improvement work environment.
 - c. Examine the roles, responsibilities, and span of control of each Facility Administrator to ensure equity, compensation, and infrastructure to support operations.
 - d. Identify comfortable cloth masks to be procured and available to staff in non-quarantine residences when the external environment infection rates subside to an acceptable level and the residence does not house an active COVID case.

SUMMARY

The vulnerability of long-term congregate care facilities, to include our Regional Centers, to COVID-19 is clear. The above list is being addressed in every Regional Center. Our challenge is to re-double our efforts to make sure all 1600 staff execute the protocols at a high level, which is not an easy task. Each Regional Center is only as strong as its weakest link.

Thank you in advance for your continued diligence.