Guide for Emergency Staffing Plan
For Long Term Care Facilities – COVID-19 Pandemic

Emergency Staffing Plan for Nursing Facilities

Intent

Staffing is identified by many healthcare leaders as the number one challenge prior to the COVID-19 outbreak and continues as a significant concern affecting nursing facilities in the nation. The health and needs of nursing facility residents are changing throughout a single day as are the regulations issued by the Federal and State government and local public health departments. Ultimately, there must be staff to meet the health and safety needs of the residents in each facility.

Maintaining appropriate staffing in facilities is essential to providing a safe work environment for our staff and to foster safe resident care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to staff exposures, illness, or need to care for family members at home. Long term care facilities, like all health care facilities, should prepare for potential staffing shortages (clinical and non-clinical) and have a plan and processes in place to mitigate potential shortages to the best of their ability.

Part of the emergency planning process is to identify contingency and crisis capacity strategies that the facility will consider in these situations. These processes should address shortages, contingency plans, access to resources, as well as return to work protocols in accordance with the Centers for Disease Control and Prevention (CDC) as well as State and local public health guidance.

Emergency Staffing Guide Overview

In this Guide are some ideas and best practices about how to approach staffing during the pandemic.

It is a requirement of the Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness regulations that the facility have an emergency staffing plan. Responding to the COVID-19 pandemic leads us back to the Emergency Preparedness Rule from 2017 now updated in November 2019 in which all long-term care facilities had to develop an Emergency Preparedness Plan, outlining numerous requirements including emergency staffing contingencies.

The Emergency Preparedness Plan outlines requirements for the Continuity of Operations which include specific plans for:

- Essential functions and critical resources to maintain operations internally and externally
- Identification of alternate facilities for transfer
- Contractual agreements
- Financial resources
- Staff and employee resources
- Communication plan

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Regulatory Requirements

- Emergency Preparedness Rule - Regulatory Requirement
  - Implemented on November 15, 2017.
    - State Operations Manual. Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types. Interpretive Guidance. The Centers for Medicare and Medicaid Services (CMS) mandates emergency preparedness requirements for 17 different types of health care providers. The rules were published in the Federal Register September 16, 2016, (Federal Register Vol. 81, No. 180). "Appendix Z, Emergency Preparedness Final Rule Interpretative Guidelines and Survey Procedures" is found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf
- As a part of emergency preparedness requirements, long-term care facilities must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments.
  - Examples of these strategies may include, but are not limited to:
  - Developing a staffing strategy if staff shortages were identified during the risk assessment or
  - Developing a surge capacity strategy if the facility has identified it would likely be requested to accept additional patients during an emergency.
- Per Appendix Z, Emergency Preparedness for All Provider and Certified Supplier Types
  - "At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency."
  - "Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.
- During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support.
  - For volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures.
  - Non-medical volunteers would perform non-medical tasks.
  - Facilities have flexibility in determining how best to utilize volunteers during an emergency as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy."

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- The Emergency Preparedness rules also require
  - "(2) A system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency.
  - If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location."

Emergency Operations Plan Activation Delegation of Authority
(part of Emergency Staffing Plan)

As leaders in long term care facilities design their emergency staffing plan, it will be important to discuss with their team and include agreed upon strategies that address the following:

- Overall staffing needs based upon increased COVID-19 residents, acuity increase, clinical needs and psychosocial needs of the residents and business continuity needs for sustainable operations during a pandemic
- Contingency capacity strategies to mitigate staffing shortages
  - When staffing shortages are anticipated, leadership teams in collaboration with human resources and other external resources will identify contingency capacity strategies to plan and prepare for staffing needs
    - Understand the staffing needs and the minimum number of staff needed to provide a safe work environment and resident care.
    - Determine a communication process with local healthcare coalitions, federal, state, and local public health partners when needed if contingency plans are difficult (i.e. rural area with limited professional and non-professional resources).
    - Identify potential licensure waivers to recruit out of state, volunteer, retired, etc. staff to fill open positions
    - Develop and implement contracts with contingency vendors. Communicate with vendors on a routine basis to determine vendor's ability to meet contingency staffing needs
    - Determine essential and non-essential positions and respective roles and responsibilities
    - Determine potential reallocation of specific job duties in which non-clinical, non licensed staff can completed those duties
    - Adjust staff schedules, hiring additional staff if able and rotate staff to positions that support patient care activities.
    - Review orientation and education needs for staffing plan
    - Attempt to address social factors that might prevent staff from reporting to work such as uncertainty about COVID-19 and its impact on the individual, family and organization, transportation, or housing if staff live with vulnerable individuals.
    - Possibly request that HCP postpone elective time off from work.

        - Develop plans to allow asymptomatic staff who have had an unprotected exposure to the virus that causes COVID-19 to continue to work per CDC and local public health guidance
        - Communications – Part of the plan should include a communication strategy to keep staff informed, routine updates and to address uncertainties and concerns
- Crisis capacity strategies to mitigate staffing shortages
    - Part of the emergency staff plan should address the overall processes that the facility will take during a staffing crisis. This may include a more flexible return to work criteria as outlined by CDC or in accordance with the local public health department. It may also include coordination with local health care providers for staffing assistance or coordination
- Chain of command - During this COVID-19 pandemic it is vital that the chain of command be clear and communicated to all staff.
    - The below is a simplified example of the delegation of authority process which documents a chain of command – responsibility for activating the emergency operations plan.
        - The individuals indicated would be responsible for assessing the emergent situation, activating emergency operations plan as applicable, contacting local authorities, coordinating the plan and staff, and overseeing the health safety and welfare of the residents and staff per plan processes.

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Specific Essential Roles and Responsibilities

The operations of the nursing facility must continue through the pandemic and will need to adjust as the health of the staff and the facility needs change. Clear communication about the leadership contacts and the back-up plan is important to avoid confusion and provide security to staff and residents. Delineate the names of both the primary and secondary leaders and communicate to the staff and residents.

Essential Roles and Responsibilities				
Essential Services	**Primary Name**	**Primary Contact**	**Secondary name**	**Secondary Contact**
Administration				
Clinical/Nursing				
Infection Preventionist				
Medical Direction				
Nutrition				
Health Information				
Financial				
Plant Operations				
Housekeeping				
Safety and Security				
Communications				
Pharmacy				
Supplies and Resources				
Transportation				
Psychosocial Needs				
Employee				

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Essential Services considerations

The CDC has strongly recommended that long term care facilities discontinue group activities and communal dining to decrease the risk of COVID-19 transmission in groups. Considering the need for social distancing and decreased contact with surfaces touched by multiple people, only essential services will be provided during high risk transmission period of the pandemic.

Identify the services that are essential, based upon the risk assessment and resident population assessment, during an emergency.
For example, will residents continue to use the common shower facility when there are no suspected or confirmed cases of COVID-19 in the facility? When there are confirmed or suspected cases?

- Identify essential services, determined by the facility, and applied generally to the resident population. Also identify services that are critically important to residents through review of resident-specific care plans.
- Resident-specific services may need to be modified to accommodate transmission risks and resource availability.
- Residents will need education and support to cope with changes in routines and inability to accommodate to their personal preferences.

As the COVID-19 illness impacts the facility's community and its' residents and staff, staffing will need to be adjusted to meet the residents' needs.

EXAMPLE			
Care/Service	**Usual delivery**	**No PUI or confirmed COVID-19**	**PUI or confirmed COVID-19**
Dining room service	Residents transported Meals from steam table	Trays served in rooms Delivery by any staff, masks, and gloves	Trays served in rooms Full PPE to enter rooms
Biweekly shower	Resident transported to spa room	Continue use of shower room	Bed bath or personal hygiene in rooms
Dental, podiatry and optometry visits on-site	Dentist comes to facility	Defer until pandemic is over. Arrange for emergencies	Defer until pandemic is over. Arrange for emergencies
Medication administration	Med cart circulates in hallway and some meds are hand carried to rooms Nurse or TMA	Med cart circulates in hallway and some meds are hand carried to rooms Nurse or TMA	Meds are hand carried to rooms Nurse or TMA

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- Define the acceptable standards for ADL care, getting residents out of bed, assisting residents with meals, exercise programs, repositioning, toileting, etc. and educate staff about how to manage resident expectations as restrictions change during the pandemic.
- Discuss how to manage wandering residents and those who may have a negative response to isolation.
- Analyze how changes effect supplies needed, such as linens, towels, incontinence products, etc. Make changes to supply quantities and distribution plans and communicate to staff.
- Determine the most efficient manner for med pass and treatments at various levels of transmission precautions.
- Provide frequent staff communication. Some opportunities are at shift change, posted in the break room, at charting stations, etc.

Streamline the roles of current staff

There is day to day routines unique to every nursing facility and every unit of the facility because of the residents who live there, the staff who care for them and the facility and regulatory requirements. Some daily routines may need to be adjusted or eliminated when a staffing emergency occurs due to the COVID-19 illness.

Recognize the routines of each shift and identify the “nice but not necessary” routines that can be eliminated without adverse resident outcomes.

- Depending upon the level of transmission precautions and the number of certified and licensed nursing staff available, consider training and delegating others to perform routine and “low error” tasks such as taking temperatures using an electronic thermometer, turning, and repositioning residents, etc.
- Involve staff from each shift to analyze how to reorganize cares to meet residents’ needs with fewer staff. Keep an open mind.
- Discuss scenarios for the time when there are no Person Under Investigation (PUI suspected to have COVID-19) cases and no Positive CODID-19 cases and again when there are PUI or confirmed COVID-19 cases.

EXAMPLE:

- Without PUI or confirmed cases, staff:
  - Are screened at shift change – prior shift stays until new shift arrives on unit
  - All staff must don medical/surgical masks (or respirators) upon entry into facility following screening
  - Serve meals and assist residents to eat in resident rooms – staff stay with residents who need assistance and are choking risks
  - Take the med cart down the hallway – no change from usual

- Assist residents to walk in the hallway with social distancing -no change from usual
- With PUI or confirmed cases, staff
  - Are screened at shift change- prior shift stays until new shift arrives on unit
  - Residents are restricted to their rooms -staff make more frequent rounds to check those with behaviors and fall risks
  - Staff wear full PPE in resident rooms -increased time to prepare for cares, cannot come out to retrieve supplies, additional time to reassure residents
  - Meds are hand carried to rooms -increased time to retrieve and serve each resident.
  - Consistent staff assignment on units to mitigate risk of transmission.
  - Other

Filling staff vacancies

- Hiring non-certified nursing assistants
  - The Federal waiver 1135 allows states to waive the requirement for nursing assistants to be certified within four months of employment in a nursing facility. Each state must then waive its nurse aide certification requirements. Check with your state to validate that the waiver is effective.
  - When non-certified nursing assistants are hired, the facility must ensure that they are competent to perform assigned tasks.
  - Orientation of new nursing assistants may typically take a few weeks.
  - In the case of a staffing emergency new nursing assistants need to be trained and ready to start working as quickly as possible.
  - Explore emergency training programs from your nursing home association and discuss the possibilities with your on-line education provider.
  - Nursing assistant new hires could complete online education at home and complete required return demonstrations on their first day in the facility.
- Licensed staff from other states
  - Some states have waived the requirements for licensed staff to obtain a temporary or reciprocal license during the COVID-19 pandemic.
  - Check with your state licensing agencies or department of health to determine if the credentialing waivers are in effect.
- The use of volunteers in an emergency
  - During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training.
  - The facility must have policies and procedures in place to facilitate this support.
  - For volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures.

- Non-medical volunteers would perform non-medical task or be trained to perform specific delegated tasks.
- Facilities have flexibility in determining how best to utilize volunteers during an emergency if such utilization is in accordance with State law, State scope of practice rules, and facility policy.

- Furloughed workers
  - In the event of a severe staff shortage, a facility may reach out to furloughed workers from local businesses and industries.
    - For example, furloughed restaurant workers may be willing to volunteer or be hired temporarily to assist with nutrition services.
- Off duty staff
  - Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other which may include, but are not limited to, utilizing staff from other facilities and state or federally designated health professionals

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DRAFT - POLICY AND PROCEDURE FOR EMERGENCY STAFFING

Policy
It is the policy of this facility to make all attempts to provide adequate amount of qualified staff to meet residents' needs.

Purpose
In the event of an emergency, the facility will identify basic resident needs and reorganize staffing assignments to best meet those needs. In an infection disease pandemic, the facility will augment staff with trained volunteers, licensed staff from other states, as allowed, and new employees as it is able.

Procedure
- Staff assignments shall be organized to abide by local, state, and national guidance and direction related to the specific emergency.
- Staff may be cross- trained between departments to provide for adequate numbers of staff in various roles.
    - Training and competencies will be documented.
- Staffing during the 2020 COVID-19 pandemic shall consider residents' basic needs, the suspicion or presence of the illness in the resident and/or staff populations and the amount of community spread.
- Staffing assignments will be made to minimize the spread of COVID-19 while meeting residents' basic needs.
    - Staff will be provided time to receive education and updates about the disease.
    - Staff will be provided time to be screened at the beginning of each shift worked.
    - Staff will be provided time to don and doff PPE as directed by the facility's leadership.
- Staff will be assigned to duties in a manner that decreases the risk for spreading the illness.
    - Consistent assignment of direct care staff and housekeeping staff will be used as much as is practicable.
- Staff providing hands-on care for residents with presumed or positive COVID-19 will not provide care for residents who do not have COVID symptoms on the same shift, unless there is an emergency or staff is able to use full PPE in accordance with facility policies, procedures and capacity.
- Staff wearing full PPE to provide care should perform as many non-care tasks as possible while in the resident's room, such as wiping down hard surfaces with disinfectants, gathering trash and soiled linen, and disposing of meal items before doffing the PPE and leaving the resident's room.

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Best Practices

Assess the number of staff that have secondary positions at other facilities. Ask them to consider limiting hours to one facility and to report exposure at their other job.
Do not underestimate the amount of time and staff needed to move residents for cohorting and isolation. Now is the time for maximum efficiency.

- Can medication orders be trimmed down, such as orders to hold multivitamins? Ask the consulting pharmacist for assistance.
- Remove all non-care tasks from nurses and nursing assistants and elicit assistance from other departments and leaders.
- Non-nursing staff and volunteers can pass water pitchers, allocate incontinence products, etc.
- Bundle tasks in isolation rooms to minimize the number of staff interacting with the resident.
- Be prepared to have staff stay on-site.
- Plan for food and sleeping rooms, personal laundry.
- Be prepared to be scrutinized by the State survey agency.
- Despite the emergency nature of the conditions, staff are still expected to follow the regulations and rules for infection prevention, basic, safe care, and resident dignity.

Return to Work

The facility will utilize the CDC Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance).

"A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious**."**[1]

"HCP with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Note: HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

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HCP with severe to critical illness or who are severely immunocompromised[1]:

- At least 20 days have passed *since symptoms first appeared*
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Note: HCP who are **severely immunocompromised**[1] but who were **asymptomatic** throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test."[2]

Test-Based Strategy for Determining when HCP Can Return to Work.

"In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, as described in the Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised[1]) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

The criteria for the test-based strategy are:

HCP who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

HCP who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV)."[3]

Note: Whenever there are questions regarding return to work decisions, contact local public health department for direction. Document decision.

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References and Resources

- The Centers for Medicare and Medicaid Services (CMS). Emergency Preparedness Rule (11/19). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.
- [1,2,3] Centers for Disease Control and Prevention (CDC). Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance). July 17, 2020: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- The Centers for Disease Control and Prevention (CDC). Strategies to Mitigate Health Care Personnel Staffing Shortages. July 17, 2020: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
- The Centers for Medicare and Medicaid Services (CMS). State Operations Manual. Appendix PP. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- The Centers for Medicare and Medicaid Services (CMS) Appendix Z, Emergency Preparedness Final Rule Interpretative Guidelines and Survey Procedures" is found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf