Chiles Healthcare Consulting LLC
1908 Maple Shade Lane, Richmond, Virginia 23227
mary@chileshealthcare.com 804-690-5824

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CDC Updates Guidance on Antigen Testing - Click here

The following practices should be considered when SARS-CoV-2 and Influenza viruses are found to be co-circulating based upon local public health surveillance data and testing at local healthcare facilities. While these considerations are specific to care of residents residing in nursing homes, some practices could be adapted for use in other long-term care settings (e.g., assisted living facilities).

- **Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for care of a resident with suspected SARS-CoV-2 infection**
  - Because some of the symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two infections based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in current room, pending results of viral testing. They should not be placed in a room with new roommates nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by SARS-CoV-2 testing.
  - Nursing home residents, including older adults, those who are medically fragile and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms of influenza virus infection and may not have fever.
  - Older adults with COVID-19 may not always manifest fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, and loss of taste or smell.
- **Test any resident with symptoms of COVID-19 or influenza for both viruses**
  - Because SARS-CoV-2 and influenza virus co-infection can occur, a positive influenza test result without SARS-CoV-2 testing does not exclude SARS-CoV-2 infection, and a positive SARS-CoV-2 test result without influenza testing does not exclude influenza virus infection.
  - Facilities should promptly their local health department for consultation and further investigation for any of the following: a suspected or confirmed case of either SARS-CoV-2 or influenza in a resident or healthcare personnel (HCP); a resident with severe respiratory infection resulting in hospitalization or death; or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
- **Obtain respiratory specimens for influenza and SARS-CoV-2 testing**
  - Check the manufacturer's package insert for approved respiratory specimens. There are no FDA-cleared influenza diagnostic assays that utilize saliva specimens.
  - If available, multiplex nucleic acid detection assay for SARS-CoV-2, influenza A and B viruses can be performed onsite, or at an offsite clinical laboratory.
  - Two different specimens may need to be collected if a multiplex nucleic acid detection assay including both influenza viruses and SARS-CoV-2 is unavailable.
- **Test for SARS-CoV-2 by nucleic acid detection4 *OR* by SARS-CoV-2 antigen detection assay.**
  - Because antigen detection assays have lower sensitivity than nucleic acid detection assays, a negative SARS-CoV-2 antigen detection assay result *in a symptomatic person* does not exclude SARS-CoV-2 infection and should be confirmed by SARS-CoV-2 nucleic acid detection assay.
  - New SARS-CoV-2 infection identified in HCP or nursing home-onset infection in a resident should prompt additional testing in the facility.
- **Test for influenza by rapid influenza nucleic acid detection assay; if a rapid influenza nucleic acid detection assay is not available, perform rapid influenza antigen detection assay.**
  - Because of lower sensitivities to detect influenza viruses, confirm negative rapid influenza antigen detection test results in a symptomatic person by influenza nucleic acid detection assay.

- **Test for other respiratory pathogens; if residents with acute respiratory illness test negative for both influenza and SARS-CoV-2 consider additional viral or bacterial testing based on respiratory pathogens known or suspected of circulating in the community.**
- **Placement Decisions**
    - Residents confirmed to have SARS-CoV-2 infection should be moved to a dedicated COVID-19 care unit.
    - Residents found to have SARS-CoV-2 and influenza virus co-infection should be placed in a single room on the dedicated COVID-19 unit or housed with other co-infected residents on that unit. These residents should continue to be cared for using all recommended PPE for the care of a resident with SARS-CoV-2 infection.
    - If single room isolation or cohorting of residents with SARS-CoV-2 and influenza virus co-infection is not possible, consult with public health authorities for guidance on other management options (e.g., transferring the resident; placing physical barriers between beds in shared rooms and initiating antiviral chemoprophylaxis for roommates to reduce their risk of acquiring influenza).
    - Residents confirmed with influenza only should be placed in a single room, if available, or housed with other residents with only influenza. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., physical barriers, antiviral chemoprophylaxis).
    - Residents with only influenza should be placed in Droplet Precautions with eye protection, in addition to Standard Precautions.
    - Residents with symptoms of acute respiratory illness who are determined to have neither SARS-CoV-2 infection nor influenza should be cared for using Standard Precautions and any additional Transmission-Based Precautions based on their suspected or confirmed diagnosis.
- **Clinical management**
    - Prescribe antiviral treatment if influenza testing is positive *OR* prescribe empiric antiviral treatment based upon a clinical suspicion of influenza while test results are pending for symptomatic residents.
    - Antiviral treatment for influenza should be administered as soon as possible following clinical diagnosis.
    - Properly manage residents with SARS-CoV-2 infection.
    - Recommendations for treatment of persons with COVID-19 are available from the National Institutes of Health COVID-19 Treatment Guidelines. Remdesivir is the only FDA-approved treatment for patients with COVID-19 who are hospitalized. There are currently no FDA-approved therapies for persons with COVID-19 who are not hospitalized. Clinicians may wish to consult clinicaltrials.gov for clinical trials of Remdesivir in outpatients that are open for enrollment.

CDC Learning Connection newsletter highlights COVID-19 vaccine trainings. Note: COVID-19 vaccine development and distribution are part of a rapidly evolving situation. Please visit CDC's COVID-19 Vaccines webpage for the latest information.

Clinical Guidance Updates -- Hear from CDC experts about the latest clinical recommendations and vaccine allocation in this webinar. Earn free CE through February 8, 2021
Allergic Reactions and Contraindications -- Learn about reports of anaphylaxis following vaccination as well as contraindications and precautions to vaccination in this webinar
Community Confidence -- Learn about research on vaccine decision-making and CDC's strategy to reinforce confidence in COVID-19 vaccines with this webinar
Vaccination Basics -- In case you missed it! Get up to speed on vaccination basics and COVID-19 vaccines with CDC's training plan. Some trainings offer free CE.

QSO 21-28 NLTC -- Revised COVID-19 Focused Infection Control Survey Tool for Acute and Continuing Care – 12/30/2020

CMS has made available to the acute and continuing care providers (i.e. non-long-term care (NLTC) providers) the focused infection control survey tool to reflect COVID-19 guidance updates, provide clarifications to existing information, and update the appropriate CMS regulatory tag considerations if a citation is warranted. In accordance with QSO-20-35-All (dated August 17, 2020) related to the revised survey prioritization, during the COVID-19 PHE, **surveyors should continue to utilize the COVID-19 FIC survey tool for Acute and Continuing Care as part of any survey that is conducted**.

- For complaint investigations, if a complaint allegation is not related to infection control concerns, then the FIC survey tool will generally not be utilized.
- However, if onsite observations of the complaint investigation reveal concerns with infection control (IC), the surveyor should contact their State Agency (SA) for possible expansion of the survey to include the FIC survey tool.
- This memo updates the FIC survey tool for acute and continuing care providers and replaces the tool originally released in QSO-20-20-ALL (dated March 20, 2020).

CMS is also taking this opportunity to revise the FIC survey tool to align with recent updates from the Centers for Disease Control and Prevention (CDC) related to screening and triage of those entering healthcare facilities. Specifically, facilities should have a screening process to assess for signs/symptoms consistent with COVID-19 and for exposure to others with known or suspected COVID-19. CDC recommends options for screening symptoms that include but are not limited to: screening questions with an assessment of illness, self-monitored pre-arrival temperature checks with reported absence of fever and symptoms, and facility-monitored temperature checks upon arrival.

Key revisions / updated Guidance include [but are not limited to]:

- **Entering the Facility/Triage/Registration/Visitor Handling --** *Does the facility have a screening process for those entering the facility (patients and visitors) to mitigate the risk of COVID-19 exposure (for example: exposure to COVID-19 screening questions and assessment of symptoms/illness);*
- **Visitation --** *Are visitors, if permitted on the premises based on state or federal guidance (e.g., reopening recommendations), instructed to frequently perform hand hygiene; limit their interactions with others in the facility; and restrict their visit to the room of the patient they are visiting, or other location designated by the facility?*
- **Hand Hygiene**
  - *Appropriate hand hygiene practices (e.g., alcohol-based hand rub (ABHR) or soap and water) are followed. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations.*
  - Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids).
  - If there are shortages of ABHR, *do staff perform* hand hygiene using soap and water instead?
  - Do staff perform hand hygiene (even if gloves are used) in the following situations:
    - Before and after contact with patients;
    - After contact with blood, body fluids, or visibly contaminated surfaces or other objects *or* surfaces in the care environment;
    - After removing personal protective equipment (e.g., gloves, gown, *eye protection,* facemask); and
    - Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, medication preparation, and/or dressing care).
  - Interview appropriate staff to determine if hand hygiene supplies *(e.g., ABHR, soap and paper towels*) are readily available and who they contact for replacement supplies
- **Personal Protective Equipment (PPE)**
  - Determine if staff appropriately use PPE including, but not limited to, the following:
    - **Gloves are worn if potential contact with blood or body fluid, mucous membranes, non-intact skin*, potentially contaminated skin, or potentially contaminated equipment*;**
    - Gloves are removed after contact with blood or body fluids, mucous membranes, non-intact skin, *potentially contaminated skin, or potentially contaminated equipment* ;

        - Gloves are changed and hand hygiene is performed before moving from a contaminated site to a clean site during care (body, equipment, etc.);
        - An isolation gown worn for direct patient contact if the patient has uncontained secretions or excretions;
        - *Appropriate mouth, nose, and eye protection (e.g., facemasks or respirator with goggles or face shield) along with isolation gowns are worn for patient care activities or procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions, or excretions;*
        - *Unless additional source control is needed, facemasks are worn by all staff while they are in the healthcare facility.*
    - If PPE use is extended/reused, is it done according to national and/or local guidelines? If it is reused, is it *appropriately* cleaned/decontaminated/*stored*/maintained after and/or between uses?
- **Aerosol–Generating Procedures *(AGPs)***
    • Appropriate mouth, nose, clothing, gloves, and eye protection (e.g., N95 or higher-level respirator, if available; gowns, face shield) is worn for performing *AGPs* and/or *any* procedures that are likely to generate splashes or sprays of blood or body fluids and COVID-19 is suspected;
    • Procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:
        - Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and a gown.
        - The number of staff present during the procedure should be limited to only those essential for care and procedure support.
        - AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is medically necessary, then it should take place in a private room with the door closed.
        - Clean and disinfect procedure room surfaces promptly and with *an* appropriate *EPA-registered* disinfectant *for healthcare settings*. Use disinfectants on *EPA's List N: Disinfectants for Coronavirus (COVID-19)* or other national recommendations.
    - **Education, Monitoring, and Screening of Staff --** *Does the facility have a screening process for all staff to complete prior to or at the beginning of their shift that reviews for exposure to others with known or suspected COVID-19, signs/symptoms of illness and includes whether fever is present (screened upon arrival or self-reported absence of fever)*?
    - **Patient Care**
        - Is the facility restricting patients *that are on transmission-based precautions* to their rooms *(to the extent possible)* except for medically necessary purposes? If patients have to leave their room, are they wearing a facemask performing hand hygiene, limiting their movement in the facility, and performing social distancing (staying at least 6 feet away from others).
        - Has the facility isolated *patients* with known or suspected COVID-19 in a private room *with access to a private bathroom* (if available), or taken other actions based on national (e.g., CDC), state, or local public health authority recommendations?

Additional Resource Links:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)
- Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages
- CMS current Emergencies Page that lists the latest updates and guidance related to COVID-19 survey activity:
- The HHS Office for Civil Rights (OCR) provides resources on complying with Federal civil rights laws during the COVID-19 pandemic . OCR also provides resources for assisting hospitals and other healthcare providers with satisfying their legal obligations to provide meaningful access to individuals with limited English proficiency and effective communication to individuals with disabilities at the following

Reminder – When sending information to the CHC team that contains resident information [i.e., names, diagnosis, progress notes, etc.] it is important to send that information encrypted. Please do not include resident identifiable or specific information in the information that you send us. This would apply to information requested during remote mock surveys, review of FRIs, information attached to the COC reports, etc.

EFFECTIVE / SUCCESSFUL USE OF A CONSULTANT

Why use a Consultant?

Experience – Consultants offer skills and expertise to augment yours and those of your staff.

Objectivity – Consultants are not emotionally attached to your organizational history and "the way we have always done it."

Best Practice – Consultants have opportunity to work with a variety of organizations and to observe and facilitate a variety of solutions/approaches to a variety of problems/improvement opportunities.

Efficiency/Expediency – Because they are not wedded to organizational history and constrained by multiple other responsibilities, consultants can frequently assess, design, and facilitate change processes more efficiently and expeditiously.

What methods might a Consultant use to assist the organization?

- Audits and investigations
- Systems analysis
- Policy and procedure review
- Position and organizational analysis
- Outcomes measurement and monitoring
- Educational needs analysis, design, and delivery of education
- Management workshops
- Ongoing systems review and role coaching

How can we best use consultant services?

- Identify the focal issue/concern for which consultant services are retained
- Adjust your schedule to maximize consultant's time on-site – be prepared
- Ensure that requested paperwork/information is available to facilitate consultation
- Question consultant as needed to understand regulations, standards and/or best practice that support his/her recommendations
- Work with consultant to develop realistic action plans, timelines/deadlines
- Review report(s) on receipt and request clarification as needed
- Follow-up on recommendations with action and/or rationale for pursuing alternative course of action

Is a Leadership Coach right for you?

Executive coaching can help you achieve higher performance and greater personal satisfaction in your work and career. There is always room for growth and change. Changes could include behavior, mindset, or both. This process requires a substantial investment of time and effort, so before you consider moving forward, the most important question is, "Am I ready to be coached?" In your consideration consider seven core characteristics that differentiate leaders who evolve through coaching from those who do not.

- Tolerance for discomfort
- Openness to experimentation
- Ability to look beyond the rational
- Willingness to take responsibility
- Capacity for forgiveness
- Self- discipline
- Ability to ask for support

It's normal to feel both excitement and trepidation when deciding to work with an executive coach. Start by assessing the degree to which you have these seven characteristics, then discuss which are the most challenging for you. You may mutually decide that it's not the right time to proceed. More likely, it will help you develop a stronger relationship and a deeper awareness of how to meaningfully develop as a leader through coaching.