

7-1-2020

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Recommended Citation

Haimowitz, Daniel and Stefanacci, Richard G., "Crisis (Pandemic) management playbook for assisted living" (2020). *College of Population Health Faculty Papers*. Paper 100.
<https://jdc.jefferson.edu/healthpolicyfaculty/100>

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Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com

Assisted Living Column



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Crisis (Pandemic) management playbook for assisted living

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As the coronavirus crisis continues to evolve across our country there has been increasing realization that residents in long-term care are at great risk. While initial focus has been on nursing homes, now there is a realization because of numerous factors, residents of assisted living communities (ALCs) and particularly memory care units/communities present a great challenge. With information overload being widespread, there are a plethora of websites and webinars. It's difficult to keep up especially when positive COVID tests start to occur in residents and staff. For that reason, it may be useful to develop a guideline for how to best keep on track both before and when the disease hits, a “pandemic playbook”.

To begin the goal or goals in managing through a Pandemic fall nicely into the Quadruple Aim.

Quadruple Aim

- (1) Individual Patient/Resident Experience through a focus on care
- (2) Population Health requires a clear appreciation of each resident's care goals
- (3) Costs/Finances involves work to continue to grow the ALC community
- (4) Staff Support especially critical in a Pandemic to prevent staff burn out which has direct impact on all other aspects of the Quadruple Aim

With these goals in mind there are five areas that ALC need to plan for success during this pandemic or similar events.

Five Areas for ALCs Success

- (1) Producing a Positive Culture,
- (2) Supporting Staff,
- (3) Treatment,
- (4) Goals of Care
- (5) Communication /Public Relations

Producing a positive culture

It all starts with having a positive culture for the ALC. Of course, there's great variance in ALC structure. Some communities are part of a larger corporation while others are stand-alone, with everything in between. In all cases strong local leadership can accomplish an on-going plan to be proactive (to quote CALTCM. Be Calm. Be Informed. Be Prepared.) and become a reassuring, knowledgeable presence to staff. This is a basic tenet of crisis management.

Communities should be doing this NOW if at all possible. It is essential—it should be done even if started at the beginning of an outbreak where administrators may be overwhelmed because there's too much to do right now. That's an understandable perspective but planning ahead can be incredibly valuable. Even if the ALC is working with corporate a local team should still meet to discuss regularly—this may even be daily depending on the state of the emergency, but at least 2 to 3 times weekly is time well spent.

In many instances around the country physicians and advanced practice nurses (APN) are putting the “lead” in leadership. While many ALCs do not have a Medical or Clinical Director, deputizing an “interim” Medical / Clinical Director may be an invaluable resource (although this may not be readily available in some areas). Having direct access to a physician / APN can improve the ability to test suspected cases in residents or staff and provide more rapid response and treatment decisions for residents. A Medical / Clinical Director can also assist in dealing with non-COVID-19 related medical issues more effectively as many emergency medical services providers are restricting cases they will respond to and/or transport (e.g., falls without injury, etc.). Whether it is a healthcare provider, administrator, corporate member or consultant, a champion must be identified to lead this effort.

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Having the positive culture and leadership in place is critical prior to getting the first case of COVID in the community as this inevitably leads to a sense of failure, of letting down your residents, of being a disappointment. It's important to stress to families, staff and residents that no one is to blame. This is an insidious, invisible infection—if we are a failure, then so is every other state in the country and country in the world! It may not be a question of if there will be positive cases, it's when. As long as we did our best, tried to do the best infection control and use of PPE and provided education to the best of our ability, well then, the message is you can't do any better than your best.

Human nature also seems to want to find fault. In many situations the first case may come from the private duty aide, or from the resident who went to the consultant's office, or from the sandwich wrapper that the family dropped off from outside, etc. It's pointless to blame. Perhaps we can take situations and use them to learn from in the future but for the present, if the coronavirus didn't make its way in one way it would have found some way else. With the prolonged asymptomatic phase and without widespread available testing, determining who/what the cause of the first case was is exceptionally difficult. We shouldn't blame anyone, or use the numbers of cases between communities as a measure of quality (because it isn't). Culture needs to be on best care of our residents.

Supporting our Staff

When the crisis hits, staffing will be a most pressing concern. Leadership should speak with staff to find out their concerns and answer their questions on a regular basis. At the same time it's imperative to develop a relationship with staffing agencies immediately. This is a crisis, so think and plan for it as such—what will you do if there's not enough staff? This is not a discussion you want to be having on Friday afternoon for the upcoming weekend.

Think right away about how you can take care for your staff. Can you temporarily decrease shower days? Are 12 h shifts a possibility? Is there an opportunity to call in non-medical staff, like young adults or people furloughed from other jobs, for help with activities or dietary needs? Are there opportunities to provide food so they don't have to go out, provide emotional support, hero pay, etc. Can medications be decreased? (see below)

A critical aspect of keeping staff at work is providing them knowledge regarding the disease. Experience shows that some key bullet points are that the risk of serious outcomes with COVID is much higher in high-risk residents, not the staff, and that proper use of PPE significantly reduces risk to staff. Typical questions from staff will revolve around keeping their family safe. Leadership should develop shared bullet points so communication with staff is consistent. It should also be timely, for all shifts, and repeated on a regular (perhaps daily) basis. This is the purpose of establishing the Leadership Team—staff needs to know that administration is with them and for them.

Staffing includes not just the clinical team but in a Pandemic it includes housekeeping. Yes, housekeeping is this high on the list. This is essential. You can't do pristine infection prevention with housekeeping. There is potential for developing a lack of housekeeping staff (and having to pay exorbitant prices for agency help), having housekeeping staff deployed to another area of a CCRC or fears that current staff may not be able to keep up with increased cleaning requirements. Anticipate and prepare for possible problems as well as opportunities.

What needs to be addressed with training is that staff needs to know how to do the best possible infection prevention procedures and how to use PPE properly. This needs to be done particularly carefully with less-trained staff (unlicensed aides vs. CNAs), with competencies/trainings pertaining to these subjects as well as to vital sign collection. In-services should be repeated at frequent intervals about these crucial topics along with continued practice. Written materials shouldn't be relied upon, but as a potentially useful adjunct. Think

carefully about where staff would be most likely to look at it (the break room? the bathroom?).

A major problem with this Pandemic is one of information overload. There are seemingly hundreds of websites, organizations, news sources and educational organizations with special sections on coronavirus. It is difficult to know where to turn, so members of the Leadership Team are all separately reading articles and watching videos and in-services to try to do the right thing.

In this instance, it may be beneficial to try to identify one or two "go to" sources, such as national AL organizations or consultant groups that can keep the community up to date. Another essential detail to prepare for is where to turn when there is a crisis such as lack of staffing and/or PPE. Some areas are having hospital-AL weekly communications, and this is a good place to turn for help. The Leadership Team should ask if any of the team members have contacts within the state or nationally if those situations develop and if not, should reach out to develop these relationships quickly.

This is a highly stressful time. Everyone is aware of the emotional distress on staff from the increased amount of work, potentially less availability of staff, speaking to concerned family members, watching loved residents become ill and so on. These same concerns apply across the spectrum of long term care, and the same interventions are equally important—the Leadership Team should do everything possible to provide emotional support to staff. There are abundant resources available through multiple organizations and websites.

What potentially will impact staffing levels most is the fact that many staff are terrified of taking infection home to loved ones. Making lodging available helps ease their mind and sends a strong message of support. Along those lines, you could think about providing uniforms for staff and offer to wash them. Staff don't necessarily like wearing the same outfits, and might not trust someone other than themselves doing the laundry. Note that many ALC uniforms such as khakis, polos, aprons, dress cloths etc., are not breathable and make for a very uncomfortable shift when wearing full PPE. Scrubs are much more tolerable. Again working with your staff on education, training and innovative approaches like on site housing will go a long way to assure adequate staffing levels.

Treating 'Right'

Treatment starts with identifying positive residents and staff knowing which comes from testing. The pros and cons of testing, both for residents and staff, are beyond the scope of this article and ever-changing. What the Leadership Team must do however is establish their policy and clearly communicate it and the reasoning behind it to staff, residents and families. If testing is to be done the source needs to be identified (either through the county, state or local labs). Staff should be provided with the name, number and hours of testing sites. It would be appropriate for the (interim) Medical / Clinical Director to be available to provide orders for testing. This may change over time. There are multiple sample letters available so an ALC shouldn't have to recreate the wheel.

Staff must not be fooled into a false sense of security when a test is negative or hasn't been performed. An overabundance of caution, a principle of Universal Precautions, should lead staff to regard all residents as potentially COVID positive. Remind staff of the importance of proper use of PPE (notably a challenge with shortages in many areas) and using proper precautions in all instances.

As testing becomes more available providers should consider the development of policies and procedures on testing that address common questions, such as:

- Will all staff and residents be tested?
- Will only symptomatic or exposed residents be tested?
- Will all new move ins be tested?
- Who will pay for testing?

An important part of treatment is 'Where' to treat or rather care for our high risk residents. For some this may actually not be the ALC. Some family members have considered relocating family members to home temporarily during the COVID-19 pandemic. Whether this is the right decision depends on many factors, including the reasons they came to the ALC to begin with, the risk of contracting COVID-19 at the community versus the home, and the resources available at home. It is crucial to consider potential safety issues at home, such as increased risk of falls and/or elopements or other cognitive challenges. If the family can do this and are able to handle the physical and medical challenges, then having residents temporarily go home is an option. When they can come back to the community will depend on a number of factors, such as when states "re-open," social distancing changes and the status of an outbreak at the ALC, and needs to be revisited frequently while staying in touch with families. This option will not apply to a large number of residents and is probably not favored; however for the small number of residents for whom it is a consideration this should be done early and prior to coronavirus being present in the building.

Turning the ALC social model into the medical model is anathema to many ALC providers. That's not the point here—this is an emergency, and things we would never have imagined of thinking or doing become ways of saving our residents' lives. Communities should promptly look to see if oxygen and pulse oximetry is available, and if staff is capable of doing frequent monitoring. This is particularly important for residents who would want hospitalization and being put on respirators if they were to become critically ill, and is information that residents/families should know as part of their decision making process. Monitoring every resident may not be realistic given nursing staffing ratios hence priority should be given to residents who want aggressive measures, underscoring the importance of advance directive discussions.

For the majority remaining within the ALC, question of where to treat positive residents must be addressed. Cohorting is difficult in both AL along with nursing homes and may be particularly challenging in a memory care unit. In some instances cohorting may be much easier said than done. The Leadership Team could focus on a different perspective, namely, is there anything possible that can be done to keep residents, especially those at the highest risk (males over 80, co-morbidities such as hypertension, cardiac disease, obesity, chronic lung disease, immunocompromised status, etc.) from becoming COVID positive.

Goals of care

Assuring appropriate care is always important but especially critical during a pandemic. It starts with assuring we are following each resident's goals of care. A process should be set up with the appropriate ALC staff to semi-urgently discuss with the resident and/or family if they have an advance directive and to document their wishes. This conversation should proactively begin with the highest risk residents. In the nursing home a Do-Not-Resuscitate order will frequently become a Do-Not-Hospitalize order, the rationale being that nursing homes have the ability to perform most hospital functions other than being put on a ventilator. This discussion is much more involved in ALC due to the lack of this ability. Families need to know what an ALC can do for monitoring and medical treatment, and how goals of care and patients' wishes can be best honored within a setting of the coronavirus pandemic. The ranges of some sentiments ("My husband saw his mother go through this and said he would never have wanted to be placed in a home" vs. "his body is strong, he recognizes me and enjoys being at the home") take on somewhat different meaning and implications when the COVID-19 infection has such a high chance of prolonged ventilator use and death risk. The concept of "dying at home" also takes on added significance when the family, who typically already has not been able to visit their loved one for weeks, may

not be able to be present at the time of death. There might be an opportunity for the (interim) Medical / Clinical Director to hold a tele-conference with multiple families at the same time, as individual discussions are time-consuming. There may be ALC staff with the ability to do preliminary end-of-life discussions but it is a different conversation when had between the healthcare provider and family.

If the ALC already has a relationship with a hospice company they should speak about the special needs during the pandemic. If no such relationship exists the ALC should try to establish one urgently. A hospice company can provide much needed staff when it may be in short supply and can also obtain equipment such as oxygen. They can provide much-needed education and emotional support to both families and staff.

Appropriate care includes assuring each resident is only prescribed medications that are consistent with their care goals as well as each treatment's benefit exceeding its risk. This provides the foundation for deprescribing. Various other terms may be used (deprescribing, medication reduction, med "pause" or "hold") but the object of reducing non-essential medications is to reduce the number of contacts between staff and residents, thereby reducing risk of infection to both, helping with use of PPE and freeing staff for more urgent care needs. This should be expanded if possible, to try to reduce non-essential testing, monitoring and med passes. This effort needs to be led by the (interim) Medical / Clinical Director or attendings and consultant pharmacist.

Communication / public relations

While the Leadership Team members are the calm voice of authority, good care and reason the same issues of increased stress apply to them and they must also take care of themselves. At every meeting it should be asked how members are doing, whether they are keeping up or if there is too much on their plate, and should give an honest answer instead of trying to be stoic or a martyr. This is a disaster—it's a time to be able to ask others for help.

These are numerous areas to consider, but forewarned is fore-armed. These are lessons learned so your community has a better chance to be prepared. ALCs need to be ready—this is an opportunity to save lives, and nothing could be more important than that.

These efforts need to be communicated both internally and externally. Communication is critical in a crisis such as this. There are numerous reporting details that will need to be done, from corporate and state and county. Be prepared, and see if there's non-clinical staff who can be trained or repurposed for this role. This shouldn't all fall on the shoulders of the administrator.

Communication is critical but perhaps nowhere more critical than with families. This is one of the most important items for the AL to do right. It's listed near the end not because of its significance but that many of the items above are needed in preparation for a potential disaster. Families should be informed on a regular basis, prior to an outbreak at least weekly, about the community's plans and preparedness. If an outbreak occurs this should be done as much as possible, probably 2–3 times a week (and daily if doable). The Leadership Team ideally can identify a communication leader, perhaps a staff member who isn't able to come to the facility due to being high risk or someone who has contracted COVID and is asymptomatic, to collate individual resident vital signs, symptoms and medical status and serve as point person for providing information to families who are desperately worried. Having regular video conferences with families is a very useful, and appreciated, option.

Finally, while this Pandemic will certainly pass at some point, lessons learned and foundations built will be needed to serve our ALC as we manage not only future crisis but the challenges that our ALCs must face daily. Having a playbook and ability to implement will serve our residents, families and staff well.