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Community Medical Center Transitional Care Unit:

Guidelines for Control of Respiratory Outbreaks in the Long-Term Care Setting:

Introduction:

Each year outbreaks of respiratory illness occur in institutional settings such as nursing homes and other long term care facilities (LTCFs). Because of their underlying health status, patients in LTCFs are at high risk for severe illness and/or death when they become acutely ill. Historically, specific emphasis has been placed on influenza, but other respiratory viruses can also be problematic in this setting; some of these include severe acute respiratory syndrome coronavirus (SARS-CoV-2 or COVID-19), adenovirus, respiratory syncytial virus (RSV), human metapneumovirus (HMPV), rhinovirus and human parainfluenza (HPIV).

Monitoring respiratory virus activity levels, ensuring patients and staff are up to date with immunizations, practicing respiratory hygiene, optimizing use of engineering controls, improving indoor air quality, and having plans for rapid testing, treatment and/or prophylaxis are crucial in preventing respiratory outbreaks.

As soon as a respiratory outbreak is suspected, the LTCF response should include laboratory testing (i.e., rapid antigen testing, PCR, and/or viral isolation) to evaluate patients and staff and determine the etiology of the outbreak. These guidelines emphasize the following priorities regarding respiratory outbreak control:

- Early detection of an outbreak
- Stopping transmission through control measures
- Measuring morbidity and mortality
- Identifying the agent responsible for the outbreak
- Using antiviral agents to help control respiratory outbreaks

Reporting:

The facility will report an outbreak when it is suspected and will not wait for confirmation before reporting.

An outbreak may be occurring if

1. Several patients who exhibit similar respiratory symptoms are in the same room, on the same wing of a facility, or attended a common activity such as a rehab session in the gym; or

2. Two or more patients develop respiratory illness within 72 hours of each other; or

3. There is an increase in employee absences with staff reporting similar respiratory symptoms.

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The facility shall:

• Immediately contact the LHD by phone to report every suspected or confirmed outbreak.

• Pursuant to NJAC 8:57, a health care facility shall report incidents of infectious and communicable diseases to public health authorities. When LHD staff cannot be reached, the facility shall make the report by phone directly to the NJDOH who will then contact the LHD.

Reporting refers not only to the initial outbreak notification, but also to the provision of routine updates on the status of the outbreak. The facility and the LHD shall be in frequent contact regarding case numbers, control measures implemented, outcomes (hospitalization and/or death) and other pertinent information

Case Investigation & Outbreak Investigation Steps:

Upon notification and evaluation, NJDOH will assign an "E" number to the outbreak, which will be used for all outbreak correspondence. The LHD, in consultation with the NJDOH epidemiologist, shall lead the investigation by providing the facility with guidance, support and assistance.

Public health authorities and facilities will collaborate to:

1. Confirm that an outbreak exists.

Confirm that an outbreak exists by gathering information to confirm an outbreak is occurring within the facility to include initial information on the number of ill and well patients.

Definition of a Respiratory Virus Outbreak in LTC Settings:

1. ≥2 facility-associated, laboratory-confirmed positive cases (e.g., influenza, RSV, adenovirus, other non-COVID-19 respiratory illnesses) identified within 72 hours of each other among patients with an epi linkage*; OR

2. ≥2 facility-associated, laboratory-confirmed COVID-19 cases identified within 7 days of each other among patients with an epi linkage*; OR

3. A sudden increase over the normal background rate of acute respiratory illness (ARI)** cases, with or without documented fever (temperature ≥ 100.4°F or 2 degrees above the established baseline for that patient).

*Epi linkage is defined as having a common exposure within the facility, e.g., patients on the same unit or cared for by the same healthcare personnel. Determining epi linkages requires judgment and consulting with public health and may include weighing evidence as to whether a common exposure exists.

**ARI includes any two of the following symptoms: fever, sore throat, cough, rhinorrhea, and nasal congestion in the absence of a known cause (e.g., seasonal allergies, COPD). Note: Elderly or medically fragile persons may manifest atypical signs of respiratory virus infection and may not present with fever.

2. Verify the diagnosis using clinical, epidemiological and lab test information, considering seasonal disease occurrence.

- Determine the cause of acute respiratory illness based on the history, physical exam and/or laboratory findings of the patient or staff member. Diagnostic testing can aid clinical judgment and guide outbreak control decisions. Be alert for noninfectious causes of symptoms such as COPD exacerbations.
- Obtain laboratory confirmation through the facility's standard procedure by lab testing specimens from all symptomatic patients and/or staff as soon as possible after illness onset. Selection of diagnostic tests should depend on the respiratory viruses circulating in the facility and/or community. Facilities should consult with public health authorities to decide which tests should be performed.

SARS-CoV-2 Testing:

- Test for SARS-CoV-2 by nucleic acid detection OR by SARS-CoV-2 antigen detection assay. Because antigen detection assays have lower sensitivity than nucleic acid detection assays for detecting SARS-CoV-2 in upper respiratory tract specimens, 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 either a negative result from a SARS-CoV-2 nucleic acid detection assay or a second negative antigen test result on an upper respiratory tract specimen collected 48 hours after the first negative test result. If the second antigen test is negative, per FDA guidance, a third antigen test could be considered if there is a high clinical suspicion of COVID-19.

Influenza Testing:

- The following influenza tests are recommended: molecular assays, including rapid molecular assays, other molecular tests, or reverse transcription polymerase chain reaction (RT-PCR). If influenza molecular assays are not available, and rapid influenza CDS Nov 2024 6 diagnostic tests (RIDTs) or immunofluorescence assays are used, false negatives can occur because of lower sensitivities. If influenza is suspected and RIDTs or immunofluorescence results are negative, molecular influenza assays should be used to confirm results.

Other Respiratory Pathogen Testing:

If other respiratory pathogens other than influenza and SARS-CoV-2 are suspected, consider using multiplex RT-PCR assays targeting a panel of respiratory pathogens based on those known or suspected to be circulating, and/or based on clinical symptomatology (e.g., RSV, HPIV, and/or bacterial testing).

After a single laboratory-confirmed case of any respiratory virus among patients has been identified, it is likely that subsequent cases of associated respiratory illness are also caused by the same organism; however, co-circulation of more than one pathogen can occur, especially when respiratory illness activity in the community is elevated. Persons developing compatible symptoms should be tested for respiratory pathogens.

Ideally, at least two laboratory-confirmed cases within an incubation period are needed to confirm an outbreak's etiology. When necessary, collect additional specimens from newly ill cases. When fewer than two laboratory-confirmed cases are found, a probable infectious agent can be inferred through clinical signs and symptoms.

Testing Asymptomatic Individuals:

- Consider testing asymptomatic patients if resources allow, especially if they have been in close contact with individual(s) with a respiratory infection, as some respiratory illnesses can be transmitted from asymptomatic infected persons to others.
- Interpretation of test results from asymptomatic individuals, along with interventions driven by those results, should be done in consultation with public health, infection prevention staff, and applicable care staff (such as an infectious disease physician.
- If COVID-19 is suspected, asymptomatic patients having close contact with an ill individual should have a series of three viral tests, with the first test no less than 24 hours after exposure. If negative, the second test should be taken 48 hours after the first, and if negative again, the third test should be taken 48 hours after the second. However, testing is not generally recommended if the patient has recovered from SARS CoV-2 infection in the past 30 days (due to challenges with result interpretation), and if the patient has recovered in the past 31-90 days, use of an antigen test (instead of a nucleic acid detection assay, or NAAT test) is recommended. Source control (i.e., patient masking) should be implemented while awaiting test results.

3. Develop a case definition based on clinical and laboratory criteria.

- An outbreak case definition describes the criteria that an individual must meet to be counted as an outbreak case. This includes clinical signs and symptoms, physical location and specific time period. Every outbreak will have a unique outbreak case definition. The outbreak case definition will be developed by the LHD or NJDOH epidemiologist in coordination with the facility based on the current situation. Outbreak cases should be counted based on this working outbreak case definition using the case line list.

4. Perform active surveillance.

- Promptly identify additional cases of respiratory illness among patients and staff. Be alert for new-onset illness among exposed persons, and review patient and staff histories to identify previous cases that may not have been correctly recognized as being part of the outbreak.
- Use respiratory viral testing promptly in newly identified cases of respiratory illness so that infection control measures can be initiated to prevent further spread.

5. Document cases in a line list.

- The facility shall develop and maintain a line list.
- The facility shall share the updated line list with the LHD daily. The facility should ensure that information on hospitalizations and deaths is promptly communicated and reflected on the line list.
- The LHD shall frequently review the line list with the facility and the NJDOH epidemiologist to assess the status of the outbreak and make recommendations regarding control measures. Use the outbreak case definition when reporting and counting outbreak cases.

6. Identify and eliminate transmission sources when possible.

- The facility, LHD and NJDOH should collaborate to determine the outbreak source. Consider using the floor plan in conjunction with the line list to document the physical locations of case-patients and ill staff to identify possible transmission routes. Occasionally, even with thorough investigation, the source might not be identified.

7. Institute control measures, balancing infection control concerns with disruption of patients' quality of life routines.

A. Maintain Standard Precautions:

Standard Precautions are intended to be applied to the care of all patients in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. Based on risk assessment, common-sense practices, and PPE use, Standard Precautions protect healthcare providers from injury or the spread of infection.

- Use PPE whenever possible exposure to infectious material is expected. This includes procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, and secretions, especially suctioning and endotracheal intubation. During aerosol generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols, wear a fit-tested N95 or higher respirator in addition to gloves, gown, and face/eye protection.
- Remove gloves and gowns after each patient encounter and perform hand hygiene.
- Perform hand hygiene immediately before touching a patient, before performing an aseptic task, before moving from work on a soiled body site to a clean body site, after touching a patient or their surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal.

- Hand washing should be performed when hands are visibly soiled, before eating, after using the restroom, and during the care of patients.
- Use of an alcohol-based hand sanitizer is the preferred method for hand hygiene in healthcare settings when soap and water are not available.

- Follow respiratory hygiene/cough etiquette principles. This includes providing facemasks to patients, healthcare personnel, and visitors with signs and symptoms of respiratory infection as part of Standard Precautions, which is distinct from Transmission-Based Precautions.
- Operate and maintain patient care equipment in accordance with the manufacturer's instructions for use, including cleaning and disinfection.
- Routinely clean and disinfect the environment. Handle textiles and laundry in a manner that prevents the transfer of microorganisms to others and to the environment.
- Use safe injection practices. Vaccines should be drawn up in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed. Multi-dose vials to be used for more than one patient should not be kept or accessed in the immediate patient treatment area. This is to prevent inadvertent contamination of the vial through direct or indirect contact with potentially contaminated surfaces or equipment that could then lead to infections in subsequent patients.
- During times of increased respiratory illness activity, implementation of more stringent precautions based on the facility's assessment of patient population risk, physical setup of the facility, etc. may occur.

B. Institute Additional Transmission-Based Precautions

Transmission-Based Precautions are used when the mode of transmission is not completely interrupted using Standard Precautions alone. Transmission-Based Precautions are used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission.

Actions Common to All Transmission-Based Precautions

In addition to Standard Precautions, some interventions/actions are to be taken in all Transmission-Based Precaution categories. These include:

• Source control (i.e., patient masking as tolerated if outside of the room) is recommended for patients suspected of having SARS-CoV-2 infection or any other respiratory infection, even if asymptomatic.

• Single-patient rooms are preferred when available (and necessary for Airborne Precautions). Decisions regarding patient placement should be made on a case-by-case basis after considering infection risks to other

patients in the room and available alternatives. Patients with symptoms of respiratory infection should be discouraged from using common areas when feasible.

• Hands must be cleaned using proper handwashing hygiene both before entering and when leaving the patient's room.

• Limit transport and movement of patients outside of the room to medically necessary purposes and cover or contain the infected or colonized areas of the patient's body. This includes masking the patient for source control, if tolerated, for Droplet, Airborne, and COVID-19 Transmission-Based Precautions.

• Ensure rooms of patients on Transmission-Based Precautions are cleaned and disinfected frequently (e.g., at least daily), focusing on frequently touched surfaces and equipment in the immediate vicinity of the patient, going from the clean areas to the dirty areas.

• Note: For asymptomatic patients being tested for respiratory pathogens after close contact with an ill individual, empiric use of Transmission-Based Precautions may be considered if the patient is: unable to be tested or wear source control as recommended; is moderately to severely immunocompromised; is residing on a unit with others who are moderately to severely immunocompromised; is residing on a unit experiencing ongoing viral respiratory virus disease transmission.

Contact Precautions:

Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. In addition to the above actions common to all Transmission-Based Precautions, for Contact Precautions also implement the following:

• Healthcare personnel should wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Put on a gown and gloves before room entry, and discard PPE before room exit. Do not wear the same PPE for the care of more than one patient.

• Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs, stethoscopes). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient.

Droplet Precautions:

Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. In addition to the above actions common to all Transmission-Based Precautions, for Droplet Precautions also implement the following:

• Healthcare personnel should wear a mask before entering the patient's room.

• If transport and movement of the patient outside of the room is medically necessary, instruct the patient to wear a mask as tolerated.

• Influenza: Droplet Precautions should be implemented for patients with suspected or confirmed influenza for seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Droplet Precautions should continue while the patient is taking antiviral treatment

Airborne Precautions

Airborne Precautions are intended to prevent transmitting pathogens via the airborne route. In addition to the above actions common to all Transmission-Based Precautions, for Airborne Precautions also implement the following:

• Ensure appropriate patient placement in an airborne infection isolation room (AIIR). When an AIIR is unavailable, masking and placing the patient in a private room with the door closed will reduce the likelihood of airborne transmission until the patient is transferred to a facility with AIIR.

• Healthcare personnel should wear a fit-tested NIOSH-approved N95 or higher-level respirator, which should be removed after exiting the patient care environment.

• If transport or movement outside an AIIR is necessary, instruct patients to wear a mask as tolerated. Healthcare personnel transporting patients who are on Airborne Precautions do not need to wear a mask or respirator during transport if the patient is wearing a mask unless this is recommended as part of outbreak control.

C. COVID-19 Transmission-Based Precautions

- Healthcare personnel should wear a fit-tested NIOSH-approved N95 or higher-level respirator, plus gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
- If transport and movement of the patient outside of the room is medically necessary, instruct the patient to wear a mask as tolerated
- Recommended duration of Transmission-Based Precautions for patients with suspected or confirmed COVID-19 can range from 10 to 20 days or more, depending on severity of illness, immunocompromise status, and risk of other patients in the facility.

D. Placement & Cohorting of Patients, Staff, & Equipment

The LHD, in consultation with NJDOH, shall provide recommendations and guidance to the facility regarding outbreak control measures. Control measures can negatively impact patients' quality of life by restricting their lifestyle for a period of time, and staffing limitations may necessitate modification of certain control measures. Nevertheless, the facility should make every effort to institute and maintain adequate control measures until the outbreak is declared over.

Additional outbreak control measures are listed below:

- As noted above, single-patient rooms are preferred when there is a concern about transmission of an infectious agent; when single rooms are limited, priority should be given to patients at higher risk of transmitting infectious material to others (e.g., uncontained secretions) and those at increased risk of infection and adverse outcomes, such asthose with immunosuppression, prolonged length of stay, or total dependence on healthcare personnel for activities of daily living.

- Cohorting patients entails grouping together individuals who are exposed to or infected with the same organism to confine their care to one area and prevent contact with other patients. Cohorts are created based on clinical diagnosis, etiologic organism confirmation when available, epidemiology, and the mode of transmission of the infectious agent.

- In general, symptomatic patients should remain in their assigned room as much as possible, including restricting them from common areas and group activities. Medically necessary services and activities should occur in their room during the infectious isolation period.

- Assigning or cohorting healthcare personnel and equipment to specific patients infected with (or exposed to) a single pathogen may help limit further transmission after implementing routine infection prevention and control measures. Staff assigned to specific patients infected with (or exposed to) a single pathogen should not rotate to unaffected patients until the LHD and NJDOH have determined that the outbreak is under control. This restriction includes prohibiting staff from working on an unaffected unit after completing their usual shift on the affected unit, when possible. If equipment must be shared, it should be terminally cleaned and disinfected before transporting to another unit.

- Consider modifying use of shared care areas (such as physical therapy rooms). Modifications may include distancing of equipment. Consider closing the facility to new admissions if the physical set-up does not allow for separation and safe care delivery within the unit.

E. Vaccinations:

Vaccinations for respiratory diseases such as COVID-19, influenza, and RSV combined with basic infection prevention and control practices can help prevent transmission among healthcare personnel and LTCF patients. Outbreaks of vaccine-preventable and other illnesses can still occur even when vaccine coverage among LTCF patients is high.

The facility should:

- Educate eligible patients and staff on the availability of vaccines for the prevention of severe illness.

- Encourage employees to follow current CDC recommendations on remaining up to date with appropriate vaccinations to reduce the spread of contagious respiratory illnesses.

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F. Antiviral Treatment & Chemoprophylaxis

The facility shall provide antiviral treatment and chemoprophylaxis as needed. Antiviral Treatments are available for influenza and COVID-19.

- Influenza: The facility's medical director or the LTCF patient's primary care provider should administer antiviral treatment immediately to patients who have confirmed or suspected influenza. Antiviral treatments work best when started within the first two days of symptoms; however, these medications can still help when given after 48 hours to those that are very sick, such as those who are hospitalized or at a higher risk for complications.
- COVID-19: COVID-19 antiviral treatments work best when started as soon as possible, and within 3-5 (for oral treatment) or 7 (for intravenous treatment) days of symptom onset.
- Antiviral chemoprophylaxis is meant for patients who are not exhibiting influenza-like illness but who may be (or may have been) exposed to an ill person with influenza, to prevent transmission.
- As soon as an influenza outbreak is determined, the facility should promptly initiate antiviral chemoprophylaxis to all non-ill patients living on the same unit as patient(s) with laboratory confirmed influenza (outbreak affected units), regardless of vaccination status.
- Consideration may be given for extending antiviral chemoprophylaxis to patients on other unaffected units based upon other factors (e.g., unavoidable mixing of patients or healthcare personnel from affected units and unaffected units).
- CDC recommends antiviral chemoprophylaxis with oseltamivir for a minimum of two weeks and continuing for at least seven days after the last known laboratory confirmed case was identified on affected units.

G. Provide In-service Education to All Staff on All Shifts

- In addition to all direct caregivers employed by the facility, staff includes volunteers, private duty, contracted or agency personnel who perform housekeeping, recreational, laundry, dietary, nursing, medical, social service, physical therapy, and administrative activities.
- Provide information on the infecting organism and its transmission, Standard and Transmission-Based Precautions, movement restrictions, environmental measures, and policies on specimen collection and submission.
- Ensure current competency assessment of infection prevention and control elements and implement routine auditing with feedback to staff to monitor for compliance.

H. Encourage Limited Visits from Family, Friends, & Volunteers:

- Visitors with respiratory symptoms and those suspected of having a respiratory infection should be encouraged to postpone their visit until their symptoms resolve. However, a family member determined to visit may do so under any circumstance. For such visitors, provide a mask and instruct them to limit their visit only to their respective family members and to avoid common areas and group settings.
- Post signs to reinforce infection control measures, including recommendations for using appropriate PPE and performing hand hygiene before entering and leaving patient rooms. Signage should be eye-catching and posted at building entrances as well as outside patient rooms.
- Educate all visitors (e.g., family, friends, volunteers) on the importance of vaccination to prevent infection.
- Provide tissues and/or masks to patients and visitors who are coughing or sneezing so that they can cover their mouth and nose.
- Provide tissues and alcohol-based hand rubs in common areas and waiting rooms. Encourage visitors to properly discard used tissues in waste bins.

I. Environmental Measures

- Increase routine and daily cleaning and disinfection frequency during a respiratory outbreak.
- Use of disinfectants that are Environmental Protection Agency (EPA)-registered disinfectants approved for use in healthcare settings. Products will be evaluated for the product claims and contact times (how long a disinfectant must stay wet on a surface to be effective) to ensure the selection of products are effective against organisms of concern (e.g., SARS-CoV-2, influenza) and commonly seen healthcare pathogens. Ensure staff demonstrates knowledge about the contact times and manufacturers' instructions for the use.
- Special handling of soiled linens is not necessary.
- Maintain general healthcare environmental cleaning techniques

8. Evaluate effectiveness of control measures and modify as needed.

Generally, an outbreak is considered over when two incubation periods have passed without a new case being identified.

- If new cases are identified after control measures have been instituted for one incubation period, continue outbreak control measures in consultation with the LHD and NJDOH.

- Evaluate and enforce adherence to infection control precautions by all staff, patients, and visitors. Continue control measures until no new cases are identified for two incubation periods.
- When no new cases are identified after two incubation periods, outbreak control measures may be discontinued, although facilities should continue active surveillance for new cases according to LHD recommendations.

9. Summarize the investigation in a written report to communicate findings.

The LHD shall submit a final written report to NJDOH within 30 days of completion of the investigation.

*Note: Steps may not occur simultaneously during the course of the investigation.

Considerations when COVID-19 & Influenza are Co-circulating Testing:

- Symptomatic patients should be tested for both viruses when COVID-19 and influenza are co-circulating in the community and/or facility. Since COVID-19 and influenza co-infection can occur, a positive influenza test result without SARS-CoV-2 testing does not exclude SARS-CoV-2 infection, and vice-versa.
- If available, a multiplex nucleic acid detection assay for SARS-CoV-2 and influenza A and B viruses is preferred and can be performed onsite or at an offsite clinical laboratory. Two different specimens are needed if no multiplex nucleic acid detection assay including influenza A and B and SARS-CoV-2 is available. Precautions & Placement:
- Patients with symptoms of acute respiratory illness who are determined to have neither SARS-CoV-2 nor influenza virus infection should be cared for using Standard Precautions and any additional Transmission-Based Precautions based on their suspected or confirmed diagnosis. Consider additional testing based on respiratory pathogens known or suspected to be circulating in the community.
- Patients who test positive for SARS-CoV-2 infection should be placed in a single room, if available, or housed with other patients with only SARS-CoV-2 infection. If unable to move a patient, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation).
- Patients who test positive for SARS-CoV-2 and influenza virus co-infection should be placed in a single room or housed with other co-infected patients. These patients should continue to be cared for using all recommended PPE for SARS-CoV-2 infection. If single room isolation or cohorting of patients with SARS-CoV-2 and influenza virus co-infection is not possible, consider other management options (e.g., transferring the patient; placing physical barriers between beds in shared rooms and initiating antiviral chemoprophylaxis for roommates to reduce their risk of acquiring influenza, improving ventilation by adding HEPA filters) and/or consult with public health authorities for guidance.

- Patients who test positive for influenza virus infection only should be placed in a single room, if available, or housed with other patients with only influenza virus infection. Patients with influenza should be placed on Droplet Precautions, in addition to Standard Precautions. If unable to move a patient, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation, antiviral chemoprophylaxis for exposed roommates)
- Asymptomatic patients being tested for SARS-CoV-2 or other respiratory pathogens:
- Place a patient with suspected or confirmed SARS-CoV-2 or other respiratory infection in a single-person room, if possible; the door should be kept closed (if safe to do so) and ideally, the patient should have a dedicated bathroom.
- Limit transport and movement of the patient outside of the room to medically essential purposes, and have the patient wear a mask if tolerated.
- Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

Lessons Learned
1. Testing exposed roommates of infected individuals assist with room management
2. Early implementation of N95 aides in the controlling transmission
3. Visitor education has to be consistent and frequent.
4. Ensure there is effective backup leadership in case current leadership is unable to perform due to the effects of the emergency

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