

# VACCINATION & IPC PREP FOR RESPIRATORY ILLNESS SEASON

## WHAT YOU NEED TO KNOW

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1

## IMPORTANT – CEU INFORMATION

TODAY'S WEBINAR HAS BEEN APPROVED FOR 2 PC CEU HOUR(S)

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- It is **REQUIRED** that you complete a brief survey/evaluation via:
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  - ✓ You only need to complete it once (either via the pop-up or the email)
- It is **REQUIRED** that you answer the question asking for your LNHA number

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2

## OBJECTIVES

- Discuss key elements of vaccination clinic preparation and implementation
- Review current CDC recommendation for respiratory vaccinations (RSV, influenza, COVID)
- Consider vaccination administration options and insurance plan coverage
- Establish best practices for effective pharmacy partnerships
- Examine infection prevention practices to mitigate respiratory illness in residents and staff



3

## RESPIRATORY VIRUS “TRIPLEDEMIC”

- Influenza, COVID-19, and RSV (respiratory syncytial virus)
- All 3 viruses will potentially surge at the same time this fall/winter
  - RSV typically starts in the fall and peaks in the winter, but timing can vary
    - Large spike in RSV last year (peaked a bit earlier than usual and lasted longer than usual)
  - The 2022-2023 flu season was earlier than usual (peaked in November/December versus January/February)
    - Will likely be another “earlier” flu season in 2023-2024
  - Recent increase in COVID-19 cases/hospitalizations
    - Likely due to new variants circulating (EG.5)
- Vaccination is key in preventing severe outcomes from these respiratory illnesses



4

# RSV

- Respiratory illness that causes mild, cold-like symptoms in most people
- Severe RSV infection = lung infection, pneumonia, worsening of asthma/COPD/CHF
- Annually in the U.S., between 60,000 – 160,000 older adults are hospitalized and 6,000 – 10,000 older adults die due to RSV
- Certain adults are at a higher risk for severe RSV infection:
  - Older adults (i.e.,  $\geq 60$  years old based on vaccine criteria)
  - Adults with chronic heart or lung disease
  - Immunocompromised adults
  - Adults living in long-term care facilities



5

# INFLUENZA

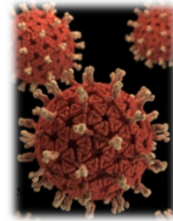
- Respiratory illness that can cause mild to severe illness
- Symptoms can include fever, cough, sore throat, runny nose, body aches, fatigue
- Complications from the flu can include pneumonia, myocarditis, multi-organ failure, sepsis
- Depending on the flu season, between 300,000 – 700,000 hospitalizations and 25,000 – 50,000 deaths annually in the U.S. (up to 85% of hospitalizations/deaths occurred in older adults)
- Certain adults are at higher risk for complications from the flu:
  - Older adults (i.e.,  $\geq 65$  years old based on high-dose/adjuvanted vaccine criteria)
  - Adults with chronic medical conditions (asthma, diabetes, heart disease)



6

# COVID-19

- Most often causes respiratory symptoms that resemble the flu or pneumonia, but can affect other parts of the body and cause a variety of symptoms and severe illness
- In the U.S., over 6,272, 227 hospitalizations and over 1,139, 457 deaths total due to COVID-19 (highest number of deaths in adults > 75 years old)
- Certain adults are at higher risk for hospitalization or death due to COVID-19:
  - Older adults (i.e., ≥ 65 years old based on vaccine criteria)
  - Adults with chronic medical conditions (lung disease, heart disease)
  - Adults who are immunocompromised



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7

## HOW TO TELL THE DIFFERENCE BETWEEN FLU, RSV, COVID-19, AND THE COMMON COLD

Common symptoms may include cough, headaches, sneezing, runny nose, and congestion. Different symptoms may include:

	Rarely
	Sometimes
	Often

	COLD	FLU	COVID-19	RSV
ACHES				
DIFFICULTY BREATHING				
FATIGUE				
FEVER				
LOSS OF TASTE OR SMELL				
SORE THROAT				
WHEEZING				

Tests can be done (typically nasal swab) to differentiate



8

# CDC VACCINATION RECOMMENDATIONS

## Influenza Vaccine

- Annual flu vaccine recommended for everyone  $\geq 6$  months old (w/o contraindication)
  - Contraindication: anaphylactic reaction to any component of the vaccine formulation
  - Precaution: history of Guillain-Barré Syndrome (GBS)
- Efficacy of flu vaccine depends on age/health of recipient, type of flu vaccine, and how well the vaccine composition matches the circulating virus
  - Composition determined by experts based on virus data leading up to each flu season
  - Antigenic drift – changes that occur in the flu virus as it replicates (can affect match w/ vaccine)
- Ideal to administer flu vaccine in September/October
  - Can continue offering flu vaccine as long as the flu virus is circulating and unexpired vaccine is available
  - Efficacy wanes every month after getting the vaccine (lasts ~ 6 months)



9

# CDC VACCINATION RECOMMENDATIONS

## Influenza Vaccine, continued

- Administer a flu vaccine that is appropriate for age/health status
- No preferred flu vaccine recommended by CDC EXCEPT for adults  $\geq 65$  years old
  - Due to increased risk of severe illness, hospitalization, and death in older adults, a high dose or adjuvanted flu vaccine is recommended for extra protection/efficacy
  - If the high dose or adjuvanted vaccine isn't available, older adults should receive standard dose
- New update: everyone  $\geq 6$  months old with an egg allergy can receive ANY flu vaccine in ANY setting (evidence shows no higher rate of reaction compared to people without egg allergy)
  - No longer recommend that people with an egg allergy should be vaccinated in a medical setting supervised by a healthcare provider who can manage severe allergic reactions
  - Most flu vaccines (except FluBlok Quad and Flucelvax Quad) may contain trace amount of egg protein



10

# CDC VACCINATION RECOMMENDATIONS

## Influenza Vaccine, continued

- Concurrent illness/COVID-19 infection
  - Do not delay vaccination for someone with a mild acute illness (regardless of fever, antibiotics, etc.)
  - Postpone the flu vaccine in someone with a moderate/severe symptomatic acute illness
  - Consider local flu activity, risk for severe illness from flu, etc. when deciding whether to postpone
- Co-administration with other vaccines
  - Inactivated and recombinant flu vaccines can be given with other inactivated or live vaccines
  - Consider selecting a non-adjuvanted flu vaccine if it needs to be given at the same time as another vaccine with adjuvants (Shingrix, Arexvy, Hekplisav-B) due to limited co-administration data
  - “Limited/evolving data” for giving the flu vaccine with the RSV vaccine



11

# CDC VACCINATION RECOMMENDATIONS

## Influenza Vaccine, continued

- Storage and administration
  - Prefilled syringe (PFS) = filled and sealed by manufacturer under sterile conditions; attach needle **ONLY** when ready to use; discard by end of workday if needle is attached and vaccine isn't used (does not contain a preservative); if removed from fridge but needle not attached, can re-refrigerate (but subtract time out of fridge from total time allowable out of fridge)
  - Single-dose vial (SDV) = contains one dose for one patient; remove cap **ONLY** when ready to use; does not contain a preservative – unused open vials must be discarded by end of day
  - Multi-dose vial (MDV) = contains more than one dose of vaccine; contain preservatives, so can be punctured more than once; don't remove more than the maximum # of doses listed; can use until expiration date on vial unless a “beyond use date” (BUD) is specified (i.e., expires 28 days after opening)
  - Should be stored at fridge temp (36-46°F) until ready to use (important to monitor fridge temperature!)
    - Discard frozen vaccine, and call manufacturer regarding other temperature excursions
  - Verify appropriate dose/volume and route (most are 0.5mL IM; HD is 0.7mL IM)



12

Vaccine name (manufacturer)	Age indication (how supplied)
<i>IIV4 (inactivated influenza vaccine, quadrivalent; standard dose, egg-based vaccine):</i>	
Alfuria Quadrivalent (Seqirus)	≥ 3 yrs (PFS); ≥ 6 months (MDV)
Fluarix Quadrivalent (GSK)	≥ 6 months (PFS)
FluLaval Quadrivalent (GSK)	≥ 6 months (PFS)
Fluzone Quadrivalent (Sanofi)	≥ 6 months (PFS, SDV, MDV)
<i>ccIIV4 (inactivated influenza vaccine, quadrivalent; standard dose, cell culture-based vaccine):</i>	
Flucelvax Quadrivalent (Seqirus)	≥ 6 months (PFS, MDV)
<i>HD-IIV4 (inactivated influenza vaccine, quadrivalent; high dose, egg-based vaccine):</i>	
Fluzone High-Dose Quadrivalent (Sanofi)	≥ 65 years (PFS); <b>0.7mL</b> dose
<i>aIIV4 (inactivated influenza vaccine, quadrivalent; standard dose, egg-based vaccine w/ MF59 adjuvant):</i>	
Fluad Quadrivalent (Seqirus)	≥ 65 years (PFS)
<i>RIV4 (recombinant hemagglutinin influenza vaccine):</i>	
Flublok Quadrivalent (Sanofi)	≥ 18 years (PFS)
<i>LAIV4 (live attenuated influenza vaccine; egg-based vaccine):</i>	
FluMist Quadrivalent (AstraZeneca)	2-49 years (intranasal)



PFS = prefilled syringe; SDV = single-dose vial; MDV = multi-dose vial



13

## INFLUENZA VACCINE - DEFINITIONS

- Quadrivalent = protects against 4 different influenza viruses (2 influenza and 2 influenza B)
- Inactivated = “killed” virus
- Egg-based = flu virus grown in chicken eggs
- Cell-culture based = virus grown in cultured cells of mammalian origin instead of chicken eggs
- High dose = contains 4x the amount of antigen as standard dose flu vaccines
- Adjuvant = ingredient added to vaccine to promote a stronger immune response
- Recombinant = flu vaccine produced synthetically using technology (not egg-grown)
- Live attenuated = weakened form of virus
- Hemagglutinin = surface protein of the virus that flu vaccine is designed to target



14

# CDC VACCINATION RECOMMENDATIONS

## RSV Vaccine

- Adults  $\geq 60$  years old may receive a single dose of the RSV vaccine
  - Use shared clinical decision-making with healthcare provider (consider risk for severe illness)
- Two FDA-approved RSV vaccines for adults  $\geq 60$  years old
  - Arexvy – adjuvanted recombinant stabilized prefusion F protein vaccine (RSVPreF3)
  - Abrysvo – recombinant stabilized prefusion F protein vaccine (RSVpreF)
    - Abrysvo also approved for pregnant individuals at 32-36 weeks gestational age to prevent RSV in infants
- One dose protects against RSV for at least 2 seasons (based on current data)
  - Arexvy was 82.6% effective in preventing symptomatic RSV-associated lower-respiratory tract disease (LTRD) during the 1<sup>st</sup> RSV season after vaccination, and 56.1% effective after the 2<sup>nd</sup> season (74.5% overall)
  - Abrysvo was 88.9% effective in preventing symptomatic RSV-associated lower-respiratory tract disease (LTRD) during the 1<sup>st</sup> RSV season after vaccination, and 78.6% effective after the 2<sup>nd</sup> season (84.4% overall)



15

# CDC VACCINATION RECOMMENDATIONS

## RSV Vaccine, continued

- None of the studies for either vaccine were powered to estimate efficacy against hospitalization, severe RSV requiring respiratory support, or death
  - Limited number of people in trials were of advanced age or in LTCF
  - Immunocompromised people excluded from studies
- Both vaccines well-tolerated overall
  - Common side effects (injection site pain, fatigue, myalgia, headache) – higher incidence w/ Arexvy
  - 6 cases of inflammatory neurologic events (i.e., GBS) reported – unknown if due to chance or vaccine
  - More cases of atrial fibrillation in intervention groups vs control groups in both studies
- Contraindication
  - History of anaphylactic reaction to any component of the vaccine



16



# CDC VACCINATION RECOMMENDATIONS

## RSV Vaccine, continued

- Concurrent illness
  - Do not delay vaccination for someone with a mild acute illness (regardless of fever, antibiotics, etc.)
  - Postpone the RSV vaccine in someone with a moderate/severe symptomatic acute illness
  - Consider local RSV activity, risk for severe illness from RSV, etc. when deciding whether to postpone
- Co-administration with other vaccines
  - RSV and flu antibody titers were lower when Arexvy was given with Flud Quadivalent (adjuvanted flu vaccine); all other flu vaccines met non-inferiority criteria for immunogenicity when co-administered with RSV vaccines
  - Co-administration with other vaccines not studied; may increase local or systemic reactogenicity



17

# CDC VACCINATION RECOMMENDATIONS

## RSV Vaccine, continued

- Storage and administration
  - Arexvy = 0.5mL IM
    - Supplied as single dose vial of lyophilized antigen to be reconstituted with vial of adjuvant suspension
    - Store in fridge prior to reconstituting; use within 4 hours of reconstituting (keep in fridge or at room temp)
  - Abrysvo = 0.5mL IM
    - Supplied as a kit that includes a vial of lyophilized antigen, a prefilled syringe with sterile water diluent, and a vial adapter to use for reconstituting
    - Store in fridge prior to reconstituting; use within 4 hours of reconstituting (keep at room temp)



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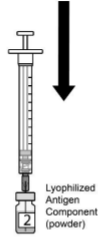


18

# AREXVY ADMINISTRATION



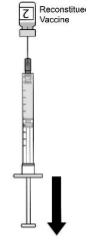
**Figure 1.** Cleanse both vial stoppers. Using a sterile needle and sterile syringe, withdraw the entire contents of the vial containing the adjuvant suspension component (liquid) by slightly tilting the vial. Vial 1 of 2.



**Figure 2.** Slowly transfer entire contents of syringe into the lyophilized antigen component vial (powder). Vial 2 of 2.



**Figure 3.** Gently swirl the vial until powder is completely dissolved. **Do not shake vigorously.**



**Figure 4.** After reconstitution, withdraw 0.5 mL from the vial containing the reconstituted vaccine and administer intramuscularly.

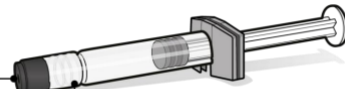


# ABRYSVO ADMINISTRATION

Vial of Lyophilized Antigen Component



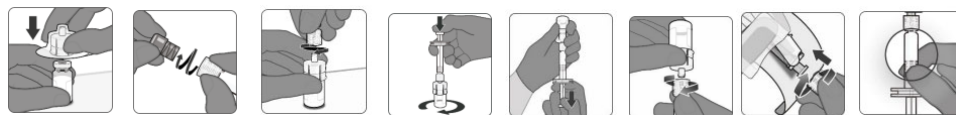
Syringe of Sterile Water Diluent Component



Vial Adapter



Syringe cap Luer lock adapter



# CDC VACCINATION RECOMMENDATIONS

## Updated COVID-19 Vaccine

- COVID-19 vaccine approved in September 2023 targets the XBB.1.5 variant
  - XBB.1.5 has been the dominant variant for most of this year
  - Initial data suggests the new vaccine will still protect against newer variants EG.5, BA.2.86
- This COVID-19 vaccine is monovalent (based on ONE strain of the coronavirus)
  - Bivalent vaccine no longer authorized for use
- The updated vaccine is fully FDA-approved for people  $\geq 12$  years old and commercially available
  - SPIKEVAX (COVID-19 vaccine, mRNA) 2023-2024 Formula (Moderna)
  - COMIRNATY (COVID-19 vaccine, mRNA) 2023-2024 Formulation (Pfizer)
  - Moderna and Pfizer have an EUA for the updated vaccine in 6 months - 11 years of age



21

# CDC VACCINATION RECOMMENDATIONS

## Updated COVID-19 Vaccine

- COVID-19 vaccine is not being referred to as a “booster” or “dose # \_\_\_\_”
  - It is called “updated” or “2023-2024 formula” since it will likely be a yearly vaccine (like flu shot)
- Everyone  $\geq 6$  years old should get one updated Pfizer or Moderna COVID-19 vaccine to be considered “up to date” (regardless of prior COVID-19 vaccination)
  - To qualify, it must be at least 2 months since the last dose of any COVID-19 vaccine received
  - Children aged 6 months – 5 years old may need multiple updated doses, depending on age/prior doses
  - People  $\geq 65$  years old may get a 2<sup>nd</sup> dose of the updated vaccine  $\geq 4$  months after the 1<sup>st</sup> dose
  - Moderately to severely immunocompromised people may get a 2<sup>nd</sup> dose of the updated vaccine  $\geq 2$  months after the 1<sup>st</sup> dose



22

# CDC VACCINATION RECOMMENDATIONS

## Updated COVID-19 Vaccine

- Contraindication
  - History of anaphylactic reaction to any component of the vaccine
- Adverse reactions
  - Pain at injection site, fatigue, headache, myalgia, chills, axillary swelling/tenderness, nausea/vomiting
- Precaution
  - Increased risk of myocarditis and pericarditis, especially in first week after vaccination
    - Risk highest in males aged 18-24 years
- Recent COVID-19 infection
  - No required waiting period, but may consider delaying vaccine by 3 months from infection

UPDATE



23

# CDC VACCINATION RECOMMENDATIONS

## Updated COVID-19 Vaccine

- Co-administration with other vaccines
  - COVID vaccine and flu vaccine safe to receive at the same time
  - Insufficient data on giving COVID vaccine and RSV vaccine at the same time
- Storage and administration
  - Adult dose = 0.5mL IM (Moderna) or 0.3mL IM (Pfizer)
  - Comes in prefilled syringes and single-dose vials (Moderna also comes in multidose vials)
  - Moderna: must be stored in freezer and thawed prior to administration
    - Good for 30 days in refrigerator and 24 hours at room temperature
  - Pfizer: must be stored in ultra-low temperature freezer
    - Good for 10 weeks in refrigerator and 12 hours at room temperature



24

# VACCINE COST AND COVERAGE

- RSV
  - Covered under Medicare Part D (like Shingrix); coverage varies among private payors and can cost up to \$330 out-of-pocket if not covered
    - Affordable Care Act requires private health insurers to cover the cost of preventative care, including vaccines recommended by ACIP (but ACIP's guidance for RSV may not be interpreted as an "official" recommendation by some insurers due to the language + not part of CDC vaccine schedule yet)
- COVID-19
  - Commercially available now; could cost up to \$130; still supposed to be free for everyone
    - Uninsured can only receive it for free from certain retail pharmacy locations
- Influenza
  - Free with no copay for Medicare patients; most plans cover flu vaccine (some w/ small copay)
    - Cost w/ no insurance depends on pharmacy (typically ~\$30 for standard dose)



25

# VACCINE ADMINISTRATION OPTIONS

- Nursing staff administers vaccines
  - Obtain vaccines from pharmacy partner for nursing staff to administer to residents
  - Pharmacy charges facility for cost of vaccine, and facility handles billing aspect
- Pharmacy partner administers vaccines
  - Pharmacy partner administers vaccines to residents and handles 3<sup>rd</sup> party billing
    - Pharmacies cannot currently bill Medicare Part B for skilled stay residents, but nursing facilities can
      - Option 1: pharmacy administers vaccines to all residents EXCEPT skilled stay residents
      - Option 2: pharmacy administers vaccines to all residents (including skilled stay), and then facility is responsible for handling billing for skilled stay residents (agreement needs to be in place with the pharmacy)
  - Specific regulations regarding pharmacist vaccine administration
    - As of 8/28/23 in Missouri, a pharmacist can independently order and administer vaccines approved prior to 1/1/23 as outlined in the Board of Pharmacy regulations (protocol w/ physician no longer required)
    - Vaccines approved after that time can still be given under medical prescription order (i.e., RSV vaccine)



26

# PHARMACY PARTNERSHIP

- Discuss potential immunization services offered
  - Pharmacist-run clinics
  - Nurse consultants (employed by pharmacy) who come give vaccines at facility
  - Ongoing vaccination opportunities
  - Vaccine education
  - Immunization history look-up/recommendations
- Policies and Procedures
  - Ensure that appropriate P&P's/agreements are in place that outline facility and pharmacy expectations in regard to vaccine provision and administration
- Communication
  - Communicate your vaccine needs to your pharmacy partner – the earlier, the better!
    - For example, many LTC pharmacies must place their flu vaccine order in February for the following fall!



27

# VACCINE CLINIC PREPARATION

- Communicate with your pharmacy partner
  - At the beginning of each year, touch base with your pharmacy partner
    - Ensure that they will be providing the vaccines you need in the fall
    - Let them know ~ how many vaccines you will need so that they can pre-order an appropriate amount, if applicable
  - In the summer, discuss plans for vaccine clinics with your pharmacy partner
    - Will the pharmacy just be providing vaccines, or will they be administering them as well?
    - When does your pharmacy expect to receive vaccine supply (so that you can plan your clinic date)?
- Pick a vaccine administration strategy
  - Will nursing administer vaccines, or will pharmacy?
  - Will your facility have one big vaccine clinic, or will you tackle vaccine administration in smaller parts on different days (by division, hall, etc.)?
  - Will you administer several vaccines at once, or administer them separately?



28

# VACCINE CLINIC PREPARATION

- Pick clinic date(s)
  - Flu vaccines should typically be given in September/October
    - Most pharmacies should have their flu vaccine supply by ~ mid-September if they pre-ordered
    - Last year (and likely this year), the COVID vaccine was shipped around mid/late September
      - If you want to co-administer vaccines, need to make sure your clinic is scheduled when both are available
  - Decide whether staff vaccines will be offered at the same time as residents, or separately
    - Consider holding a health fair, offering incentives, etc. to encourage staff vaccination
  - If your pharmacy partner is administering vaccines, coordinate a clinic date/time with them
- Obtain consent
  - Easiest to obtain consent for vaccines upon admission when possible
    - Also gather vaccine history upon admission to ensure eligibility/need for various vaccines, if applicable
  - If pharmacy is administering vaccines, will need to use their consent form
  - Start trying to obtain consent early – call family members for verbal consent and document, send out consent forms in advance and follow up with reminders, etc.
    - Keep track of who gave consent and when on a spreadsheet and/or in the EHR



29

# VACCINE CLINIC PREPARATION

- Advertise clinic/compile sign-ups
  - Ensure that residents/their family members and staff are aware of the clinic date/vaccines being given
    - Utilize flyers, newsletters, etc. to encourage sign-ups and submission of consent forms
    - Provide the Vaccine Information Statement (VIS) about each vaccine to residents/family members
  - Make sure you have an accurate sign-up list that includes:
    - Resident name, DOB, and room number
    - Which vaccine(s) the resident is signed up for (important to make sure each resident gets the appropriate vaccines, including whether they should get high dose versus standard dose flu vaccine)
    - Consider noting allergies that may require extra monitoring (i.e., history of reaction to prior vaccine, etc.)
    - If your pharmacy provider is administering vaccines, ensure they get the sign-up list in advance of the clinic
- Order supplies
  - If nursing is administering vaccines, ensure you have the appropriate supplies on hand
    - Needles to attach to pre-filled syringes, needle/syringe for vials, alcohol swabs, gloves, band-aids, cotton balls, Epi-Pen
  - If pharmacy is administering vaccines, confirm whether they will be providing their own supplies



30

# VACCINE CLINIC PREPARATION

## • Documentation

- Create order sets in the EHR and/or develop procedures for charting the appropriate information during the clinic
  - Typically resident temperature, vaccine administration site (R or L deltoid), vaccine name/dose/lot #/exp date, vaccine administration date/time, and post-vaccination monitoring should be charted in the EHR
  - Provide the Vaccine Information Statement (VIS) about each vaccine to residents/family members

## • Clinic set-up

- Determine whether the clinic will be held in a central location (where staff brings residents to the vaccinators) or whether the vaccinators will go room-to-room to administer vaccines
- Ensure that facility staff are available to help during the clinic (especially if pharmacy is vaccinating)
  - Identify residents, transport residents, help with accessing deltoid, charting, monitoring, etc.
  - Recommend having residents wear short sleeves during the clinic when possible – it is VERY difficult for the residents and vaccinators when multiple layers of long-sleeves have to be removed to access the deltoid



31

# VACCINE CLINIC PREPARATION

## • During clinic

- For consistency/resident safety, it is best to give the same vaccine in the same arm for each person
  - Ex: COVID vaccine always in left arm, and flu vaccine always in right arm (unless resident requests otherwise)
  - If resident requests multiple vaccines in the same arm, ensure the vaccines are given at least one inch apart
- Best practice is to monitor for ~15 minutes after receiving a vaccine
  - Ensure that staff check in on residents to monitor for feeling faint, having a reaction, etc.

## • Follow-up

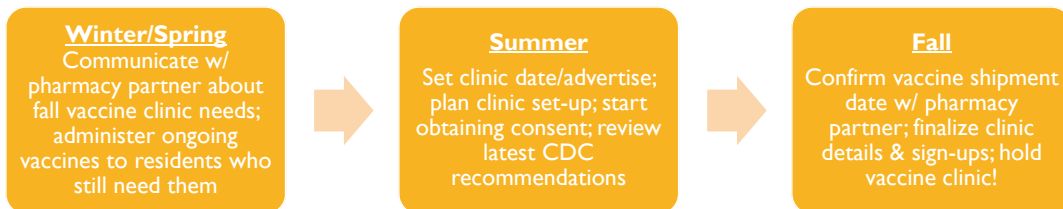
- Complete EHR documentation and obtain necessary documentation from pharmacy, if applicable (vaccine administration record, COVID card, etc.)
- Keep track of which residents still need vaccines if they weren't able to obtain them at the clinic
- Develop a plan for ongoing vaccine opportunities (i.e., nursing to provide; monthly vaccine days with pharmacy partner, etc.)



32



# VACCINE CLINIC PREPARATION



33

# ADDITIONAL RESOURCES

- CDC website on vaccines and immunizations
  - <https://www.cdc.gov/vaccines/index.html>
- CDC “Vaccine Storage and Handling Toolkit”
  - <https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf>
- FDA package inserts for each vaccine
- [Immunize.org](https://www.immunize.org) website
  - Has all current Vaccine Information Statements and many other useful tools
- Missouri Department of Health and Senior Services (DHSS) website – immunizations page
  - <https://health.mo.gov/living/wellness/immunizations>
- Your pharmacy partner!



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34

# GET READY!



35

# IPC EDUCATION REFRESH

## Project Firstline

<https://www.cdc.gov/infectioncontrol/projectfirstline/about.html>

## Infection Control Training Toolkits

<https://www.cdc.gov/infectioncontrol/projectfirstline/healthcare/training.html>

- Micro-Learns– perfect for huddles or team meetings
  - Blood
  - Rash
  - Cough and Congestion- <https://www.cdc.gov/infectioncontrol/pdf/projectfirstline/PFL-CoughandCongestion-508.pdf>



36


## Infection Control Micro-Learns User Guide

**About the Micro-Learns**

The Project Firstline Infection Control Micro-Learns are a series of guided infection control discussions that provide brief, on-the-job educational opportunities. Each micro-learn focuses on a single infection control topic and connects infection control concepts to immediate, practical value. Healthcare workers can easily apply the key points to their daily work and perform the recommended actions to keep germs from spreading.

**Using the Micro-Learns**

The micro-learns can be incorporated into existing opportunities where groups of healthcare workers gather, such as pre-shift "huddles" or team meetings. The sessions should be led or facilitated by an experienced team member with infection control expertise.




**Each micro-learn package includes an adaptable discussion guide for the facilitator and one job aid.**

**Discussion Guide.** The discussion guide is not a script. Facilitators are encouraged to adapt the guide for their audience by incorporating relevant and practical questions and ideas. For instance, facilitators can connect the content to the audience's job duties, facility-specific cases or issues, resources and points of contact, or other information.


**Job Aid.** The one-page, visual job aid helps to reinforce the key messages of the micro-learn. Facilitators are encouraged to make the job aid available after the micro-learn session, such as in digital or hard copy form.


**Notes for Facilitators**

- Before presenting a micro-learn, check the policies and protocols at your facility and adapt the content accordingly.
- Build on your knowledge, experience, and awareness to connect the content to local context or relevant recent events so that your audience can apply the concepts confidently.
- The micro-learns reinforce infection control concepts when risks are observed in patients or in the patient environment, not necessarily in visitors or other staff members.
- Remind your audience that if they see a patient in distress—e.g., with shortness of breath, bleeding, or otherwise at risk of immediate harm—they should respond to the emergency according to facility protocols.



[www.cdc.gov/ProjectFirstline](http://www.cdc.gov/ProjectFirstline)





37

## Cough and Congestion Micro-Learn Discussion Guide: What to do when you see a patient with cough and congestion

**Use the talking points below and accompanying job aid to engage your team in short, focused discussion. Adapt to meet your needs.**

**1. Introduce the topic**

Share key information about the topic that your audience should know and connect to your local context:

- Coughing by itself can be caused by a lot of things, but a cough in combination with congestion—a stuffy, runny nose, itchy eyes, and a nasal voice—is commonly caused by a virus.
- These viruses spread easily when an infected person talks, breathes, coughs, or otherwise blows air out of their nose or mouth. One person releasing these germs into the air can infect multiple people quickly.
- Some of these viruses, like cytomegalovirus (CMV), don't cause major problems for healthy people, but they can cause harm to vulnerable patients.

**2. Expand on the topic**

Share information about what your audience should do:

- If you're near a patient with cough and congestion and don't know what's causing their symptoms, you can protect yourself from breathing in infectious particles by using a facemask and considering use of a NIOSH-approved respirator according to facility policies.
- As soon as possible, the patient should be placed in a separate room, away from others.
- The patient should wear a mask to keep their germs from reaching you and others, if it's safe for them to do so, i.e., if they're over the age of 2 and are able to remove the mask on their own if they need to.
- Check that air vents in the room are not blocked, as this could prevent the ventilation system from working properly.

**3. Discuss with your team**

Find out how your audience feels about the topic. Sample questions include:

- What do you usually do when you see a patient who is coughing and has congestion? Do you worry that you might catch something? When might you call for help or assistance?
- Do you have all the tools and information you need to do your job safely?
- As a team, how can we help each other take the right infection control actions when we see a patient who is coughing and has congestion to keep germs from spreading?


**4. Wrap up and reinforce**

Reinforce key takeaways:


- If you're near a patient with cough and congestion and you don't know what's causing it, use a facemask or respirator to keep from breathing in infectious particles.


Share related facility-specific information and cue to follow-up opportunities:

- Connect content with information such as facility protocols for patients with respiratory virus symptoms, facility triage and screening procedures, where to find respirators and whom to call if there are none left, recent cases or examples of patients with cough and congestion, or other relevant information.
- Share reminders, prompts, and opportunities for further learning as appropriate, including the Project Firstline website at [www.cdc.gov/projectfirstline](http://www.cdc.gov/projectfirstline).



[www.cdc.gov/ProjectFirstline](http://www.cdc.gov/ProjectFirstline)





38

One patient with cough and congestion can release germs into the air and infect multiple people quickly.

You can help stop the spread of germs.

Ask the patient to wear a mask.

If you are near the patient, wear a respirator or mask.

Check to make sure air vents are not blocked.

Place the patient in a separate room.

If the patient also has a rash, check with clinical and infection prevention teams for additional infection control steps.

Clean your hands.

Clean and disinfect surfaces and shared devices.

Learn More  
 Germs Can Live in the Respiratory System Infographic: <https://bit.ly/46Qa0WE>  
 Infection Control Actions to Stop the Spread of Respiratory Viruses: <https://bit.ly/3Q1UXDM>  
 Ventilation in Healthcare Settings: <https://bit.ly/3Q0YWs>

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[www.cdc.gov/ProjectFirstline](http://www.cdc.gov/ProjectFirstline)

CDC U.S. Department of Health and Human Services Center for Disease Control and Prevention

**PROJECT FIRSTLINE**

Sinclair School of Nursing  
University of Missouri

39

## OTHER TIMELY EDUCATION

- Hand Hygiene
- PPE Selection, Donning and Doffing
- Cleaning
  - Surfaces- High Touch (common areas and rooms)
  - Shared Medical Equipment (glucometers, lifts, vital machines, wheelchairs, etc.)

... and let's talk disinfection contact time!



40

# TRANSMISSION-BASED PRECAUTIONS (TBP)

Are your isolation policies updated? Who can place resident on TBP? Who can d/c TBP? What is the length of isolation for COVID (Staff, residents), influenza, RSV?

Are PPE carts packed and ready (including ABHS)? And is signage kept with them for the specific TBP? AND can staff access them 24/7

Are residents and families included in education for hand hygiene and facility IPC practices? How are these communicated?

Do you have a cohorting plan in place to accommodate several infected residents? (non-infected roommates should be moved to a quarantine room. If not possible, **document** and **discuss** with health department and/or DHSS)

Are testing supplies adequate? If PCR testing is needed, are you familiar with your laboratory's current process?

**Have you scheduled your pharmacy clinic? Collected consents?**



41

# TBP RESOURCES

IPC Recommendations for HCP (COVID): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

CDC Isolation Recommendations (per infection type):

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html>

DHSS COVID and Flu A/B Test Kits: <https://ltc.health.mo.gov/archives/15834>

CDC TBP Signage:

Contact - <https://www.cdc.gov/infectioncontrol/pdf/contact-precautions-sign-P.pdf>

Airborne - <https://www.cdc.gov/infectioncontrol/pdf/airborne-precautions-sign-P.pdf>

Droplet - <https://www.cdc.gov/infectioncontrol/pdf/droplet-precautions-sign-P.pdf>



42

## IN SUMMARY

**P**olicies and Procedures are in place for respiratory virus season

**R**eport and record infections and vaccinations

**E**ngage staff residents and family in IPC

**P**raise all those involved in keeping everyone safe!



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43

## IMPORTANT – CEU INFORMATION

TODAY'S WEBINAR HAS BEEN APPROVED FOR 2 PC CEU HOUR(S)

### IN ORDER FOR MO LNHA'S TO GET CREDIT:

- It is **REQUIRED** that you complete a brief survey/evaluation via:
  - ✓ A pop-up at the end of this webinar, *or*
  - ✓ An automated email from GoToWebinar that will be sent to attendees *approximately 24 hours after the webinar*
  - ✓ You only need to complete it once (either via the pop-up or the email)
- It is **REQUIRED** that you answer the question asking for your LNHA number

**NOTE:** the certificate that will be linked in GoToWebinar's automated "thank you for attending" email is **NOT YOUR CEU CERTIFICATE** – it is simply a *participation certificate*. Your official CEU certificate will be sent out by QIPMO staff in approximately 2 weeks.

*\*The amount of your credit will be adjusted based on the time spent on the webinar*

44

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[QIPMO Webinar Survey](#)

Your certificate is available here:

[My Certificate](#)

**<-- this is NOT your CEU certificate;  
<-- it's just a participation certificate  
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45

# CLINICAL EDUCATION NURSES

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46

# INFECTION CONTROL TEAM

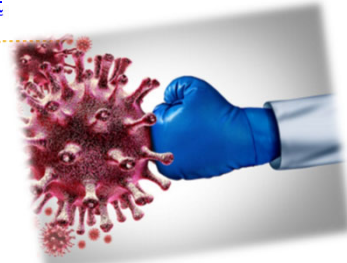
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47

# LEADERSHIP COACHES AND ADMIN TEAM

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48