



## COVID-19 Control Measures for Long Term Care

Interim Guidance (subject to change) March 20, 2020

### **Outbreak definition:**

One lab confirmed case of COVID19 and at least one case of COVID-like illness (CLI) with onsets within 14 days of each other

**NOTE: Once one positive case is identified, no additional testing is needed in either residents or staff**

### **Residents:**

- All residents should be screened by obtaining full set of vitals AND pulse oximetry every 8 hours (Q8 hours)
- If patients have been screened and their testing is POSITIVE for COVID-19 OR if patients have signs/symptoms of a respiratory viral infection:
  - a) Full Vitals AND pulse oximetry every 4 hours (Q4hours) {twice a shift}
  - b) Private Room or Cohort with another symptomatic/positive patient
  - c) Maintain Standard, Contact and Droplet Precautions (including eye protection)
  - d) Consider that staff caring for positive or symptomatic patients do NOT care for negative or asymptomatic patients.
  - e) Positive or symptomatic patients should be given a surgical mask and encouraged to wear at all times. These patients should be wearing a surgical mask when close contact with others is anticipated.
- Any resident identified with symptoms of fever and lower respiratory illness (cough, shortness of breath, sore throat) should be immediately placed in both Contact and Droplet transmission-based precautions.
- The isolation should be implemented by the healthcare member who discovers the symptoms pending a physician order.
- Residents with confirmed COVID-19 or displaying respiratory symptoms should receive all services in room with door closed (meals, physical and occupational therapy, activities, and personal hygiene, etc.)
- Symptomatic residents should only leave their room as required for medical procedures not available on site (i.e., dialysis, medical specialist appointment, and critical testing not available at the facility). If the resident is to leave room for these purposes the shortest route should be utilized and the immediate are/route to the exit/treatment areas should be cleared of all residents and unnecessary staff.
- Testing to rule out routine pathogens may be completed via rapid influenza testing and respiratory viral panels (Rhinovirus, RSV, etc.).
- Determination to send the resident to the hospital should be based on the same criteria used for other illnesses.
- Those residents with severe illness requiring hospitalization should be transferred to the hospital with notification to EMS and the receiving hospital.

### Facilities:

- Should communicate with physician, local health department, regulatory agency, families, staff and residents.
- Processes and activities which increase residents' risk should be modified or suspended.
- Immediately inform the local health department and IDPH of symptomatic residents to determine if COVID-19 testing is indicated. Once a positive case is identified in a facility, no additional testing is needed in either residents or staff.
- Stop large group congregate activities and provide alternatives (arrange in room dining or dining that maintains social distancing and activities, stop bingo, beauty shop, outside volunteer presentations, church, etc.)
- If not already being performed begin screening all residents and staff including temperature checks and use of checklists to identify symptomatic individuals.
- Inform staff to stay home when sick insuring non-punitive practices during this period. Screen all staff prior to shift for temperature and respiratory symptoms. If present staff member should be sent home until symptoms resolve.
- Focus on decreased staff rotation and cohort staff to work with symptomatic residents whenever possible.
- Ensure staff are educated on and correctly performing hand hygiene, donning and doffing of PPE, and using appropriate products for environmental cleansing/disinfection.
- Ensure adequate supplies of PPE are easily accessible to staff.
- Post signage for Hand hygiene and cough etiquette, ensure necessary supplies to accomplish these tasks are present at all entries and patient care areas. Notify all residents, staff, visitor and families of current situation.
- Visitation should be restricted to essential individuals. All visitors should be informed of risk and instructed on proper PPE use prior to entering unit. Other avenues of communication with family should be explored (i.e., face time, skype, etc.).
- Identify additional isolation rooms limiting to single unit if possible, cohort like cases if necessary (e.g., influenza with influenza, COVID-19 with COVID-19, etc.).
- Ensure adequate testing supplies and masks are available for staff collecting specimens (for first resident being tested). Avoid aerosol generating procedures. If necessary, use face and eye protection, N95 or respirator, close door and pull curtain. Wipe horizontal surfaces with EPA registered and approved product (List N products) after procedure. If supplies become scarce, follow CDC recommendations for crisis capacity use.
- Facilities should be able to accept COVID-19 residents from the hospital if clinically stable.
- New admissions (residents and families) should be notified if the facility has COVID-19 in the building.

### Environmental Services/controls:

- Disinfect frequently touch surfaces **every two hours or as frequently as possible** with EPA registered and approved product (List N products).



- Educate and observe practice on appropriate disinfection (clean to dirty, appropriate dwell time, when to switch clothes and wipes, etc.). Ensure cleaning and disinfection policies and procedures are being followed consistently and correctly.
- Ensure appropriate PPE is worn during cleaning and disinfection work.
- Limit access to facility and post signage reading rationale. Only essential visitors, employees and contract staff should be allowed to entrance.
- Ensure adequate facilities for completion of hand hygiene-hand washing sink or alcohol-based hand rub. Alcohol-based hand rub should ideally be both inside and outside of patient rooms, at all entrances, and throughout the clinical areas. Ensure all dispensers contain product within expiration date.

#### **Employees:**

- All employees should promptly notify supervisor of any symptoms of illness in themselves or individual in their care.
- Employee who are ill will exclude themselves from work environments and will seek the advice of their health care provider.
- Provide symptoms report and allow temperature monitoring upon entry to work.
- Symptomatic staff do not require testing but, should considered possible cases and work restriction and isolated at home for a minimum of 7 days after onset and can be released after afebrile and feeling well (without fever reducing medications for at least 72 hours).
- Asymptomatic staff do not need to be tested for SARS-CoV2.
- Employees may utilize extended use techniques with masks and eye protection when caring for residents.
- Mask should be worn when entering unit. Change mask if touched soiled or moist. Remove when leaving isolation rooms.
- Agencies of contract employees should be notified of risk and screen their staff to prevent transmission from facility to facility. Use limited and or consistent agency staff during the COVID-19 pandemic if possible.
- Perform hand hygiene on arrival at the facility, during the 5 moment so of patient care activities, and prior to going home.
- PPE should not be worn off affected units or areas unless approved as enhanced control measure.
- All employees should be pre-screened for fever and symptoms prior to shift.
- If employee has been tested and has a negative COVID-19 test and does NOT have symptoms, they may continue to work. Symptom screening is done pre-shift and every 4 hours during shift.
- All asymptomatic employees must wear a mask during their shift to protect residents.

#### **Return to Work Criteria for HCP with Confirmed or Suspected COVID-19**

Use one of the below strategies to determine when HCP may return to work in healthcare setting:

1. Non-test-based strategy:
  - Resolution of fever without the use of fever-reducing medications and



- Improvement in respiratory symptoms (e.g., cough, shortness of breath),  
**AND**
- At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath);  
**AND**
- At least 7 days have passed since symptoms first appeared
- If HCP were never tested for COVID-19 but have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

## 2. Test-based strategy. Exclude from work until

- Resolution of fever without the use of fever-reducing medications  
**AND**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath)  
**AND**
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected  $\geq 24$  hours apart (total of two negative specimens) [1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

- **Return to Work Practices and Work Restrictions**

After returning to work, HCP should:

- Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

### **Guidance for Communal Dining (update March 25, 2020)**

Residents identified as being positive for COVID-19 or who are displaying symptoms of COVID-19-like illness (fever, cough, sore throat, shortness of breath) should have meals in their rooms (dine-in meals).

If residents are not displaying ANY symptoms of COVID-19, the facility should consider the following measures to balance the directive to eliminate communal dining and the need to provide nutritional meals to residents in a safe manner.

- Stagger dining periods, so fewer residents dine at a time.



- Utilize all available dining halls in the facility (providing additional space to separate residents)
- Those residents that can feed themselves without any issues or concerns should dine in their room (this decreases the number of residents in the dining hall).
- Those residents needing assistance to eat should be separated by at least six feet. Depending on the size of the dining table, only 1 to 2 residents per table. Tables need to be at least six feet apart as well.
- The facility should consider utilizing resident attendants and speech therapists to assist nursing assistants in feeding residents.
- Staff should wear a facemask when feeding residents.
- Hand hygiene is to be performed between resident care (feeding).
- Only ONE resident should be transported (pushed) at a time to the dining room. Do not attempt to push more than one wheelchair at a time. The same process is used for return trips to resident rooms---only ONE resident at a time.
- Ensure cleaning and disinfection of environmental surfaces between dining periods. Only use EPA registered disinfectants. Ideally, use a product from List N. Refer to CDC/EPA website for List N products. If your current disinfectant is not listed on the List N products, check the label and ensure the product is at least effective against human coronavirus.