Frequently Asked Questions Regarding COVID-19 and PALTC

When COVID-19 Is Currently In Your Regional Community (i.e., Community Spread)

COVID-19 is the abbreviated name for novel Coronavirus Disease 19 that first emerged in Wuhan, Hubei Province, China and has spread globally. Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person.

The situation with this outbreak is evolving rapidly with new information being learned daily. The CDC is monitoring the outbreak and working closely with federal, state, and local health departments. Because of this, healthcare personnel working in post-acute and long-term care (PALTC) settings should refer to the CDC website for the latest updates.

General Information

Strategies to Prevent the Spread of Infection in Long-Term Care Facilities

Early identification of patients with acute respiratory illness including COVID-19 is crucial. We recommend surveillance of all residents and staff for clinical signs and symptoms of respiratory illness or fever.

If you identify a cluster of acute respiratory illness in residents or staff irrespective of etiology you should contact your local public health department immediately for further guidance.

We recommend that the residents with respiratory illness be immediately isolated pending testing.

Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes (REVISED)

The vision of AMDA – The Society for Post-Acute and Long-Term Care Medicine is a world in which all post-acute and long-term care patients and residents receive the highest-quality, compassionate care for optimum health, function, and quality of life.
VISITORS AND VOLUNTEERS

What should we tell our visitors and volunteers?

It is important to thoughtfully communicate the need for visitor restrictions with families, friends, and volunteers. Limiting visitors and volunteers during periods of community spread is important to reduce the risk of transmission to other residents, families, staff members, as well as the larger community.

Facilities may have many entrances which pose a challenge when trying to screen for ill visitors. Facilities should identify all potential entrances used by the public and limit access to just a few entrances where screening can be performed.

Post large warning signs (“stop signs”) at all entrances which include instructions regarding visits.

<table>
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<tr>
<th>We strongly recommend that facilities screen and restrict the following visitors irrespective of local transmission of COVID-19:</th>
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<tr>
<td>1. Individuals with clinical symptoms of respiratory illness and fever. If visitors are found to have respiratory illness, then we strongly recommend that they should not visit nursing home residents.</td>
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<td>2. Visitors who have traveled internationally within the last 14 days to the restricted countries. Check updates: Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States</td>
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<tr>
<td>3. Any visitors who may have had contact with an individual with confirmed or suspected COVID-19 in the prior 14 days.</td>
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<td>4. Residing in a community where community-based spread of COVID-19 is occurring.</td>
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In addition, facilities should ask visitors if they took any recent trips (within the last 14 days) on cruise ships or participated in other settings where crowds are confined to a common location. If so, facilities should suggest deferring their visit to a later date. If the visitor’s entry is necessary, they should use PPE (mask) while onsite and should wash hands prior to entry and at exit.

We also suggest that children be restricted from visiting the facilities as reports suggest that they may exhibit mild symptoms that may go undetected.
Local COVID transmission: If your facility is located in counties, or counties adjacent to other counties where a COVID-19 case has occurred, the Centers for Medicare and Medicaid Services (CMS) recommends limiting visitation, which means no visitor should be allowed to come into the facility, except for certain situations, such as end-of-life situations or when a visitor is essential for the resident’s emotional well-being and care.

No Local COVID transmission: If your facility is not located in counties or adjacent to other counties where there are COVID-19 cases, CMS recommends that facilities discourage visitation (except in certain situations). Discouraging visitation means that the facility allows normal visitation practices (except for those individuals meeting the restricted criteria) but advises individuals to defer visitation until further notice (through signage, calls, etc.).

Visitors:
If allowed to visit, visitors should limit contact to the residents’ room or a place the facility has specifically dedicated for visits rather than common area.

If a visitor is exposed to a resident with COVID-19, they should monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure and, if ill, should self-isolate at home and contact their healthcare provider.

If a visitor develops acute respiratory illness or COVID-19 within 14 days of visiting a facility they should report that to the facility.

Volunteers should suspend visits.

Please regularly review the CMS Guidance for Infection Control and Prevention of Coronavirus Disease for updates.

What if a family member who may be ill also has a need to visit a resident?
CMS guidance dated 3/9/2020 states that any family member who is ill should not be allowed to enter the facility until the illness is resolved and they are no longer considered infected with the respiratory illness or COVID-19.

We recommend use of technology such as Skype, FaceTime, or similar phone and iPad applications if possible to avoid an unnecessary exposure.

What about other people who access the building—like vendors delivering medications from the pharmacy, linens, food, and other supplies?
These individuals should not enter the building if possible. Instead, as part of social distancing, they should be instructed to leave their delivery at an appropriate location well away from residents and, if possible, staff. Post signs at the doors and entrances used by vendors that remind individuals about cough etiquette. Provide alcohol hand rub and direct vendors that must enter the building to sinks with soap and water if needed. Facilities should identify and plan for such situations.

**STAFF**

**Should we screen our staff for COVID-19?**
The director of nursing (DON) is accountable for ensuring that staff does not work while they have signs or symptoms of a respiratory illness.

All nursing home staff, including both direct care workers (e.g., nurses, CNAs, therapists, activities staff, hospice staff, and dietary staff) AND non-direct patient care staff such as environmental service or maintenance staff should be assessed at the start of a shift through a tiered accountability approach. Direct patient care staff should be assessed for respiratory illness or fever by nurse managers of the units and supervisory staff prior to provision of patient care duties. Staff should report recognized exposure to individuals with known or suspected COVID-19 to the DON or designated staff, regularly monitor themselves for fever and symptoms of respiratory infection, and not report to work when ill. Any ill staff should not be allowed to provide patient care.

Any staff that develop signs and symptoms of a respiratory infection while on the job should:

- Immediately stop work, put on a facemask, and self-isolate at home
- Inform the facility’s infection preventionist of contacts with individuals, equipment, and locations
- Contact and follow the local health department recommendations for next steps (e.g., testing).

Facilities should contact their local health department for questions, and frequently review the [CDC website dedicated to COVID-19 for healthcare professionals](https://www.cdc.gov/coronavirus/2019-ncov/healthcare.html).

**When should someone who had a respiratory viral illness be allowed to return to work?**
The DON is accountable for ensuring that staff does not work while they have signs or symptoms of a respiratory illness. Facilities should define a process for determining when and under what conditions an ill staff member may return to work. This process should include input by the DON, infection preventionist, or other designee with a clinical background. In addition, the facility should consult with the medical director as needed.

Typically for most respiratory viral infections, the amount of virus shed by a person decreases as symptoms resolve. Staff who have a respiratory viral infection not caused by COVID-19 should be excluded from work until at least 24 hours after they are no longer febrile (without the use of fever-reducing medications such as acetaminophen, ibuprofen, or naproxen) and after respiratory symptoms have improved, typically 4-5 days from the onset of symptoms. Frequently, people may have a lingering cough after a respiratory viral illness.

The length of time that people shed COVID-19 is not yet known. Experience with similar viruses indicates people may shed virus for at least 12 days after illness onset. People with more severe disease shed higher amounts of virus. **Return to work of staff diagnosed with COVID-19 should be decided on a case-by-case basis and discussed with the public health department.**

**RESPIRATORY ILLNESS IN NURSING HOME RESIDENTS**

**One of our residents has a fever, cough, and shortness of breath. What should we do?**
These symptoms could be caused by several different respiratory viral illnesses including influenza, respiratory syncytial virus (RSV), and COVID-19.

➢ **Isolate** the resident and initiate testing for influenza and other potential respiratory viruses. If initial tests are negative, evaluate the need for SARS-CoV-2 testing in consultation with your local and/or state public health department.

➢ **Assess the resident carefully for severity of illness** and need for hospitalization in conjunction with goals of care.

➢ **Implement standard, contact, and airborne precaution and eye protection.** See details below.

**What about the roommate and other contacts?**
If the ill resident is confirmed to have COVID-19, any roommates or other contacts should be placed under surveillance for development of respiratory illness. If moved, the roommate
should be placed in a private room to minimize ongoing exposure to other residents and staff. Management of contacts should be coordinated with the local or state health department.

**What about the healthcare workers?**
If the ill resident is confirmed to have COVID-19, the exposed staff should immediately begin wearing a mask and be referred to occupational health for assessment of the degree of exposure and the need to furlough.


**We have a diagnosed case of COVID-19 in our nursing home. What do I do?**
If there is a new diagnosis of COVID-19 in the LTC facility:

- Immediately notify your local and state health department for further guidance.
- We recommend that facilities follow standard practices during a respiratory illness outbreak like influenza outbreak.
  - Have symptomatic residents stay in their own rooms as much as possible, including restricting them from common activities, and have their meals served in their rooms when possible.
  - Limit the number of large group activities in the facility and consider serving all meals in resident rooms when the outbreak is widespread (involving multiple units of the facility).
  - Avoid new admissions or transfers to wards with symptomatic residents.
  - Limit visitation and exclude ill persons from visiting the facility via posted notices. Consider restricting visitation by children during community outbreaks of influenza.
  - Monitor healthcare personnel absenteeism due to respiratory symptoms and exclude those who are ill from work.
  - Restrict healthcare personnel movement between affected and unaffected areas/units of the facility.

*Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities*

- A decision to stop new admission to the facility should be made in conjunction with the local and state health department.

- All visitors, including volunteers to the facility, must be restricted. If a visitation cannot be avoided due to an urgent reason (e.g., end of life), the decision to allow visitation should be made on a case-by-case basis by the DON in consultation with the medical
director. Electronic means of communication, i.e. visitation through FaceTime, etc. should be offered as an alternative.

➢ Facilities should have a communication plan with families. Communications may be provided through a variety of means such as letter, email, website postings, etc.

INFECTION CONTROL AND PREVENTION IN NURSING HOMES

What kind of personal protective equipment (PPE) should we use when caring for someone with a respiratory viral illness other than COVID-19?

We recommend standard, contact, and droplet precautions with eye protection. This means wearing a gown and gloves, together with a facemask and goggles or a face shield. In case of PPE shortages, eye protection should be prioritized to staff administering any respiratory treatment that may result in aerosolization of viral particles. Examples of respiratory treatments that may lead to aerosolization of viral particles include use of nebulizers, suctioning, tracheostomy care, and application or adjustment of oxygen masks.

We further recommend that the resident should remain in their room, with the door closed if possible. We also recommend engineering controls such as pulling curtains and using consistent staffing assignments to limit the number of individuals to whom residents and healthcare staff have exposure. Personnel should not move from unit to unit during their assignments. This may include flexible staffing and roles to minimize movement of staff throughout the building.

Are the recommendations different for someone with COVID-19?

Although SARS-CoV-2 is thought to spread mainly from person to person through respiratory droplets, currently out of an abundance of caution the CDC is recommending that healthcare facilities use airborne precautions and eye protection in addition to standard and contact precautions. This means wearing a gown, gloves, an N-95 facemask, and goggles or a face shield during care. However, PALTC facilities in multiple regions are reporting shortages of N-95 masks. PALTC facilities generally do not stock N-95 masks since most sites do not have airborne isolation capabilities. Related to this, most PALTC staff are not being routinely fit tested for use of N-95 masks. Many PALTC facilities are currently indicating they are not able to obtain N-95 masks from their suppliers. As such, it is highly likely N-95 masks will not be available to most PALTC facilities, particularly as the number of cases of COVID-19 expand.

Given the available information on transmission and in consideration of the issues of limited access to adequate supplies of N-95 masks, the following strategies are reasonable options
consistent with World Health Organization (WHO) recommendations and CDC recommendations for resource-limited settings.

Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected

Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies

Facilities should consult with public health authorities when considering these recommendations.

- **We recommend staff use surgical masks and eye protection or face shield before administering any respiratory treatment that may result in aerosolization of viral particles to individuals not suspected of having COVID-19, but who appear to have another respiratory viral infection. Examples of respiratory treatments that may lead to aerosolization of viral particles includes use of nebulizers, suctioning, tracheostomy care, and application or adjustment of oxygen masks.**

- **If N-95 masks are available to PALTC providers, we recommend staff prioritize use of N-95 masks to individuals likely to have COVID-19.**

- **If N-95 masks are in limited supply to PALTC providers, we recommend staff prioritize use of N-95 masks during respiratory procedures likely to result in aerosolization of viral particles. During all other lower-risk care, surgical masks should be utilized.**

- **We recommend that staff use N-95 mask and eye protection in addition to other PPE when obtaining respiratory samples in individuals with suspected COVID-19.**

Do we need to use PPE for all of our residents who get respiratory care? Some of them have a tracheostomy and need pulmonary toilet every shift.

For residents who require routine respiratory care such as daily nebulizers or who have a tracheostomy, continue to use the same infection control measures previously in place for those individuals. Should they manifest a change in symptoms, such as fever, increased sputum production, or increased oxygen requirements, this may indicate the development of an acute respiratory illness. Assess the resident for influenza, RSV and, working with state and local healthcare authorities, for COVID-19. Have a high index of suspicion. Early detection is crucial.

We recommend that the continued need for nebulizer therapy in all residents be periodically reassessed, and if no longer required, it should be discontinued.

We recommend that staff close bedside curtains when performing respiratory procedures in semiprivate rooms.
We do not have any COVID-19 in our building but it is in our community. I am concerned about asymptomatic shedding by our staff. What are some options?

To reduce the risk of asymptomatic staff infecting their residents, we recommend universal masks and glove use as a precaution when there is local, regional, or widespread transmission of COVID-19 in your community but not your nursing home. We also strongly recommend active surveillance of both residents and staff members when there is evidence of community-wide transmission.

How do I know if I am using PPE correctly?
We recommend training and practicing proper use of PPE with your staff. Use a buddy system to help catch common errors. In a training scenario, it is okay to reuse gowns.

The CDC has posters that show how to put on and take off (don and doff) PPE: Sequence for Putting on Personal Protective Equipment (PPE)

There are also videos available through the University of Nebraska:
Hospital PPE - Infection Control: Donning and Doffing

What else can we do to help our staff use PPE correctly?
Post signs on the door about the type of precautions needed with the required PPE.

Ensure that PPE is readily accessible. Ideally, supplies should be made available immediately outside the resident's room. Assign someone to check and restock supplies each shift.

Staff should be trained to don and doff their PPE at the entrance to the resident’s room. A trash can should be placed near the door of the room to discard the PPE. Alcohol-based hand wash should be accessible for use after doffing the PPE.

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)

We are running low on PPE. What can we do?
Nursing homes that are part of a larger network may share the same supply resources as hospitals within their network. Individuals responsible for allocating supplies at a systems level may attempt to prioritize hospitals. We recommend working with these individuals and with senior level administrators to advocate for a supply of PPE for nursing homes as well. Stress the risk of outbreak among vulnerable elders living in a communal setting as well as the increased risk of death due to COVID-19 among adults aged ≥70 years (8% mortality for those aged 70-79; 15% for those ≥80 years).
Allow personnel caring for several people with the same respiratory illnesses to use the same face mask or N-95 as they move between residents. We recommend a new gown and gloves when moving between residents. If this is not possible due to a critical shortage of PPE supplies and there is an outbreak of possible COVID-19 in your building, healthcare personnel can also use the same gown when caring for several individuals with the same illness. Should those individuals require contact precautions for other reasons, such as a drug-resistant bacteria, we suggest starting with the residents with the least burden of potential pathogens first and working with those with the most potential pathogens last. Further, use hand hygiene and don new gloves between individuals to reduce the risk of disease transmission. Should even gloves need to be rationed, alcohol hand rub may be applied to gloves between tasks and activities for the same resident, rather than changing gloves as is recommended when going from dirty to clean tasks, such as during dressing changes.

Check the links for measures to rationalize the use of PPE and N-95:

- [Rational use of personal protective equipment for coronavirus disease 2019 (COVID-19)](http://example.com)
- [Strategies for Optimizing the Supply of N95 Respirators: COVID-19](http://example.com)

**TRANSFER TO ACUTE CARE**

**Should I transfer my resident with a respiratory viral illness to the hospital in order to help reduce the spread of disease?**

We recommend transferring residents based on their medical needs, not as a means to reduce the spread of infection. Before transferring, determine if hospital transfer is part of the resident’s goals of care. If the resident is sick enough that hospital transfer is indicated, alert the personnel transporting the resident as well as the receiving hospital that the resident has a suspected viral respiratory illness. Share the results of influenza and or RSV testing as well.

Although CDC recommends standard, contact and airborne precautions, CMS in its Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes released 3/4/2020 states that facilities without an airborne infection isolation room (AIIR) are not required to transfer the patient assuming:

1. The patient does not require a higher level of care.
2. The facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19.*

CMS and CDC are currently reviewing information around the use of airborne precautions. Facilities should consult the CDC website frequently for any changes.
We have a resident who needs to be transferred to acute care for suspected COVID-19. The hospital has resources to care for the individual and has accepted them. How do we approach this?

Transferring a resident with suspected or confirmed COVID-19 to the hospital requires consultation and communication with the local/state health department, receiving institution, and EMS services.

While making the arrangements for transfer, the individual will still require care from staff, who should continue to use standard, contact, and airborne precautions as described above. Keep the door to the resident’s room closed as much as possible. Pull curtains and limit the number of staff going in and out of the room and the unit. Alert the transport crew of the concern for COVID-19 so they can be prepared with their own respiratory protection. The hospital should be aware and have plans to minimize the risk of transmission once the individual arrives at the building, such as placing them into a negative pressure room.

During the physical transfer of the resident into a gurney for transport, personnel should continue to wear gloves, gown, and a face shield or facemask with goggles. The resident should have a facemask if tolerated. Once the individual is on the gurney, with clean sheets and blankets, staff should remove their PPE and gloves and perform thorough hand hygiene.

Transfer from Acute Care:
When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?

CMS guidance states that a nursing home can accept a patient diagnosed with COVID-19 and still under Transmission based Precautions for COVID-19 as long as it can follow CDC guidance for transmission-based precautions.

Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

If a nursing home cannot, it must wait until these precautions are discontinued. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room).
We have accepted a patient diagnosed with COVID-19 in our facility. When can we discontinue transmission-based precautions?

CDC states that decisions to discontinue transmission-based precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials.

**Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes**

**ENVIRONMENTAL CLEANING**

How do we clean the resident’s room with possible COVID-19?

**Daily cleaning:** We recommend that to minimize the exposure and optimize use of PPE, only essential clinical staff enter the rooms of residents with suspected or confirmed COVID-19. CDC recommends that nursing staff taking care of residents perform the daily cleaning of frequently touched surfaces (such as door handles, bedrails, tabletops, light switches, elevator buttons [inside and out], computers, remotes, phones etc.) with an EPA-registered, hospital-grade disinfectant that has an emerging viral pathogens claim for use against SARS-CoV-2.

**List N: Disinfectants for Use Against SARS-CoV-2**

**CDC Infection Prevention and Control FAQ for COVID-19**

Ensure that dedicated equipment is available and remains in the resident’s room and that alcohol hand rub is available and a process is in place to refill empty dispensers and restock PPE.

All non-dedicated, non-disposable medical equipment used for patient care should be cleaned according to facility policies.

Environmental service staff should continue to clean the other resident rooms as their routine practice and should ensure that an adequate supply of alcohol-based hand sanitizers is in the dispensers. They should clean the frequently touched surfaces like doorknobs and door handles, and surfaces at the nurses’ stations at least twice daily and more frequently as needed.

For **terminal cleaning**, environmental service staff should observe contact and droplet precautions (based on above recommendations) when cleaning residents’ rooms. Educate staff on proper use of PPE and appropriate choice of disinfectant. A facemask and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated. Standard practices using an EPA-registered, hospital-grade disinfectant with an emerging viral pathogens claim are recommended for use against SARS-CoV-2.
Do we need any special precautions for laundry?
There are no special recommendations for management of laundry, food service utensils, and medical waste. Follow routine procedures.

What are the other precautions that facilities can take?
CMS, in its guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes, recommends the following measures:

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019.
- Increase the availability and accessibility of alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc. Ensure ABHS is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect, and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurses’ stations, phones, internal radios, etc.).