Frequently Asked Questions Regarding COVID-19 and PALTC

This document assumes that there is community spread of COVID-19 in your region. We have organized this by general topics with subtopics and specific questions under each general topic heading. Some questions may appear under more than one heading. Please click on the question or topic below to be taken to additional information.

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

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

- Coronavirus (COVID-19) information from the CDC
- COVID-19 for Long-term Care Facilities from the CDC
- Steps Healthcare Facilities Can Take Now to Prepare for COVID-19
- AMDA’s Resolution on COVID-19, dated March 19, 2020, states that a COVID-19 naïve facility should not accept an admission with clinical or lab evidence of active disease. Instead, care of these patients should be provided in alternate care sites and specialized COVID-19 facilities.

- What regions of the country and world are most affected by COVID-19?

The links below are to global situation reports:

World Health Organization Situation Dashboard

Johns Hopkins Coronavirus Resource Center

- How do I find out what is happening in my state?

Please look at your state health department website to learn what is happening in your region.

State & Territorial Health Department Websites
General Topics:

Tools and Concepts

- Preparedness checklist for nursing homes
- Active Screening for COVID-19 Infection in Nursing Home Residents
- Facility specific goals and Patient-specific Goals for buildings with a COVID-19 case(s)

Clinical Presentations and Response

- What are the signs and symptoms of COVID-19?
- What are risk factors for developing a severe COVID-19 infection?
- I’ve heard that dialysis patients are at high risk for getting COVID-19. Is that true?
- What should we do to identify the disease early?
- One of our residents has a fever, cough, and shortness of breath. What should we do?
- Should I test my resident for COVID-19?
- Should I test all of my residents for COVID-19?
- How do we collect a sample to test for SARS-CoV-2 and where do we send it?
- Where do we send the swab for testing?
- How common is co-infection with other respiratory viruses?
- The COVID-19 test on one of our residents came back positive. What do I do?
- What about the roommate and other residents in the same area as our COVID-19 positive resident?
- What about the healthcare staff that cared for our COVID-19 positive resident before she was placed on contact and droplet precautions?

Managing a Facility with COVID-19

- How should I get my facility prepared for a COVID-19 case/outbreak?
- We have two residents from different units with new onset respiratory symptoms. Should they be in the same room?
- Managing Residents with COVID-19 Infection
- Should I transfer my resident with COVID-19 to the hospital?
- 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?
• **We have several residents with COVID-19 and our hospitals are overwhelmed. We have decided to treat in place. What can we do to support our residents through this devastating illness?**
• **Should we hold NSAIDs or ACE-I?**
• **Are there any medications I can give to help my residents who are sick with COVID-19?**
• **Does hydroxychloroquine work for prophylaxis?**

**Leaving the Facility for Non-Urgent Medical Care**
• **One of our residents has an appointment scheduled with a specialist they saw in the hospital. Should we send her to that appointment?**
• **Several of our residents get hemodialysis. What should we do for them?**

**Admissions**
• **We have not had a COVID-19 patient in our facility, but we are starting to see it in the community. What can I do to prepare for it?**
• **We have not yet had any COVID-19 positive staff or residents in our building. The hospital has asked us to accept a COVID-19 positive patient. I’m not sure what to do.**
• **We have not yet had any COVID-19 positive staff or residents in our building. The hospital has asked us to accept a patient who was admitted for 1 day for a chronic-obstructive pulmonary disease (COPD) exacerbation. Should we accept this patient?**
• **We have accepted a patient who is recovering from an acute myocardial infarction. What are your recommendations for when the patient arrives to our building?**
• **When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?**
• **We have accepted a patient diagnosed with COVID-19 in our facility. When can we discontinue transmission-based precautions?**

**Infection Control and Prevention in Nursing Homes**
• **We are running low on personal protective equipment (PPE). What can we do?**
• **We are critically short on PPE of all types---face masks, gowns, gloves. Any suggestions?**
• **We are completely out of gowns. Now what?**
• **We are completely out of gloves. Now what?**
• **We are completely out of surgical masks. Now what?**
• **I heard we can re-use N95s. How do we do that?**
• **What are some of the basics for infection prevention and control that we can do?**
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- **What kind of personal protective equipment (PPE) should we use when caring for someone with a respiratory viral illness?**
- **What can we do to help our staff use PPE correctly?**
- **Can equipment like stethoscopes, blood pressure cuffs or pulse oximetry devices transmit COVID-19?**
- **We do not have negative pressure or airborne infection isolation rooms (AIIR) in our building. What should we do for a resident with possible COVID-19 infection?**
- **When should we use N-95 respirators? We have a few and want to conserve them.**
- **What procedures generate aerosols?**
- **Is there a way to reduce the use of nebulizers?**
- **One of our residents is scheduled to be fitted for dentures next week. Should we let the dentist into the building?**
- **Our speech therapist recommended a fiberoptic evaluation for a resident who recently had a stroke. I’m reluctant to have this done. What do you recommend?**
- **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.**
- **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?**
- **Some of our staff work at multiple buildings. What should we do?**
- **What about our medical providers? They work at multiple nursing homes and have outpatient practices.**

**Environmental Cleaning**

- **How do we clean the room of a resident with possible or confirmed COVID-19?**
- **Are there special protocols for shared medical equipment?**
- **Should we do something different to clean the rest of the building?**
- **One of our residents with COVID-19 has gone home. What should we do for terminal cleaning of that room? Do we need any special precautions for laundry?**
- **Several of our family members do laundry for our residents. Should we stop that?**

**Staff**

- **How should we screen our staff upon entry into the building?**
- **What do we do for staff who do not pass screening?**
- **What should we do when a staff member is exposed to a resident with possible COVID-19?**
- **What if a staff member develops respiratory symptoms while at work?**
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• What other symptoms should staff report?
• When can a staff member who had a respiratory viral illness be allowed to return to work?
• Some of our staff work at multiple buildings. What should we do?
• What about our medical providers? They work at multiple nursing homes and have outpatient practices.
• We have not done telehealth previously and don’t have the equipment. What can we do?
• We have done telehealth before but do not want to bring the machine into the room of a COVID-19 positive resident. What should we do?

Visitors, Volunteers, Students and Trainees

• It sounds like almost no one should enter the building except for employees. Is that correct?
• Who is allowed into the building?
• How should we screen people that we consider letting into the building?
• Should we limit the number of entrances to our building?
• What should we tell our visitors and volunteers?
• Are students and other trainees considered essential personnel? They do a great deal of work for us.
• We depend on our volunteers to help us. Are they essential personnel?
• Are people from hospice considered essential personnel?
• What about other people who access the building—like vendors delivering medications from the pharmacy, linens, food, and other supplies?
• One of our residents is actively dying of cancer. They do not have any signs of symptoms of COVID-19. Their family members pass screening criteria to enter the building. Now what?
• We allowed visitors to enter last week. Now we have 2 potential cases of COVID-19. What do we tell those visitors?
• What if a family member who may be ill wants to visit a resident?
• What do we tell the families and friends of our residents?
Tools and Concepts

- COVID-19 Preparedness Checklist for Nursing Homes and Other Long-Term Care Settings (pdf)
- Active Screening for COVID-19 Infection in Nursing Home Residents

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- Facility specific goals and Patient-specific Goals for buildings with a COVID-19 case(s)

This table addresses the two key goals of minimizing spread of infection within the facility and of managing patients who have tested positive for COVID-19. The bulleted lists below the table expand on the recommendations made within the table.
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<th><strong>Patient specific goal:</strong> Close monitoring and supportive care. COVID-19 patients can rapidly deteriorate.</th>
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<td>▪ Strict cohorting of COVID-19 patients in a separate unit. (Resident movement)</td>
<td>▪ Specialized unit and increased medical director oversight (Hospital like setting)</td>
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<td>▪ Dedicated staff</td>
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<td>▪ Increased vigilance in all residents of the facility</td>
<td>▪ Reestablishing goals of care including decision to hospitalize and placement on ventilator/ life support in an informed discussion.</td>
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<td>▪ Strict, complete, correct use of PPE</td>
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<td>▪ Restricting family/ unskilled volunteers</td>
<td>▪ Need for palliative care / hospice services</td>
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<td>▪ Lower resident to CNA/MA ratio for feeding assistance – no communal dining feeding assistance</td>
<td>▪ Treatment modalities</td>
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**Facility-specific goal: Minimize spread of infection to other residents and staff:**
- Strict cohorting of COVID-19 patients in a separate unit.
- All residents on the unit should be carefully screened for common and uncommon symptoms of COVID-19.
- If a resident is diagnosed with COVID-19 on a unit, there should be a low threshold for testing other symptomatic residents on the affected unit.
- If there are multiple positive COVID-19 cases on the unit, diagnosis can be made based on symptoms.
- No movement of staff between units.
- No sharing of equipment, including medicine carts and wound care supplies, between the units.
- Practice strict adherence to infection control practices.
- Rehabilitation services should be suspended for the COVID-19 unit to avoid staff-based transmission.
- Facilities should only cohort COVID-19 confirmed residents and not cohort suspected cases on respiratory isolation pending testing results.
- Patients who are COVID-19 positive and negative for flu or other respiratory viruses can be in the same room.
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**COVID-19 patient-specific goal: Close monitoring and supportive care**

Nursing home residents who are COVID-19 positive can deteriorate very quickly. These patients need a higher level of nursing and clinical care than typical nursing home residents.

- Goals of care should be reestablished, including the decision to hospitalize and placement on ventilator/life support, in an informed discussion in light of COVID-19.
- Decision to treat in place should be based on care goals and medical necessity.
- COVID-19 patients should be frequently monitored with pulse oximetry.
- Staff should be vigilant for signs that signal quick deterioration; this includes respiratory distress. This could present as a drop in the patient’s oxygen saturation being the only clue.
- Staff should provide supportive care with supplemental oxygen (often at high concentrations), with IV fluids as needed.
- There is currently no clear evidence of effective treatment or prophylaxis although several studies are ongoing.
- Palliative care should be considered as appropriate.
Clinical Presentations and Response

- **What are the signs and symptoms of COVID-19?**

  The signs and symptoms that are most common are fever, a dry cough and shortness of breath. Some people experience an influenza-like illness. Similar to influenza illness, residents could present with exacerbation of underlying cardiac or respiratory condition such as COPD. Approximately 10% patients may have diarrhea followed by the respiratory symptoms. A lower threshold should be set to evaluate these residents. As with many infections, the illness may show up differently in different people.

- **What are risk factors for developing a severe COVID-19 infection?**

  Increasing age appears to be the most notable risk factor for death. Among the over 70,000 cases in China, the case-fatality rate was 2.3%. Among those aged 70-79 years, it was 8.0% and for those aged ≥ 80 years, 14.8%. Other risk factors include underlying comorbid conditions, specifically cardiovascular disease, diabetes, chronic respiratory disease, hypertension, and cancer. From the nursing home outbreak in King County, WA, the risk factors among nursing home residents were hypertension, cardiac disease, renal disease, diabetes, obesity and pulmonary disease. The case-fatality rate was 33.7%.

- **I’ve heard that dialysis patients are at high risk for getting COVID-19. Is that true?**

  Dialysis patients are at high risk for acquiring the COVID-19 virus. This is likely due to both inherent immunocompromise in this population as well as possible exposures encountered during transport to/from as well as within the dialysis center itself.

  We recommend:
  
  o Residents who are going to dialysis should wear a facemask for the entire time they are out of the LTC facility.
  o Upon the resident’s return, staff should assist the resident with thorough hand washing and changing of clothes.
  o Place these residents in a single room with standard, contact, and droplet precautions.
Staff should give special attention to surveillance for influenza-like illness and should have high level of suspicion for COVID-19 in these residents.

The LTC facility should communicate with the dialysis facility if one of its patients is suspected or tested positive for SARS-CoV-2.

There should be a preemptive communication of the plans for how dialysis centers are handling the COVID-19 patients from the community.

• **What should we do to identify the disease early?**

Staff should conduct active surveillance of residents for signs and symptoms of acute respiratory illness including fever. Staff should be cognizant that some residents may have atypical symptoms. They should be systematically marked on the facility map for identification of clusters of respiratory illness. They should also be recorded in a log of respiratory surveillance.

**Instructions for the Long-Term Care (LTC) Respiratory Surveillance Line List**

We recommend using the following criteria to screen residents for COVID-19.

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• **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. Implement standard, contact, droplet precaution and eye protection. Use an N-95 or higher-level respirator for aerosol generating procedures.

**Assess** the resident for severity of illness and need for hospitalization in conjunction with goals of care. Residents with acute respiratory symptoms should be placed on an active monitoring protocol. Active monitoring includes checking vital signs, measuring pulse oximetry, and assessing for common and less common signs and symptoms of COVID-19 every 6 to 8 hours.

• **Should I test my resident for COVID-19?**

**Testing** for COVID-19 is changing rapidly based on the availability of tests and this varies region by region. The decision to test for COVID-19 is based on clinician’s judgment, prevalence of disease in the community and also is subject to the availability of tests. Ideally, the resident would get a respiratory viral panel test to evaluate for COVID-19 and other common respiratory viruses. We recommend checking with your state and local health departments, or with the CDC, for current information regarding testing availability.

Use the [COVID-19 Persons under Investigation and Care Report Form](#) to collect information requested by the CDC as well as state and local health departments. Refer to the CDC guidance for reporting a person under investigation (PUI) or confirmed case: [Reporting a PUI or Confirmed Case](#)

• **Should I test all of my residents for COVID-19?**

We recommend testing patients with acute respiratory illness for COVID-19.
Ideally, we would be able to test our residents for COVID-19. In particular early testing would be helpful in identifying residents that could be moved to an area of the building designated for the care of COVID-19 residents.

Unfortunately, given the limited availability of tests, as well as the long time for results, other testing strategies may be necessary. One of these is to approach COVID-19 in your building similar to how we often identify an influenza outbreak. Specifically, consider testing only the initial 2-3 residents on a unit that develop symptoms suggestive of a respiratory viral infection. Once one person is positive, assume others with a similar presentation are also positive. Testing several residents may consume a limited supply of tests.

If residents in another unit or floor also develop respiratory symptoms, it may be reasonable to test 1 or 2 of those individuals as well. It would also be reasonable to assume that COVID-19 is now widespread in the facility.

Facilities should report COVID-19 cases to the local and state health department.

• How do we collect a sample to test for SARS-CoV-2 and where do we send it?

Collect samples using a nasal (nasopharyngeal) swab. The individual collecting the sample should wear an N-95 respirator or facemask if a N-95 is not available), eye protection, gloves, and a gown as there is risk of the resident coughing or sneezing.

Use a swab with synthetic fibers and plastic shafts; these are the same swabs used for collecting samples to test for influenza (dacron/nylon). Place swabs into sterile tubes with 2-3 mL of viral transport media (pink liquid). If old kits with two vials are available in the same bag, they can be separated to use as two testing kits. Refrigerate specimens (2-8°C) for up to 72 hours after collection. The CDC has guidelines for the collection of clinical specimens. There are short videos for nasopharyngeal specimen collection on the AMDA website (under Other Resources).

• Where do we send the swab for testing?

This is also an evolving situation. Labcorp will test for COVID-19 though their turn-around time may be several days. Local hospitals may have limited capacity to run
Updated March 31, 2020

tests. Other vendors and laboratories, including your state and local health departments, may be able to run tests.

Contact your state or local health department to determine where to send the test. The CDC has contact information and further details: Reporting a PUI or Confirmed Case.

Some local labs may be able to perform Flu/RSV testing and then send the same material off to testing for COVID-19. Contact your lab to develop strategies to conserve swabs and viral transport media.

- **How common is co-infection with other respiratory viruses?**

The rate of virus co-infection reported ranges from 2 to 16%. Depending on the burden of influenza in your regions, clinicians should use their clinical judgment to consider testing concomitantly for influenza and COVID-19, as the former may be treated and prophylaxis can be offered to other residents.

- **The COVID-19 test on one of our residents came back positive. What do I do?**

Immediately notify your local and state health department.

We recommend that facilities follow infection prevention and control practices similar to how they respond to an influenza outbreak.

- Continue to isolate symptomatic residents.
- Continue to restrict all group activities including dining
- Avoid new admissions or transfers to wards with symptomatic residents.
- Continue to restrict visitation via posted notices.
- 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

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

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

- **What about the roommate and other residents in the same area as our COVID-19 positive resident?**

  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. The roommate should be placed in a private room to minimize ongoing exposure to other residents and staff. Management of other contacts should be coordinated with the local or state health department and Infection Preventionist.

- **What about the healthcare staff that cared for our COVID-19 positive resident before she was placed on contact and droplet precautions?**

  Exposed staff should be referred to occupational health for assessment of the degree of exposure (website below) and the need to furlough. In many nursing homes, the function of occupational health is performed by infection preventionist.

  We recommend that nursing facilities create interim small teams who perform the occupational health function. This is in anticipation of increased need for such function, to cover all shifts and to allow IP to perform other functions related to Infection control and prevention.

Managing a Facility with COVID-19

- **How should I get my facility prepared for a COVID-19 case/outbreak?**
  
  o Facilities should identify an area for cohorting COVID-19 patients. This should be an area that can be closed off from other parts of the facility.
  o There should be no sharing of equipment and supplies. Extra equipment like medication carts and wound care supplies should be planned for and available.
  o Staff movement should be minimized and assignments should be adjusted.
  o Isolation carts and PPE supplies should be made available.
  o Oxygen concentrators and contingency arrangements should be made.
  o Have medications meant to provide comfort, including at the end of life, available. These include morphine, lorazepam, and similar agents.
  o Work with environmental services (EVS) to adjust their schedule to be available on-call if possible.
  o Plan for extra hospice support may be needed.

- **We have two residents from different units with new onset respiratory symptoms. Should they be in the same room?**

  If two or more residents have acute respiratory symptoms suggestive of influenza, RSV or COVID-19, we suggest implementing facility-wide precautions. Until there is a confirmed diagnosis for the involved residents, they should not be cohorting. Once it is known that there are two individuals with the same infection, then those individuals may be cohorting if necessary.

  We recommend, if possible, dedicating one hallway or unit to the care of individuals with respiratory viral syndromes. There should be consistent staffing of this unit as well (i.e., the same staff members work in this area, including staff that works on evening and night shift). If other staff needs to come into this area to perform specialized care, such as hospice care, this should be the last group of residents to receive care before that person goes home. Prioritize the use of PPE in this area of the building. If possible several nursing functions (e.g., wound care) should be performed by the assigned staff to limit staff caring across the facility. If this is done consideration should be given to the increased intensity of work during staff assignments.

  Guidance from the CDC dating from 3/10/20 states that residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. Public health authorities can assist with decisions about resident placement.

- **We have several COVID-19 positive residents in varying stages of recovery. May we place them in the same wing? Can we cohort our COVID-19 positive residents?**

  Nursing facilities should identify units that can be effectively used to cohort COVID-19 patients who test positive while they are in the facility.

  - COVID-19 patients should be cohorted in a single unit.
  - There should be dedicated nursing staff to care for COVID-19 patients. They should not work on other units.
  - Equipment should not be shared between units.
  - Staff providing care to multiple patients should minimize contact with test positive or suspected COVID-19 patients and should provide care to these residents last.
  - Cohorting of residents with known COVID-19 is permissible as long as there is consideration of other reasons they may require different infection prevention and control procedures (e.g., recent history of *C. difficile* infection or known colonization with an extended-beta lactamase producing bacteria).
Managing Residents with COVID-19 Infection

- **Should I transfer my resident with COVID-19 to the hospital?**

  This depends on several factors, including the burden of disease in your community, the burden of disease in your building, the ability to provide supportive care for your residents and on the resident’s goals of care. Goals of care should be readdressed with the residents and their families when there is a COVID-19 outbreak in the facility.

  For residents with mild illness, we recommend to treat-in-place. For those with moderate to severe symptoms, consider hospital transfer if that is part of their goals of 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.

- **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, droplet precautions and eye protection 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.
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.

- **We have several residents with COVID-19 and our hospitals are overwhelmed. We have decided to treat in place. What can we anticipate as the course of illness? What can we do to support our residents through this devastating illness?**

The case fatality rate for COVID-19 for nursing home residents in Kirkland, WA was around 33%. Some residents may get a mild illness and recover. Some patients may have an indolent course with high fevers and respiratory symptoms for 1-3 weeks and recover with supportive care. Some may have and indolent course with fever and respiratory symptoms and show worsening between day 7 and 9 with acute respiratory failure. Some may present with acute respiratory failure and a rapid decline.

Patients with COVID-19 should be monitored closely with frequent vital signs and oximetry checks. Drops in oximetry and change in mental status may herald worsening. Supportive care measures include acetaminophen to reduce fevers, high flow oxygen, and intravenous fluids for hydration.

Consider using meter-dosed inhalers with or without spacers, and oral albuterol to ease respiratory symptoms. If possible, continue to avoid nebulized treatment due to significant risk of transmission to staff.

For patients with significant respiratory illness and symptoms consider palliative and hospice care in conjunction with patient’s goals of care. For these patients, symptom relief with opioids and benzodiazepines will likely be required for end of life care.

- **Should we hold NSAIDs or ACE-I?**

There is not evidence to indicate that either non-steroidal anti-inflammatory drugs (NSAIDs) or angiotensin-converting enzyme inhibitors/angiotensin receptor blockers (ACE-I/ARBs) make COVID-19 infections worse.
NSAIDs certainly come with their own risks and side effects. For people who do not routinely take these medications, we do not recommend using them for residents with a possible COVID-19 infection. Acetaminophen is a good antipyretic and analgesic agent.

The FDA issued a statement about NSAIDs and COVID-19 on 3/19/2020.

Similarly, we do not recommend initiating an ACE-I or ARB during an acute respiratory illness. For people who take anti-hypertensive medications, we recommend preferentially stopping this class of agents first, before discontinuing other classes of agents, such as beta-blockers or thiazide diuretics.

There is a viewpoint (editorial) in the Journal of the American Medical Association (JAMA) on 3/24/2020.

- **Does hydroxychloroquine work for prophylaxis?**

  There is presently no evidence that hydroxychloroquine prophylaxis is effective. Randomized controlled studies are underway.

- **Are there any medications I can give to help my residents who are sick with COVID-19?**

  As of March 30, 2020, there is no approved therapeutic treatment for COVID-19 patients except for supportive care. Several in vitro and observational studies identified potential agents and many randomized studies are underway. Several potential agents are under investigation, table below describe 3 of these agents.

  Two articles review the available evidence, summarized in the table below.\(^3^4\) The CDC also comments therapeutic options.

  Tocilizumab in an IL-6 receptor inhibitor that is only used for individuals with severe COVID-19. Plasma from convalescent individuals is also being tested. There is no evidence to suggest that elderberry, zinc or vitamin C (ascorbic acid) offer any benefit.
### Potential therapeutic agents

<table>
<thead>
<tr>
<th>Efficacy</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Remdesivir has broad antiviral activity including SARS and MERS and shown to have in vitro activity against SARS-CoV2. Compassionate use in the first COVID-19 patient in the United States showed clinical improvement of a progressive pneumonia and raised hope that this drug might be effective in the treatment of COVID-19. <a href="https://www.nejm.org/doi/full/10.1056/NEJMoa2001191">https://www.nejm.org/doi/full/10.1056/NEJMoa2001191</a></td>
<td>Initially use limited to compassionate use. Manufacturer transitioning to expanded access programs. Can only be administered intravenously to hospitalized patients. Several randomized control trials underway.</td>
</tr>
<tr>
<td>Chloroquine and hydroxychloroquine Both drugs have in-vitro activity against SARS-CoV2, hydroxychloroquine is more potent and has less known side effect. Chinese Public Health officials recommended chloroquine for treatment of COVID-19, based on in vitro data and early studies showing reduction in fever, clearance of abnormalities on chest CT and earlier recovery. A randomized study in China of 30 patients showed no benefit. A French open label study that included 36 patients showed a reduction of SARS-CoV2 in nasopharyngeal sample at 6 days in cases. In 6</td>
<td>FDA issued emergency authorization for COVID-19 on March 29, 2010. Drug is administered orally. Randomized post exposure prophylaxis studies are underway.</td>
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</table>
patients the combination of azithromycin (used for potential bacterial coinfection) with hydroxychloroquine resulted in more dramatic reduction in nasopharyngeal viral load. This study has several limitations including the exclusion of 6 patients due to death ICU admission or discontinuation of the study. Clinical outcome or adverse events were also not reported. Due to the limited evidence and potential toxicity, we would caution about using combination of azithromycin with hydroxychloroquine.

The same French researchers performed an additional study, using a combination of azithromycin and hydroxychloroquine in 80 COVID positive patients. The lack of control group makes it difficult to interpret the results of the combined treatment.

Based on this information, there is presently no strong evidence to recommend the use of hydroxychloroquine.

| Lopinavir/ritonavir | A randomized controlled open label study in 199 severe COVID-19 patients showed no clinical benefit compared to standard of care. The lack of benefit might be attributed to the late start of the treatment; the median was 13 days from start of symptoms. Subgroup analysis showed faster improvement in patients started on treatment before 12 days. Lopinavir/ritonavir might have a role in early treatment but further studies are needed. | Drug administered orally. Additional studies planned by the world health organization. |
Leaving the Facility for Non-Urgent Medical Care

- **One of our residents has an appointment scheduled with a specialist they saw in the hospital. Should we send her to that appointment?**

  We recommend that the staff call the outside consultants and delay non-urgent visits or procedures. If there is a pressing medical need for the appointment, explore options such as electronic consults or other telehealth modalities to limit exposure of the resident to other healthcare settings. We also recommend suspending all non-emergent dental visits either in or out of the facility.

  If there is truly an urgent need for follow-up, some offices may have a physician, nurse practitioner, or physician assistant who is willing to come see residents at your building. For residents that must go to a medical appointment, we recommend that they follow the same precautions we recommend for patients that must leave the facility to receive dialysis:

  o Residents should wear a facemask for the entire time they are out of the LTC facility.
  o Upon the resident’s return, staff should assist the resident with thorough hand washing and changing of clothes.
  o Place these residents in a single room with standard, contact, and droplet precautions.
  o Staff should give special attention to surveillance for influenza-like illness and should have high level of suspicion for COVID-19 in these residents.
  o The LTC facility should communicate with the office if one of its patients is suspected or tested positive for SARS-CoV-2.
  o There should be a preemptive communication of the plans for how ambulatory settings are handling the COVID-19 patients from the community.

- **Several of our residents get hemodialysis. What should we do for them?**

  The CDC has interim guidance for hemodialysis facilities. The guidance is focused on infection prevention and control measures for the care of patients with a respiratory
illness or with known or suspected COVID-19, including recommendations for cohorting.

Dialysis patients are at high risk for acquiring the COVID-19 virus. This is likely due to both inherent immunocompromise in this population as well as possible exposures encountered during transport to/from as well as within the dialysis center itself.

We recommend:

- Residents who are going to dialysis should wear a facemask for the entire time they are out of the LTC facility.
- Upon the resident’s return, staff should assist the resident with thorough hand washing and changing of clothes.
- Place these residents in a single room with standard, contact, and droplet precautions.
- Staff should give special attention to surveillance for influenza-like illness and should have high level of suspicion for COVID-19 in these residents.
- The LTC facility should communicate with the dialysis facility if one of its patients is suspected or tested positive for SARS-Cov-2.
- There should be a preemptive communication of the plans for how dialysis centers are handling the COVID-19 patients from the community.
Admissions

- **We have not had a COVID-19 patient in our facility, but we are starting to see it in the community. What can I do to prepare for it?**

Plan for the care of COVID-19 patients with considerations for a case or outbreak that develops in your building.

Preemptively communicate the plan to the hospital and consider sharing [AMDA’s Resolution on COVID-19](#), and Joint Statement of AMDA and AHCA as well. Part of this communication is to discuss the rationale for increased screening and inability to accept a COVID-19 patient into a COVID-19 naïve facility.

Considering providing disposition support for non COVID-19 positive patients. As long as your facility remains COVID-19 naïve, urge your hospital to preemptively plan for alternate sites for COVID-19 throughput needs.

We recommend revising your admission screening process to include questions about common and less common signs and symptoms of COVID-19 and sharing this with the hospital.

- **We have not yet had any COVID-19 positive staff or residents in our building. The hospital has asked us to accept a COVID-19 positive patient. I’m not sure what to do.**

[AMDA’s Resolution on COVID-19](#), dated March 19, 2020, states that a COVID-19 naïve facility should not accept an admission with clinical or lab evidence of active disease. Instead, care of these patients should be provided in alternate care sites and specialized COVID-19 facilities.

The CDC has guidance for [discontinuing transmission based precautions](#). These recommendations state that if transmission-based precautions have been discontinued and the patient’s symptoms have resolved, they do not require further restrictions based upon their history of COVID-19. That guidance favors a test-based strategy for discontinuing transmission-based precautions for individuals being discharged to long-term care settings.

We agree with this in principle and also have grave concerns about the potential for introducing COVID-19 into a building that has managed to remain COVID-19 naïve. The potential risk to other residents is severe. The experience in Kirkland, WA
indicated a hospitalization rate of 57% for residents and a case fatality rate of 36% and 7% among residents and visitors, respectively.2

- We have not yet had any COVID-19 positive staff or residents in our building. The hospital has asked us to accept a patient who was admitted for 1 day for a chronic-obstructive pulmonary disease (COPD) exacerbation. Should we accept this patient?

We recommend that all facilities follow a robust admission process to assess for common and uncommon COVID-19 symptoms. If COVID-19 is suspected on chart review, staff should communicate with the discharging team and request them to test the patient for COVID-19.

<table>
<thead>
<tr>
<th>Common and Less Common Signs and Symptoms of COVID-19 in Older Adults</th>
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<tbody>
<tr>
<td><strong>Typical Signs and Symptoms</strong></td>
</tr>
<tr>
<td>Fever $\geq 37.5^\circ$C (99.5°F)</td>
</tr>
<tr>
<td>Cough</td>
</tr>
<tr>
<td>Shortness of breath. <em>Increased oxygen requirements or increased frequency of nebulizer treatments may be surrogate symptoms for shortness of breath.</em></td>
</tr>
<tr>
<td><strong>Atypical Signs and Symptoms</strong></td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Confusion or change in mental status. <em>If noted, check pulse oximetry to determine if increased oxygen requirements</em></td>
</tr>
<tr>
<td>Exacerbations of congestive heart failure or chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>Muscle aches, headache</td>
</tr>
<tr>
<td>Sore throat, runny nose</td>
</tr>
<tr>
<td>Chest pain</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
</tr>
</tbody>
</table>

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.
• **We have accepted a patient who is recovering from an acute myocardial infarction. What are your recommendations for when the patient arrives to our building?**

We recommend that staff follow standard, contact, and droplet precautions during the admission assessment to minimize the potential for staff exposure.

**CDC published MMWR Early release on March 27.** It states that symptom-based screening of SNF residents might fail to identify all SARS-CoV-2 infections. Asymptomatic and presymptomatic SNF residents (approximately 50% of all tested positive) might contribute to SARS-CoV-2 transmission.

Residents admitted to the facility should be put on standard contact and droplet precaution for observation for 14 days. Further, they should not be placed with a roommate until this observation period is complete. **CMS states** that if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital.

• **When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?**

As per the recent [AMDA Resolution on COVID-19](https://www.amda.org), a COVID 19 naïve nursing facility should not accept a COVID 19 patient who is considered a transmission risk. As per CMS guidance, “If a nursing home cannot effectively implement transmission-based precautions, it must wait until the resident does not require these precautions.”

The CDC has guidance for [discontinuing transmission based precautions](https://www.cdc.gov). These recommendations state that if transmission-based precautions have been discontinued and they patient’s symptoms have resolved, they do not require further restrictions based upon their history of COVID-19. That guidance favors a test-based strategy for discontinuing transmission-based precautions for individuals who are discharged to long-term care settings.

Ideally, nursing homes will 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).
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.

• **We have accepted a patient diagnosed with COVID-19 in our facility. When can we discontinue transmission-based precautions?**

  The CDC has guidance for [discontinuing transmission based precautions](https://www.cdc.gov/coronavirus/2019-ncov/hcp/patient-care.html) in long-term care settings. They call for maintaining transmission-based precautions until symptoms are completely resolved or until 14 days after illness onset, whichever is longer.

**Infection Control and Prevention in Nursing Homes**

There is a critical shortage of personal protective equipment (PPE) across all healthcare settings, including nursing homes. The CDC has general recommendations for infection control and prevention related to COVID-19, for infection prevention and control for long-term care settings, and for conserving PPE.

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

**Interim Infection Prevention and Control Recommendations for Healthcare Settings**

**Strategies for Optimizing Supply of N95 Respirators**

**Healthcare Supply of Personal Protective Equipment**

**Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators**

**Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life**

**Personal Protective Equipment (PPE) Burn Rate Calculator**

• **We are running low on personal protective equipment (PPE). What can we do?**

  We recommend that facilities adopt stewardship practices for PPE in accordance with [CDC guidance on strategies to optimize PPE supply](https://www.cdc.gov/infectioncontrol/ppe/guidance.html).

  Immediate steps you can take (detailed below) are:

  o Minimize face-to-face visits
Updated March 31, 2020

- Make use of telehealth visits whenever possible
- Limit laboratory studies to only those that are medically necessary
- Change from nebulizer to metered dose inhalers and consider oral albuterol
- Limit or eliminate point of care capillary blood sugars
- Allow staff to wear one face mask for the entire shift
- Decrease the frequency of medication administration

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).

We recommend that clinicians minimize face-to-face visits with residents for routine matters. Further, we recommend that clinicians also, for now, limit routine visits and laboratory studies. While blood draws are important for residents on coumadin, lipid tests, glycosylated hemoglobin and thyroid studies can likely be delayed for weeks to months.

Clinical staff should also consider limiting the frequency of other processes that involve direct interactions with residents, such as point-of-care capillary blood sugars, nebulizer treatments, etc.

We recommend that nursing facilities should offer telehealth whenever possible. They should encourage telehealth visits in lieu of outside appointments with specialists and other necessary clinical evaluations.

Facemask may be worn throughout an entire shift and do not need to be changed when going from resident to resident. If a facemask becomes soiled, wet, torn, or no longer covers the nose and mouth, it should be discarded.

- **We are critically short on PPE of all types---face masks, gowns, gloves. Any suggestions?**
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. Some places are conserving N95 masks by covering them with a cloth mask and discarding cloth masks at the end of the shift. Cloth masks alone aren’t shown to prevent transmission.

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. Gloves should not be used in the care of more than one resident.

- **We are completely out of gowns. Now what?**

Some places are using rain ponchos, garbage bags, or coveralls from a hardware store in place of gowns. The rain ponchos and garbage bags can be wiped down. Washable cloth gowns are also a consideration.

While one gown may be work for multiple residents, we do not recommend reusing a gown until it has been cleaned. It is too difficult to remove the gown without contaminating the side worn toward the body. When a used gown is put back on, the side facing the body now becomes a means to transmit fomites to the person who can transmit fomites to themselves, other staff and other residents.

- **We are completely out of gloves. Now what?**

Encourage hand hygiene with alcohol hand rub or soap and water.
• **We are completely out of surgical masks. Now what?**

Some places are using cloth masks sewn and donated by community members. Patterns for these are available through sites on-line.

Surgical face masks may be taken off carefully and re-used. People can write their names on the outside of the mask. The side of the mask that faces the residents or patients is the “dirty” side.

The individual should use hand hygiene before removing the mask and then carefully straighten the mask before storing it. After the mask is stored, they should practice hand hygiene again.

A removed mask can be hung from a peg with the patient-facing side toward the wall. If there is not sufficient area to hang the masks, then it can be placed, patient-facing side down, on a paper towel placed on a counter. The towel is discarded after the mask is re-donned. A mask can also be placed in a paper (not plastic) bag. The patient-facing side will contaminate the inside surface of one side of the paper bag; the bag should be discarded after one use.

• **I heard we can re-use N95s. How do we do that?**

Some places are using cloth masks sewn and donated by community members. Patterns for these are available through sites on-line. These can be worn over the N95 masks.

N95 masks may be taken off carefully and re-used. People can write their names on the outside of the mask. The side of the mask that faces the residents or patients is the “dirty” side.

The individual should use hand hygiene before removing the mask. After the mask is stored, they should practice hand hygiene again.

A removed mask can be hung from a peg with the patient-facing side toward the wall. If there is not sufficient area to hang the masks, then it can be placed, patient-facing side down, on a paper towel placed on a counter. The towel is discarded after the mask is re-donned. A mask can also be placed in a paper (not plastic) bag. The patient-facing side will contaminate the inside surface of one side of the paper bag; the bag should be discarded after one use.
• **What are some of the basics for infection prevention and control that we can do?**

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.) frequently. We recommend at least once daily and advocate for at least once per shift.

• **What kind of personal protective equipment (PPE) should we use when caring for someone with a respiratory viral illness?**

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.

We recommend that staff use N-95 mask (or facemask if a respirator is not available) and eye protection in addition to other PPE when obtaining respiratory samples in individuals with suspected COVID-19.

• **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)](https://www.cdc.gov/infectioncontrol/guidelines/protective-equipment/don-doff.html)
There are also videos available through the University of Nebraska:

**Hospital PPE - Infection Control: Donning and Doffing**

**Video on appropriate use of face mask through World Health organization**

- **What 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.

- **Can equipment like stethoscopes, blood pressure cuffs or pulse oximetry devices transmit COVID-19?**

Yes. COVID-19 is thought to be transmitted through respiratory droplets. The risk of transmission by fomites is also a concern. Respiratory droplets that land on surfaces near an individual and are later touched by a healthcare worker may lead to transmission.

In addition to following standard infection control practices on cleaning common equipment to assess residents, like thermometers or pulse oximeters, staff should be asked to clean personal equipment, such as stethoscopes before and after examining an individual, and to clean their personal devices, like cellphones, frequently.

- **We do not have negative pressure or airborne infection isolation rooms (AIIR) in our building. What should we do for a resident with possible COVID-19 infection?**
We recommend that the resident should remain in their room, with the door closed. 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. We recommend that staff close bedside curtains when performing respiratory procedures in semiprivate rooms.

Personnel should not move from unit to unit during their assignments. Medication carts and other medical equipment should not be shared with other units. Staff from other units should not come into the COVID-19 unit. This may include flexible staffing and roles to minimize movement of staff throughout the building.

- **When should we use N-95 respirators? We have a few and want to conserve them.**

  We recommend using N-95 respirators (or their equivalents) when doing procedures that may generate aerosols.

  If N-95 masks are in limited supply to PALTC providers, we recommend staff prioritize use of N-95 masks during respiratory procedures used in the care of residents with a possible respiratory viral infection that 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 (or facemask if a respirator is not available) and eye protection in addition to other PPE when obtaining respiratory samples in individuals with suspected COVID-19.

- **What procedures generate aerosols?**

  Examples of respiratory treatments that may lead to aerosolization of viral particles include use of nebulizers, suctioning, and tracheostomy care. Also, the application or adjustment of oxygen masks, bilevel positive airway pressure (BiPAP), and continuous positive airway pressure (CPAP) masks are also aerosol generating procedures.

  Collecting samples to test for influenza, RSV, and COVID-19 also carry the risk as there may be droplet exposure at very close range when residents cough or sneeze.
We recommend that staff close bedside curtains when performing respiratory procedures in semiprivate rooms.

Limit procedures that involve manipulation of mucosal cavity, e.g., dental cleaning, denture fitting, fiberoptic evaluation of swallowing. If the study is thought to be urgent, the need should be weighed against the elevated risk of transmission due to these procedures.

- **Is there a way to reduce the use of nebulizers?**

Most residents can be switched from nebulizers to metered-dose inhalers. For those that cannot be taught how to use a metered-dose inhaler (MDI), use a spacer. Metered-dose inhalers, with or without the use of a spacer, are not aerosol-generating procedures. In residents who are unable to use MDI even with spacers, oral albuterol can be considered. All PRN use of nebulizer should be discontinued. This is to ensure that increased need of nebulizer, as a surrogate symptom for COVID-19 is not overlooked.

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

- **One of our residents is scheduled to be fitted for dentures next week. Should we let the dentist into the building?**

Limit procedures that involve manipulation of mucosal cavity, e.g., dental cleaning, denture fitting, fiberoptic evaluation of swallowing. If the procedure is thought to be urgent, the need should be weighed against the elevated risk of transmission due to these procedures.

- **Our speech therapist recommended a fiberoptic evaluation for a resident who recently had a stroke. I’m reluctant to have this done. What do you recommend?**

Limit procedures that involve manipulation of mucosal cavity, e.g., dental cleaning, denture fitting, fiberoptic evaluation of swallowing. If the study is thought to be urgent, the need should be weighed against the elevated risk of transmission due to these procedures.
• 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 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?

We strongly recommend active surveillance for respiratory illness and fever of both residents and staff members when there is evidence of community-wide transmission. This includes screening all staff upon entry into the building.

To reduce the risk of asymptomatic staff infecting their residents, we recommend universal facemasks and glove use as a precaution. The situation in King County, WA indicates that residents shed COVID-19, even without symptoms. Staff may similarly shed virus.

• Some of our staff work at multiple buildings. What should we do?

Transmission of COVID-19 across long-term care facilities through staff working at multiple facilities has been reported. Facilities should keep a log of names of all other health care settings where staff members are working. They should continually assess and attempt to mitigate the cross exposure risk for COVID-19 through staff transmission.

Staff that provide direct resident care on a daily basis should be advised to only work at one building. Staff working at multiple buildings was part of how the outbreak spread in
King County, Washington. If those personnel insist on working in more than one setting, they should work with their supervisors to arrange a schedule to minimize their transitions. Scheduling in blocks (e.g., a week in one building, a week in another building) is one option.

- **What about our medical providers? They work at multiple nursing homes and have outpatient practices.**

Encourage and support the use of telehealth so clinicians can avoid bringing COVID-19 into buildings or exposing themselves.

If the clinicians are providing outpatient care in addition to nursing home rounding, we recommend asking clinicians to visit the building first thing the morning rather than at the end of the day. Also, if staffing permits, have clinicians limit their visits to one building. If this is not possible, then ask clinicians to only visit one building each day. The rational for rounding in the morning is that the clinicians will have had overnight to know if they are starting to feel ill and can self-quarantine if needed.

Clinicians should also practice universal masking and gloving while seeing residents.

- **We have not done telehealth previously and don’t have the equipment. What can we do?**

The Centers for Medicare and Medicaid (CMS) has expanded access to telehealth services in response to the COVID-19 pandemic. Medicare will now pay for telehealth visits across a variety of settings (e.g., skilled nursing facility, office, hospital) and providers (e.g., physicians, nurse practitioners, clinical psychologists, and licensed clinical social workers). These visits will be reimbursed at the same rate as regular, in-person visits. CMS has also broadened acceptable platforms to perform telehealth by waiving enforcement of HIPAA health privacy law violations. In addition to current telehealth platforms, providers are now able to utilize common communication tools such as FaceTime and Skype.

[Additional details and billing advice are available here.](#)

- **We have done telehealth before but do not want to bring the machine into the room of a COVID-19 positive resident. What should we do?**
One potential solution is to designate a dedicated portable device, such as a table (e.g., iPad) or smartphone for COVID-19 positive or persons under investigation (PUI). If possible, have the device covered with a water resistant covering so that it can be wiped down after use. Have a Certified Nursing Assistant (CNA) – in appropriate personal protective equipment (e.g., contact and respiratory precautions) -- carry the device into the room so the resident does not have to hold the device. After completion of the visit the CNA can wipe down the device. Of course, the CNA should practice good hand hygiene and change PPE in accordance with the facility’s current policy.

**Environmental Cleaning**

- **How do we clean the room of a resident with possible or confirmed COVID-19?**

  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 inside the resident’s room (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. Staff assignment should account for extra services that the staff is providing to allow effective care of the residents.

  **List N: Disinfectants for Use Against SARS-CoV-2**
  **CDC Infection Prevention and Control FAQ for COVID-19**

- **Are there special protocols for shared medical equipment?**

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

  For buildings with a COVID-19 unit or floor, we recommend dedicating some equipment for the care of residents with known COVID-19 and leaving that equipment in a designated unit.

- **Should we do something different to clean the rest of the building?**
Environmental service staff should clean the frequently touched surfaces like handrails, doorknobs and door handles, and surfaces at the nurses’ stations at least twice daily and more frequently as needed.

They 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. There should be a process in place to refill empty dispensers and restock PPE.

- **One of our residents with COVID-19 has gone home. What should we do for terminal cleaning of that room?**

Environmental service staff should observe contact and droplet precautions 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.

- **Several of our family members do laundry for our residents. Should we stop that?**

We do not recommend that family members continue to do laundry for their loved ones at present. While this is clearly an act of caring and helps reduce the burden on staff, the risk of transmission of COVID-19 from a household to the building or vice versa outweighs the potential benefit. We recommend that friends and families use videos, emails and text messages to stay connected to their loved ones during this trying time.
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Staff

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 (e.g. environmental service or maintenance staff) should be assessed at the start of a shift through a tiered accountability approach. Diligent logs should be maintained of the staff working in the facility. This is helpful to determine staff and resident exposure patterns.

Direct patient care staff should be actively assessed for respiratory illness or fever by nurse managers of the units and supervisory staff prior to provision of patient care duties.

- **How should we screen our staff upon entry into the building?**

  Screen for:
  - CMS requires temperature checks for all staff.
  - Other symptoms, such as new cough, myalgia, fatigue, diarrhea should also be assessed as fever may be absent in some patients.
  - Recent onset diarrhea or influenza-like symptoms.
  - If they have traveled outside of the state within the previous 14 days.
  - Whether they’ve had contact with an individual with confirmed or suspected COVID-19 in the prior 14 days.

- **What do we do for staff who do not pass screening?**

  If staff do not pass the above screening criteria, they should not be permitted entry. They should be directed to return home and to call their supervisor, occupational health department or DON to discuss their symptoms. They should also seek evaluation through their primary care provider, beginning with a phone call to the office.

  The CDC offers [recommendations for people who may be ill with COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/index.html).
• **What should we do when a staff member is exposed to a resident with possible COVID-19?**

If a staff member was exposed to individuals with known or suspected COVID-19, the staff member needs to immediately alert the DON or designated staff, regularly monitor themselves for fever and symptoms of respiratory infection, and not report to work when ill. These individuals should not continue to participate in direct resident care until further details about the exposure are known.

Asymptomatic staff members with a COVID-19 exposure should be assessed by a designated employee, either the DON or the infection preventionist (IP), as per [CDC guidance](https://www.cdc.gov/coronavirus/2019-ncov/community/worksites/exposure-prevention.html). Based on these guidelines, if the exposed staff is allowed to work they should wear a facemask while at work for 14 days post exposure and practice hand hygiene and monitor for respiratory symptoms and fever prior to coming to work.


• **What if a staff member develops respiratory symptoms while at work?**

Any ill staff should not be allowed to provide patient care. Sick leave policies should be non-punitive, flexible and consist with public health guidance. Encourage the Human Resources Department to review and consider revising policies given current circumstances.

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

- Immediately stop work, put on a facemask, inform the supervisor, 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).

• **What other symptoms should staff report?**
Some early signs and symptoms of COVID-19 are diarrhea, muscle aches and a pounding headache. Educate your staff to be aware of these symptoms for themselves and for their residents.

Diarrhea in particular may be an early indication of infection that many staff may not recognize as COVID-19 is largely a respiratory virus.

- **When can a staff member 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, IP, or other designee with a clinical background. In addition, the facility should consult with the medical director as needed.

The CDC recommends that staff with suspected or positive COVID-19 should be excluded from work until at least 3 days (72 hours) have passed since recovery, defined as:

- Resolution of fever without the use of fever-reducing medications
- Improvement in respiratory symptoms (e.g., cough, shortness of breath)
- At least 7 days have passed since symptoms first appeared.

All staff returning to work must wear a mask for 14 days after the onset of illness; practice hand hygiene and cough etiquette and self-monitor for recurrence of symptoms. If there is a recurrence, they should immediately stop working and report to the supervisor for guidance.

- **Some of our staff members work at multiple buildings. What should we do?**

Staff that provides direct resident care on a daily basis should be advised to only work at one building. Staff working at multiple buildings was part of how the outbreak spread in King County, Washington. Keep a log of staff that works at multiple buildings. If those personnel insist on working in more than one setting, they should work with their supervisors to arrange a schedule to minimize their transitions. Scheduling in blocks (e.g., a week in one building, a week in another building) is one option.
• **What about our medical providers? They work at multiple nursing homes and have outpatient practices.**

Encourage and support the use of telehealth so clinicians can avoid bringing COVID-19 into buildings or exposing themselves.

If the clinicians are providing outpatient care in addition to nursing home rounding, we recommend asking clinicians to visit the building first thing the morning rather than at the end of the day. Also, if staffing permits, have clinicians limit their visits to one building. If this is not possible, then ask clinicians to only visit one building each day. The rational for rounding in the morning is that the clinicians will have had overnight to know if they are starting to feel ill and can self-quarantine if needed.

Clinicians should also practice universal masking and gloving while seeing residents. Clinicians should clean their stethoscopes between use. They should wear gowns (not lab coats) when seeing patients.
Visitors, Volunteers, Students and Trainees

On March 13th, 2020, the Center for Medicare & Medicaid Services (CMS) issued recommendations to restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life. Recommendations include:

- Cancel communal dining and all group activities, such as internal and external group activities.
- Implement active screening of residents and staff for fever and respiratory symptoms.
- Remind residents to practice social distancing and perform frequent hand hygiene.

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

- It sounds like almost no one should enter the building except for employees. Is that correct?

Yes, that is correct. At this point, with COVID-19 cases present in most communities, the severity of the illness and the tremendous train on our healthcare system, we must all take as many measures as possible to keep our residents, employees and communities as safe as possible.

We strongly recommend that any visitors who enter the building must leave their name and contact information in case the building needs to notify them about a possible exposure.

Please make any visitors aware that if they develop acute respiratory illness, diarrhea or COVID-19 within 14 days of visiting a facility they should report that to the facility.

- Who is allowed into the building?

Other than for end-of-life situations, only essential healthcare personnel should be allowed to enter the building. Essential healthcare personnel includes hospice staff, phlebotomists, radiography technicians and other therapists that provide clinical care.
Anyone entering the building must be screened upon entry and comply with the policies and procedures related to preventing the spread of COVID-19. Failure to comply with those policies is grounds for denying entry.

- **How should we screen people that we consider letting into the building?**

  Screen for:
  - Clinical signs and symptoms of respiratory illness and fever.
  - Recent onset diarrhea or influenza-like symptoms.
  - If they have traveled outside of the state within the previous 14 days.
  - Whether they’ve had contact with an individual with confirmed or suspected COVID-19 in the prior 14 days.

  COVID-19 naïve nursing homes: If visitors do not pass the above screening criteria, they should not be permitted entry into a COVID-19 naïve nursing home, *even for compassionate reasons such as end-of-life.*

  Nursing homes with limited numbers of COVID-19 cases: If visitors do not pass the above screening criteria, they should not be permitted entry. Exceptions for compassionate reasons may be considered on a case-by-case basis. We discourage allowing these individuals into the building.

  For all nursing homes: Visitors who are unable to follow infection control precautions guidelines (washing hands, wearing mask, following cough etiquette) should be restricted from visitation.

- **Should we limit the number of entrances to our building?**

  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 at all entrances, which include instructions regarding visits.
• What should we tell our visitors and volunteers?

This visitation restriction should be thoughtfully communicated with families, friends, and volunteers. Restricting visitors and volunteers, especially 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.

We recommend that activity staff should proactively offer scheduled telephone or electronic face-to-face visits for residents and their families as visitor restriction and cancellation of communal dining can lead to isolation.

• Are students and other trainees considered essential personnel? They do a great deal of work for us.

We recommend that students and trainees should suspend visits. Some facilities have come to rely on the efforts of students and trainees to help reduce the burden on their licensed staff. However, students and trainees represent another possible source of individuals with asymptomatic COVID-19. This risk is compounded if they participate in classes or other social gatherings that put them at risk for acquiring COVID-19.

For students and trainees that want to serve, the nursing home is obligated to teach them how to use PPE safely and to screen them upon entry as for employees. Students and trainees involved in resident care must also be trained in policies and procedures, as they would under ordinary circumstances, as well as in additional safety requirements during this COVID-19 pandemic. The potential risks and benefits to the employees, residents and the students and trainees must be weighed carefully and considered on a case-by-case basis. Additional considerations are the consumption of PPE by these individuals as well as their value to off-load some responsibilities from other personnel, such as assisting with telehealth visits.

• We depend on our volunteers to help us. Are they essential personnel?

Volunteers should suspend visits.

Some facilities have come to rely on the efforts of volunteers to help reduce the burden on their licensed staff. However, volunteers represent another possible source of individuals with asymptomatic COVID-19. Lack of healthcare training and in many cases,
age, may place the volunteer at risk for acquiring COVID-19, endangering their own health as well as that of residents in the building.

- **Are people from hospice considered essential personnel?**

  We recommend continuing to allow hospice personnel to enter the building. These are trained healthcare personnel and may be able to help reduce the burden on the staff in your building.

  Please work with those individuals and agencies to limit the number of individuals going into multiple buildings. Ideally, each staff member would only visit one building or would only visit one building each day. Those visits should be at the beginning of the day.

  Anyone entering the building must be screened upon entry and comply with the policies and procedures related to preventing the spread of COVID-19. Failure to comply with those policies is grounds for denying entry.

- **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.

- **One of our residents is actively dying of cancer. They do not have any signs of symptoms of COVID-19. Their family members pass screening criteria to enter the building. Now what?**

  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. Visitor should be directed to frequently perform hand hygiene, follow proper cough etiquette, avoid touching surfaces, and use a mask. Staff may need to specifically instruct visitors on the use of alcohol hand rub, proper hand washing techniques and proper use of mask. All visitors should use a mask for the duration of the visit.
Visitors who are unable to follow infection control precautions guidelines (washing hands, wearing mask, following cough etiquette) should be restricted from visitation.

- **We allowed visitors to enter last week. Now we have 2 potential cases of COVID-19. What do we tell those visitors?**

  We strongly recommend that all visitors who enter the building must leave their name and contact information in case the building needs to notify them about a possible exposure.

  Call the individuals who may have been exposed to COVID-19 and instruct them to self-isolate and to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure. If they become ill, they should contact their healthcare provider.

- **What if a family member who may be ill wants to visit a resident?**

  They should not be permitted entry. Even if they do not have COVID-19, there is still a risk of acquisition and the risk of transmission of infection other than COVID-19 to other residents. In our current situation, introducing a rhinovirus or other non-COVID-19 respiratory illness into the building will lead to illness, increased use of tests and of PPE.

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

- **What do we tell the families and friends of our residents?**

  In addition to large warning signs (”stop signs”) at entrances, we also suggest sending emails and letters to family members of residents. Consider asking the resident and family council to assist with these efforts. We recommend that the administrator plan for frequent communications with family. One example is assigning the activities staff to schedule phone or video conferencing between the residents and families especially as group activities decrease. It is important for the director of nursing (DON) or administrator to be available to talk to resident’s families if needed.
If a visitor develops acute respiratory illness or COVID-19 within 14 days of visiting a facility they should report that to the facility.
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