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PUBLIC HEALTH SERVICES
COMMUNICABLE DISEASE CONTROL

OCHCA Guidance on Prevention and Management of COVID-19 IN RCFEs 8-19-20

The threat of COVID has changed the approach to older adult care and living. COVID-19-related mortality rate in older adults in long term care facilities (LTCF) and residential care facilities for the elderly (RCFEs) averages between 10-20%, but can be as high as 75% in some settings. The disease can manifest with a variety of symptoms, often leading to delayed recognition. Additionally, some older adults can have no symptoms at all, yet can pass the virus to others. Federal, state and local authorities have issued guidance for the prevention and detection of COVID in ALFs, yet the approach to management once a facility has identified a case of COVID-19 varies. The following guidance from the Orange County Health Care Agency (OCHCA), which provides public health services to the County of Orange, is based on experience from over 70 outbreaks in LTCF and RCFEs, as well as recommendations from state and national authorities. Many RCFEs have been able to adequately care for their COVID+ residents onsite following this guidance.

I. Prevention and Mitigation of COVID Spread

a. Limitation of visitors: as outlined in prior PINs, only essential visitors allowed. All visitors should be pre-screened with temperature and review of COVID symptoms and should not be allowed in if fever or symptoms present.

b. Symptom screening: temperature check and review of symptoms should be performed for all staff prior to start of shift, and for residents on a daily basis. **Older adults may not have the classic symptoms of COVID** (fever and cough), but can present with more mild or less common symptoms, such as the following:

   i. Cold/flu symptoms: lower grade fever (99.2 – 99.3), sore throat, runny nose, headache and/or muscle aches
   ii. Gastrointestinal symptoms: nausea, vomiting or diarrhea, diminished appetite
   iii. Weakness or falls
   iv. Loss of sense of taste or smell
   v. Confusion, altered mental status
   vi. Neurologic symptoms (stroke)
   vii. Behavioral changes: increased agitation, sudden sadness, reduced activity
   viii. Be vigilant for any change in status, and if change noted, test right away. If test negative, but suspicion for COVID-19 is high, repeat test in 2-3 days.

c. Cancellation or modification of group activities/congregate meals: such activities should be canceled if there are cases of COVID in the facility, but can be continued in a modified fashion if no cases in last 14 days; see separate guidance for activities.

d. Social distancing and masking:

   i. Residents: should wear masks and attempt to maintain distance of at least 6 feet from others when in common areas.

ii. Staff: mask at all times when in the facility and maintain 6 feet distance as much as possible; staff must maintain 6 feet separation during breaks.

e. Hand hygiene: encourage frequent hand hygiene, either hand washing or alcohol-based hand sanitizer (non-alcohol-based hand sanitizer, such as benzalkonium chloride, not recommended for COVID) for both staff and residents.

f. Environmental cleaning/disinfection: regularly scheduled cleaning and disinfection with EPA-listed disinfectant of frequently touched surfaces in common areas. Be sure to follow the product label and maintain the proper contact time. Dirty surfaces should be cleaned with soap and water or other cleaning agent before disinfection.

g. Quarantine of New Residents: ensure that any prospective resident has tested negative for COVID prior to move in (ideally within 48-72 hours), then keep resident separated from the rest of the community and repeat the test at 14 days. Do not allow resident to socialize with others until repeat test is back. If symptoms develop anytime during the 14 days period, test immediately. A previously COVID+ resident who has fully recovered from the illness and at least 3 weeks have passed from the date of initial symptoms can move in directly without quarantine or retesting.

II. Management of COVID-19 Suspects (Persons Under Investigation, or "PUIs")

a. Resident:

i. Isolate PUI in a single room (ideally) and test as soon as possible. Call OC Public Health at 714-834-8180 to facilitate testing (you'll need to collect sample) or send to commercial lab if turnaround time is good (48 hours or less).

ii. Use full personal protective equipment (PPE) including gown, gloves, face shield and mask, when dealing with PUI; remove gown and gloves after contact and perform hand hygiene.

iii. Doors closed to room; DO NOT let resident out of room to mingle with other residents (even if symptoms resolve) before test result back.

iv. If initial test negative, but high suspicion for COVID, keep isolated and retest in 2-3 days.

b. Staff:

i. Remove from work immediately (or instruct them not to come to work) and test as soon as possible. Call OC Public Health at 714-834-8180 to arrange quick testing, if desired, or test with commercial lab with quick turnaround time (< 72 hours), or refer to community testing resources (see https://occovid19.ochealthinfo.com/covid-19-testing).

ii. DO NOT let staff member back to work before test result back, even if symptoms improve.

iii. If initial test negative, but high suspicion for COVID, keep off of work and retest in 2-3 days.

III. Management of COVID+ or COVID-Exposed Residents or Staff

a. COVID+ Resident:

i. Isolate in room and monitor by doing vitals, pulse oximetry and review of symptoms (see I.b. above) 3-4 times per day.

ii. Consider transfer to ER (if not on comfort care) for following changes:

1. Fast breathing/shortness of breath or oxygen saturation below 95%

2. Fast pulse rate (>100-110), or systolic blood pressure that is below 110 or is much lower than their normal
3. Significantly decreased oral intake (skipped multiple meals or not drinking sufficient fluids), vomiting, or diarrhea that is moderate to severe
4. Change in mental status/confusion, neurologic symptoms
5. Prolonged high fevers
6. Moderate to severe weakness or a fall
7. Chest pain

iii. Review end of life wishes to determine further actions if resident decompensates; COVID is hospice-qualifying condition and mortality of COVID in older adults is 10-20%.

iv. If multiple residents infected, consider creating a COVID or "red" unit (see III.d. below); can have multiple positive residents in same room if needed.

v. Ideally dedicate staff to care for COVID+ (that is, staff work only with COVID+ each shift; may work with COVID-negative on other days, but do not float between COVID+ and COVID-negative on same day). If multiple positive residents on site, consider having licensed medical staff to help monitor.

vi. Use full PPE (surgical mask or N95, gown, gloves, and face shield; see V below) when giving care to COVID+ residents; may practice extended use of PPE (same mask, gown and face shield used whole shift), but change gloves and perform hand hygiene between patients. Must remove PPE and perform hand hygiene before breaks.

vii. COVID+ resident **DO NOT** need retesting

1. CDC recommends time or symptom based clearance from isolation; 10 days for mild to moderate illness, 20 days if severe disease or if immune system compromised. For more information, see https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html
2. Older adults often have weakened immune system due to age and other illnesses (e.g., diabetes, kidney or liver disease, etc,), and are known to shed other respiratory viruses for a longer period of time
3. For these reasons, **OCHCA recommends a more cautious approach to release from isolation**:
    a. 3 weeks for those who never develop symptoms
    b. 4 weeks for those who do develop symptoms (and should be substantially improved before release from isolation)

b. Roommates or close contacts of COVID+ residents

i. "Close contact" means being within 6 feet for 15 minutes or longer without PPE.

ii. Roommates have a 50-75% chance of becoming COVID positive; more difficult to estimate risk for non-roommate close contacts.

iii. Roommates of COVID+ need to be **quarantined in a single room and tested at 7 and 14 days after last contact with COVID+**; **do not let them leave room** and roam about the facility! If result of 14 days test is negative, can be released from quarantine.

iv. Exposed residents should be monitored 2-3 times per day with vitals and symptom check; test immediately if symptoms develop.

v. Staff should use full PPE when dealing with these close contacts.

vi. If many close contacts, consider creating a quarantine, or "yellow" unit or zone and dedicate staff to this area (see III.e. below).

c. COVID+ Staff:

i. Isolate at home; may qualify for hotel placement if unable to safely isolate at home.
ii. Return to work: based on CDC guidance https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html
    1. If no symptoms, 10 days off of work (time-based)
    2. If symptoms, at least 10 days, but should have no fever x 1 day and symptoms should be improving substantially (symptom-based); may want to extend to 14 days or longer if symptoms still substantial.
    3. **Do not** advise test-based clearance; may take up to 3 months to test negative, and positive test after 10 days does not indicate infectiousness.

d. "Red" Unit/Zone:
    i. RCFEs have created red units by subdividing a wing (e.g., closing fire doors or putting in a temporary wall or barrier to separate positive residents), or by utilizing a vacant wing or vacant apartments.
    ii. Ideally a red unit should be a distinct area separated from the rest of the facility, with a separate entrance/exit from the rest of the facility, if possible. Also, a separate break room and bathroom for staff (could be an empty room or part of an apartment) is advisable.
    iii. COVID+ residents should not be allowed to have contact with COVID-negative residents; if plastic barriers used to contain them, need to post signs on the plastic barriers that indicate "Tear Down In Case of Emergency".
    iv. Residents may leave their rooms in a COVID unit if masked and if HCW are using full PPE at all times.

e. "Yellow" Unit/Zone:
    i. Ideally next to the red zone; for the roommates/close contacts of COVID+ residents.
    ii. Residents should be one per room, if possible; no more than two per room.
    iii. Residents should stay in room at all times with doors closed; no interaction with COVID+ or COVID-negative and non-exposed residents.
    iv. Staff should wear full PPE when interacting with residents, but should change both gown and gloves between residents.

IV. Testing for COVID

a. Residents:
    i. At a minimum, test new residents (see I.g. above) and any resident who have been cared for by a COVID+ staff member, was a close contact of a COVID+ resident, and any resident who has symptoms suggestive of COVID.
    ii. In an outbreak setting, need to test COVID-negative residents in a high risk setting (e.g., memory care unit, or MCU) every 7 days instead of every 14 days.
    iii. In ALs and other lower risk settings, test exposed residents (or all residents) every 14 days as per PIN 20-23-ASC.
    iv. A negative test only means negative that day (and time); if symptoms develop, test again, even if not due for testing -- do not wait for next scheduled round of testing!
    v. New admissions should be tested prior to or upon move-in, and tested again after 14 days; keep new admission separated from rest of community until second test if possible.

vi. Regular surveillance testing generally not recommended for residents, but consider testing those who leave facility on a regular basis (e.g. dialysis or frequent medical appointments) every 2-4 weeks.

b. Staff:
   i. At a minimum, test those who have cared for a COVID+ resident, close contacts to COVID+ and anybody who has symptoms suggestive of COVID. Also consider testing new staff prior to hire.
   ii. In an outbreak setting, may need to test COVID-negative staff in a high risk setting (e.g., MCU) every 7 days instead of every 14 days.
   iii. In non-outbreak setting, minimum surveillance testing is 10% of staff every two weeks; would consider testing a higher percentage of staff every two weeks or testing more frequently. Additionally, consider more frequent testing in high-risk staff groups, such as those who work at other facilities, have travelled recently, have a COVID+ household member, or those with most direct patient contact (caregivers).

V. Personal Protective Equipment (PPE)

a. Mask use: CDC says that N95s are preferred over surgical masks for confirmed COVID, but that surgical masks are acceptable if N95s in short supply. N95s are definitely needed for any aerosol generating procedure (AGP), (such as nebulizer therapy or CPAP), but in all other situations, either N95 or surgical mask are acceptable.
   i. The most important factors in considering which type of mask to use is fit, consistency and correctness of use. Some facial morphologies may be better fit with a surgical mask, and others with a N95.
      1. Each HCW should be assessed visually for fit of mask, trained on proper donning and doffing, observed for compliance and need for adjusting mask during work, and educated on the importance of hand hygiene before putting on mask, after doffing mask and after touching/adjusting mask.
      2. A quick seal check should be performed with each donning of an N95 or KN95 mask to ensure effective seal and filtration https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf.
   ii. Facilities using N95s should follow CDC's guidance for extended use and limited reuse https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html ; it is not clear if these guidelines for reuse apply to KN95s.
   iii. Use of two masks, or double-masking, should be discouraged. The double-masking strategy provides no additional protection, wastes PPE resources, and increases risk of self-contamination

b. Gown use:
   i. Due to limited supplies of disposable gowns, facilities are encouraged to purchase long sleeved, washable cloth gowns.
   ii. Ideally, gowns should be single use, being washed or discarded after each use.
   iii. In periods of shortage, the facility can assign one gown per staff per COVID+ patient per shift (unless in red zone, where one gown per staff member for all patients is OK), but minimize numbers of times donned and doffed (each reuse lead to possible contamination).
   iv. Gowns must be doffed and discarded or laundered if soiled or wet, and at end of shift.

v. Full body suits/rain jackets not advised; high risk for self-contamination when doffing.

c. Other PPE Practices:
    i. Staff should be able to demonstrate proper doffing of PPE to avoid self-contamination.
    ii. Shoe coverings should be discouraged as they pose a fall hazard and may increase risk of self-contamination.
    iii. Hair coverings not necessary and may increase risk of self-contamination when doffing. Hair that is long should be secured so it does not contact the patient care area.