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PUBLIC HEALTH SERVICES
COMMUNICABLE DISEASE CONTROL

OCHCA Guidance on Prevention and Management of COVID-19 IN RCFEs 2-1-21

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 about 15%, but can be much higher 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 RCFEs, 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 100 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, continue to limit non-essential visitors; visits should follow COVID prevention core concepts, including social distancing, wearing masks that cover their mouth and nose and proper hand hygiene at all times, and should ideally be monitored by staff for compliance. All visitors (essential or nonessential) should be pre-screened with temperature and review of COVID symptoms and should not be allowed in if fever or symptoms present. See separate guidance for visitation recommendations.

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, because residents may be incubating COVID and spread the virus further, even without symptoms. Dining and activities may be resumed in a modified fashion once there have been two consecutive weekly rounds of testing of both staff and residents which have all resulted negative; 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. Testing of staff: see IV.c, page 4.
h. Testing and quarantine of new/returning residents: See IV.b, page 4.

II. Management of COVID-19 Suspects (called "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 (facility should collect sample if able; testing team may be able to assist in certain situations) 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 N95 respirator, 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 15-20%.
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 (N95, gown, gloves, and face shield; see V below) when giving care to COVID+ residents; if staff only caring for COVID+ residents, may practice extended use of PPE (same respirator, 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. See V for more information.
vii. Release of COVID+ residents from isolation
    1. CDC recommends time or symptom based clearance from isolation; 10 days from symptoms onset for mild to moderate illness, 20 days from symptoms onset if severe disease or if immune system compromised. For more information, see https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html. **CDC and CDSS do not recommend retesting COVID+ residents to determine clearance from isolation**.
    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. For these reasons, **OCHCA recommends a more cautious approach to release from isolation**:
        a. Minimum of two weeks for those who are relatively healthy, had no symptoms or very mild disease, and who can follow COVID prevention guidance.
        b. 3 weeks for those who had no symptoms or very mild disease, but who have many medical problems or who cannot reliably follow COVID prevention guidance (e.g., cognitive impairment for dementia).
        c. 3 to 4 weeks for those who develop more significant symptoms (longer if unable to follow CVOID prevention guidance).
        d. Residents should have no fever for at least one day and symptoms should be substantially improved before release from isolation.

b. <u>Roommates or close contacts of COVID+ residents</u>
    i. "Close contact" means being within 6 feet for 15 minutes or longer without PPE (cloth face coverings do not count as PPE).

ii. Roommates have a 50-75% chance of becoming COVID+; more difficult to estimate risk for non-roommate close contacts.
iii. Roommates of COVID+ need to be **quarantined in a single room and tested via PCR at 5 and 10-14 days after last contact with COVID+**; **do not let them leave room** and roam about the facility! If result of test at 10-14 days after last contact is negative, and no symptoms have developed, resident 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 several months to test negative, and positive test after 10 days does not necessarily 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. Staff should not use resident restrooms in a COVID unit.
   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 (ideally, they should be masked); HCW should use N95, gown and face shield at all times, and gloves for any contact with body fluids. Staff should perform frequent hand hygiene, and remove all PPE in a "clean area" (e.g. break room), sanitize face shield and perform hand hygiene after doffing
   v. Creating a red unit allows residents to get more exercise and social interaction, which helps prevent social isolation and may assist in recovery.

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, and should change both gown and gloves between residents.

IV. Testing for COVID

a. Types of COVID Tests:
   i. PCR tests are the preferred type of test, ideally from a nasal specimen; throat specimens are less sensitive (not as good at picking up infection) and saliva or oral-based specimens are now available, but data on these is mixed and experience is very limited.
   ii. Rapid antigen tests are now being distributed to some facilities; these tests can detect a part of the virus and result in 15 minutes. These tests are not as sensitive as PCR, but perform reasonably well in people who have had COVID symptoms for several days, and if positive in a symptomatic person, likely indicate active COVID infection. They are not as good at picking up asymptomatic infection (e.g. for screening of staff or visitors without symptoms). For more information in use of these tests, see https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/APHL-SARSCov2-Antigen-Testing-Considerations.pdf
   iii. Blood tests should not be used to test for active COVID infection.

b. Testing Residents:
   i. At a minimum, test new/returning residents (see iii. & iv. below) and any resident who has been cared for by a COVID+ staff member, was a close contact of a COVID+ person, or who has symptoms suggestive of COVID.
   ii. In an outbreak setting, need to test COVID-negative residents every 7 days until two negative sequential rounds of testing; may need to test more frequently in a high risk setting (e.g. memory care unit, or MCU). 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!
   iii. Testing and quarantine of new residents (see iv. below for new residents admitted from hospital/SNF): ensure that any new resident has tested negative for COVID prior to move in (ideally within 48-72 hours prior to move-in day). In a higher-risk setting (memory care unit or widespread community COVID-19 transmission), keep resident separated from the rest of the community and repeat the test at 10-14 days; do not allow resident to socialize with others until repeat test is back. If symptoms develop anytime during the quarantine period, test immediately.
      1. A COVID+ resident who has fully recovered from the illness, passed the time or symptom-based clearance period, and who is within 3 months of COVID diagnosis can move in directly without quarantine or retesting.
      2. A resident who was diagnosed with COVID-19 more than 3 months ago should be considered for quarantine and retesting, although some may continue to have residual positive test from their initial infection even up to 4-5 months later.
   iv. Testing and quarantine of residents returning from hospitals/SNFs: ideally tested within 48 hours prior to return; if not, test on admission. Strongly consider quarantine and retest at 5 and 10-14 days as both hospitals and SNFs are higher risk areas for COVID transmission than the community.

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

c. Testing of 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, test all COVID-negative staff every 7 days until two sequential negative rounds; if symptoms develop, test again, even if not due for testing -- do not wait for next scheduled round of testing!
   iii. In non-outbreak setting, minimum surveillance testing is 25% of staff every week per PIN 20-38-ASC. Staff who were previously COVID+ should not be tested for 3 months after their diagnosis, but after that time should be returned to the regular surveillance testing of once a month. Additionally, consider more frequent testing in high-risk staff groups, such as those who work at other facilities or who have travelled recently.

V. Personal Protective Equipment (PPE)

a. Mask use: CDC says that N95s are preferred over surgical masks when caring for confirmed COVID-19 patients, 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 and according to Cal/OSHA, are now mandated for any staff member caring for known or suspected COVID patient, per the Emergency Temporary Standards issued on November 30, 2020 (https://www.dir.ca.gov/title8/3205.html). These Emergency Temporary Standards require a written COVID-19 Prevention Plan, including free COVID testing for employees during their work hours, and respiratory protection according to the California Code of Regulations Title 8, Section 5144 (https://www.dir.ca.gov/title8/5144.html)
   i. The most important factors in considering which type of mask to use is fit, consistency and correctness of use. Note that OSHA does not consider KN95s as equivalent to N95s; any N95 used should be NIOSH-certified.
      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 mask to ensure effective seal and filtration https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf.
      3. Fit testing of staff who will need to care for COVID+ residents should be pursued as soon as possible.
   ii. Facilities using N95s can follow CDC's guidance for extended use and limited reuse of respirators **IF** supply is insufficient for single use: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html.
   iii. Use of two masks, or double-masking, should be discouraged. The double-masking strategy provides no additional protection, may affect seal of mask, wastes PPE resources, and increases risk of self-contamination

b. Gown use:

i. Due to previous shortages 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. If staff is working only with COVID+ residents, gowns may be used for extended periods (for several patients) in a red zone (see III.d. above) as long as patients do not have any drug-resistant bacteria. However, gowns must be doffed and discarded or laundered if soiled or wet, before breaks and at end of shift. If residents' rooms are scattered throughout facility, it is best to doff gown upon exiting a resident's room to avoid contaminating the rest of the facility.
iv. Use of full body jump suits or rain jackets are not advised; these pose a 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; CDC videos on proper technique can be found at:
      1. Donning: https://www.youtube.com/watch?v=H4jQUBAlBrI
      2. Doffing: https://www.youtube.com/watch?v=PQxOc13DxvQ
      3. Don't forget to sanitize hands before putting on and after taking off gloves, and after touching/adjusting mask or face shield.
   ii. All PPE should be removed during breaks, with masks (if to be reused) stored in open-to-air baggy and face shield disinfected and hung to dry. Break rooms should have hand sanitizer and sanitizing wipes available for staff to use, and appropriate area for storage of PPE.
   iii. Shoe coverings should be discouraged as they pose a fall hazard and may increase risk of self-contamination.
   iv. 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.