Utah Department of Health & Human Services

Recommendations and resources for COVID-19 prevention and response in the long-term care setting

Table of Contents

Background

This document is intended to help guide infection prevention and response activities related to COVID-19. Additional guidance can be found on the Utah COVID-19 long-term care webpage.

COVID-19 prevention and preparation in long-term care

Long-term care facilities (LTCFs), including nursing homes, assisted living*, memory care, and intermediate care facilities (ICF/IID), should develop plans to care for residents who are infected or suspected of being infected with COVID-19. Adequate preparation includes encouraging staff and residents to stay up to date on vaccination, developing protocols for when cases do emerge, maintaining supplies of personal protective equipment (PPE), educating staff on proper PPE use and disposal, as well as making sure adequate cleaning and disinfecting practices are in place.

*Assisted living facilities should perform an assessment of their residents and take into consideration residents' health conditions, the spread of COVID-19 in the community, and evidence-based practices for infection control. Assisted living facilities may choose to follow the guidance in this document or choose to adopt community prevention strategies based on COVID-19 community levels. Universal masking is recommended for everyone in the facility when community transmission levels are high, regardless of what guidance an assisted living facility chooses to follow. However, all healthcare personnel who enter assisted living facilities (including visiting or shared healthcare personnel) to provide healthcare to 1 or more residents (e.g., physical therapy, wound care, intravenous injections, or catheter care, etc.) should follow the guidance below.

Create a COVID-19 strike team

- Identify appropriate team members to lead the COVID-19 strike team (administration, nursing, housekeeping, maintenance, etc.) who can mobilize quickly when a case is identified.

Establish an infection prevention and control program

- Assign 1 or more individuals with training in infection prevention and control (IPC) to manage the IPC program. This should be a full-time role for at least 1 person in facilities that have over 100 residents or that provide onsite ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on resident population and facility service needs.
- The CDC has created an online training course that can orient individuals to this role in nursing homes.
- Request an Infection Control Assessment and Response (ICAR) from HAI or DHHS partners.

- Post signs at the entrance and in common areas with instructions about current IPC recommendations (e.g. source control, cough etiquette, and hand hygiene).
- Post signs that include clear instructions for visitors who may have respiratory symptoms, recent close contact with COVID-19, or a current infection.

Encourage residents and staff to stay up to date on vaccination

- Remaining up to date on vaccination reduces the chance of hospitalization and death from COVID-19.
- Work with your pharmacy partners to make sure that remaining up to date is convenient for residents and staff.

Maintain an inventory of personal protective equipment (PPE)

- Facilities should maintain adequate supplies of facemasks, N95 or higher-level respirators (e.g. PAPR), gowns, gloves, and eye protection.
- Staff caring for residents who are infected or suspected of being infected with COVID-19 should wear a fit-tested N95 respirator, gloves, gowns, and face shield or goggles.
- Perform inventory of PPE and use the CDC's PPE burn rate calculator to identify when PPE supplies need to be replenished.
- Utilize competency-based training and audits to monitor adherence to proper PPE selection and use.
    - The CDC has created training resources for front-line staff that can be used to reinforce recommended practices for preventing transmission of COVID-19 and other pathogens.
- Used PPE may be discarded in the regular trash, unless evidently soiled with bodily fluids. Place trash cans near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting.
- Follow PPE optimization strategies, which offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted.

Establish an OSHA/NIOSH respiratory protection program

- A respiratory protection program should include medical evaluations, training, and fit-testing.
- Perform fit-testing for each brand of N95 mask available at the facility.
    - Staff should be aware of the model and size of N95 for which they are fit-tested.
- Make sure staff members are properly trained and fit-tested for N95s or PAPRs annually or anytime a new respirator model is acquired.

Identify a dedicated space to care for multiple residents with suspected COVID-19

- Decide on a location in the facility that can be separated and dedicated for residents requiring isolation. Ideally, the space should be separated from COVID-19 negative areas by a barrier or closed doors.
- Dedicate spaces with an airborne infection isolation room (AIIR), if available. Prioritize the AIIR for patients with aerosol-generating procedures (e.g., CPAP, BiPAP, nebulizer treatment).
- The facility's air system should be examined by an expert to make sure there is no recirculated air from the COVID-19 isolation area to COVID-19 negative areas.
- Develop plans for emergency evacuation and fire extinguishers in the dedicated isolation area.
- For facilities unable to isolate residents with confirmed COVID-19, such as memory care or residents with disabilities, consider transfer to a dedicated COVID-19 unit (if available) or cohort cases with residents who have recovered from COVID-19 within the last 30 days.

Maintain standards for source control and eye protection

Nursing homes and intermediate care facilities should reference CDC community transmission levels to guide decisions regarding resident and staff use of source control and eye protection.

- **High** community transmission levels:
    - Source control recommended for everyone (residents, staff, and visitors) in areas where residents are present
    - Newly admitted residents should mask for 10 days
    - Consider eye protection for all staff
- If community transmission levels are **NOT high**:
    - Masking is recommended for individuals who:
        - Have suspected or confirmed respiratory infection
        - Had close contact with someone with COVID-19 (for 10 days after contact)

Even if not otherwise required by the facility, individuals should always be allowed to wear source control based on personal preference.

After identifying a COVID-19 case in long-term care

Contact tracing

- Identify staff and residents who may have had a higher-risk exposure/close contact to the individual infected with COVID-19 within 48 hours prior to the case's symptom onset or if, asymptomatic, within 48 hours prior to positive test.

- If you are unable to confidently identify all close contacts, investigate the uncontrolled transmission at a facility-level or group-level (e.g., unit, floor, or other specific area of the facility).

Testing

- Please review the outbreak response algorithm to determine whether a targeted or broad based testing approach is more appropriate.
- Either molecular (PCR) or POC antigen tests may be utilized for testing.
- Persons within 30 days of a prior COVID-19 infection should be tested *only* if symptomatic. These individuals, as well as those within 90 days of prior infection, should only be tested with rapid antigen tests.

Targeted Approach:

- If all close contacts can be identified, staff with a higher-risk exposure and residents with close contact to the individual infected with COVID-19, should be tested.
- A series of 3 viral tests (POC Ag or PCR) recommended for individuals following an exposure to someone with COVID-19 infection
  - Immediately (but not earlier than 24 hours after the exposure),
  - 48 hours after the first negative test, and
  - 48 hours after the second negative test.

Broad based approach:

- If unable to confidently contact trace or if there is evidence of ongoing transmission in the facility, then implement a broad based testing strategy using the same series of 3 tests as outlined above.
- If no additional cases are found, no further testing is needed unless symptoms develop.

Discordant results:

- Sometimes individuals who present with symptoms after an exposure to COVID-19 do not test positive in the first few days.
  - Please consult considerations for interpretation of SARS-CoV-2 antigen tests algorithm to guide decisions on follow-up testing.

Managing staff with COVID-19 or following a higher-risk exposure

- All staff who **test positive for COVID-19** should be excluded from work until they meet CDC criteria to return to work:
  - Staff with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:

    - At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications, and
    - Symptoms (e.g., cough, shortness of breath) have improved.

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, staff should have a negative test obtained on day 5 and again 48 hours later.

- Following a higher risk exposure, may continue to work however, they should be tested using the 3 test series, wear source control for 10 days from the exposure, and monitored for symptom onset.
- Please refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 for additional information on work restrictions following COVID-19 infection.

Managing residents with COVID-19 or following close contact

- All residents who **test positive for COVID-19**, or suspected to have COVID-19, should be placed on contact/droplet precautions in a private room (with a private bathroom), regardless of vaccination status.
    - If there are multiple residents infected with confirmed COVID-19, consider establishing an isolation unit to cohort these residents or transfer to a long-term care facility with a COVID-19 unit, if available.
    - In nursing and intermediate care facilities, residents should remain in isolation for 10 full days, with onset of symptoms or positive test (whichever comes first) being day ‘0’.
- Following close contact with someone with COVID-19 infection,
    - Residents should wear a surgical mask for 10 days post-exposure when outside their room and be tested for COVID-19 using the 3 test series as described above.

Personal protective equipment (PPE)

- When there are known COVID-19 cases in a facility, all staff should wear source control and consider wearing eye protection when in resident care and common areas.
- Staff caring for residents in isolation or during an aerosol-generating procedure should wear eye protection, fit-tested N95 respirator, gown, and gloves.

Symptom monitoring

- When a COVID-19 case is identified among staff or residents, monitor staff and residents closely for signs and symptoms of COVID-19, regardless of vaccination status.
- Isolate and test residents immediately if they show signs and symptoms of COVID-19. If a resident has a known exposure and shows signs or symptoms of COVID-19, isolation and repeat testing is recommended if the initial test is negative.
- Test staff immediately if they show signs and symptoms of COVID-19.
    - Note that antigen testing may not identify early infections. Please use the considerations for interpretation of SARS-CoV-2 antigen tests algorithm to evaluate whether additional testing is needed.

Therapeutics

- Work with clinical providers and pharmacy partners to acquire antiviral therapy for symptomatic residents.
- Discuss with your medical director standing orders for providing COVID-19 treatment to residents.

Communal dining and group activities

- Communal dining and group activities should only continue for residents who do not meet criteria for isolation and are asymptomatic. When transmission is widespread within the facility, consider a temporary pause on group activities.

Disinfection

- Schedule regular cleaning and disinfection of frequently touched surfaces and objects and in between use of shared equipment using EPA registered List N disinfectants for COVID-19.

Communication and documentation

- Notify residents, resident families/guardians, visitors, and new admissions of COVID-19 positive cases within the facility and of the quarantine of any exposed residents.
- Document, internally, all testing and mitigation measures taken.

Visitation

- Facilities must allow indoor visitation at all times for all residents.
- Facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.

Admissions when COVID-19 positive cases are within the facility

- Formulate a plan to admit residents when COVID-19 positive cases are within the facility, including:
    - Identify a dedicated area and staff for new admissions.
    - If a dedicated area and staff cannot be implemented, then identify rooms for new admissions in areas without a COVID-19 exposure.
    - If there are no areas without exposure, consider holding off on admitting residents until a negative round of testing has been completed 7 days after the last identified case.

Definitions

Higher risk exposure: occurs when staff had prolonged close contact with someone with confirmed COVID-19 and any of the following:

- Staff was not wearing a respirator (N95) or eye protection and the person with COVID-19 infection was also not wearing a face mask;
- Staff was not wearing all recommended personal protective equipment (gown, gloves, eye protection, respirator) while performing an aerosol generating procedure.

Mild to moderate illness: Individuals who have any of the various signs and symptoms of COVID-19 infection (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging. Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Close contact: A cumulative time period of 15 minutes or more in a 24-hour period within 6 feet of a person with confirmed COVID-19 infection or any unprotected direct contact with infectious secretions or excretions. Any duration should be considered prolonged if exposure occurred during an aerosol-generating procedure.

Severe to critical illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%. Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Severely immunocompromised: Individuals who suffer from conditions, such as chemotherapy for cancer, being within 1 year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may

cause a higher degree of immunodeficiency and require actions such as lengthening the duration of staff work restrictions.

Up to date on vaccination: means a person has completed a COVID-19 vaccine primary series and received the most recent booster dose recommended for you by CDC.

References

Centers for Disease Control and Prevention. (2022, Sept. 23). Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

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Recommendations of the Long-Term Care Facility Subcommittee of the Utah Governor's COVID-19 Community Task Force