
Guidance for Mitigating Staffing Shortages in Long-Term Care Facilities During the COVID-19 Pandemic

Many facilities are now experiencing workforce shortages due to the COVID-19 pandemic that impact the way their facility is run and the ability to provide appropriate care for the residents in their facility. The purpose of this guidance is to provide recommendations to allow healthcare workers who have experienced an unprotected exposure to COVID-19 or are known to be infected with COVID-19 to continue working when there are no longer enough staff to provide safe resident care.

Conventional Work Restrictions for Unprotected Exposures or Cases of Known COVID-19

An unprotected exposure to COVID-19 among healthcare workers occurs when the healthcare worker had prolonged* close** contact with someone with confirmed COVID-19 and any of the following:

- Healthcare worker not wearing a facemask or respirator
- Healthcare worker not wearing eye protection when the person with COVID-19 was not wearing a facemask or cloth face covering
- Healthcare worker not wearing all recommended personal protective equipment (gown, gloves, eye protection, respirator) while performing an aerosol generating procedure.

*Prolonged contact is defined as 15 minutes or more, however, any duration should be considered prolonged if exposure occurred during an aerosol-generating procedure.

**Close contact is defined as within 6 feet of a person with confirmed COVID-19 or any unprotected direct contact with infectious secretions or excretions of a person with confirmed COVID-19.

A 14-day quarantine, self-monitoring for signs and symptoms of COVID-19, and testing with the onset of any signs or symptoms are recommended for any healthcare worker with an unprotected exposure.

For healthcare workers with known COVID-19, a symptom-based strategy should be used to determine when it is safe for the healthcare worker to return to work. A test-based strategy is not recommended in the majority of cases, as it results in excluding from work healthcare workers who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. Healthcare workers with mild to moderate illness who are not severely immunocompromised can return to work when the following criteria are met:

- At least 10 days have passed since symptoms first appeared, 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.

Healthcare workers who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive test.

Consultation with infection control experts is recommended for all healthcare workers with severe to critical illness or who are severely immunocompromised.

Contingency and Crisis Capacity Strategies

When staffing shortages are anticipated, long-term care facilities should use contingency capacity strategies to plan and prepare for mitigating this problem, including adjusting staff schedules, hiring additional healthcare workers, and rotating healthcare workers to positions that support direct resident care activities. Be aware of state-specific emergency waivers or changes to licensure requirements for select categories of healthcare workers and make plans to allow asymptomatic healthcare workers who have had an unprotected exposure but are not known to be infected to continue to work. Should a healthcare worker with an unprotected exposure return to work prior to completing a 14-day quarantine, the following steps are recommended:

- Continuous self-monitoring and daily facility screening for signs or symptoms of COVID-19, including temperature checks, with immediate exclusion from work for signs or symptoms of COVID-19.
- Rapid point-of-care testing for SARS-CoV-2 onsite at the facility prior to the start of each shift, with a negative test required before proceeding to work.
- Full personal protective equipment, including gown, gloves, eye protection, and a facemask. For all aerosol generating procedures, a fit-tested N95 (not a PAPR) should be worn. In addition, all residents receiving care should wear a facemask (not a cloth face covering). If this is not possible, then the healthcare worker should not be involved in caring for these residents. Personal protective equipment should be worn at all times, including when around other staff and in break areas.
- Reassignment or redesign of duties to minimize contact with residents. If continued resident care is necessary, strictly avoid contact with immunocompromised patients. Only interact with residents who are currently positive or tested positive for COVID-19 within the last 90 days, where possible.
- Minimize contact with other staff, including during breaks and meals. If possible, provide a separate area for exposed healthcare workers to take breaks and perform work tasks such as charting, etc.

Only when staffing shortages persist despite other mitigation strategies should long-term care facilities use crisis capacity strategies allowing healthcare workers with suspected or confirmed COVID-19 well enough and willing to work to resume work before meeting all return to work criteria. If healthcare workers are allowed to work before meeting all criteria, they should be restricted from contact with immunocompromised residents and not interact with staff unaffected by COVID-19 (e.g., use of dedicated entrances, donning and doffing areas, break rooms, bathrooms, and charting areas). Long-term care facilities should prioritize duties in the following order:

- Allow healthcare workers with suspected or confirmed COVID-19 to perform job duties where they do not interact with others, such as teleworking.
- Allow healthcare workers with confirmed COVID-19 to provide direct care only for residents with confirmed COVID-19, preferably in a cohort setting.
- Allow healthcare workers with confirmed COVID-19 to provide direct care for residents with suspected COVID-19.
- As a last resort, allow asymptomatic healthcare workers with confirmed COVID-19 to provide direct care for patients without suspected or confirmed COVID-19.

Following each of the above recommendations is critical to ensure the ongoing safety of long-term care facility residents and staff. Additional questions should be directed to the Infection Preventionist working with your facility or to HAI@utah.gov.

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