UTAH DEPARTMENT OF HEALTH

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 a higher risk 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 COVID-19 Work Restrictions for Healthcare Workers

Healthcare Workers with Higher Risk Exposure to COVID-19

Fully vaccinated healthcare workers should not be restricted from work following a higher risk exposure to COVID-19, unless symptomatic. They should self-monitor for signs and symptoms for 14 days following the exposure. Immediate testing for COVID-19 infection and again at 5-7 days after the exposure is also advised.

Unvaccinated healthcare workers should quarantine and be restricted from work for 14 days following any higher risk exposure. They should also monitor for symptoms and test as described above. This recommendation also applies to vaccinated healthcare workers who are severely immunocompromised.

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

*Prolonged contact is defined as a cumulative time period of 15 minutes or more in a 24-hour period, however, any duration should be considered prolonged if exposure occurred during an aerosol-generating procedure.[1]
**Close contact is defined as within six feet of a person with confirmed COVID-19 infection or any unprotected direct contact with infectious secretions or excretions of a person with confirmed COVID-19 infection.

Healthcare Workers with Confirmed COVID-19

For healthcare workers with confirmed COVID-19, regardless of vaccination status, a symptom-based strategy should be used to determine when it is safe for the healthcare worker to return to work. 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 the 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.[4]

Healthcare workers with severe to critical illness may return to work when the following criteria are met:

- At least 10 days and up to 20 days have passed since symptoms first appeared, AND
- At least 24 hours have passed since fever without the use of fever-reducing medications, AND
- Symptoms (e.g., cough, shortness of breath) have improved.
- Consider consultation with infection control experts.

Healthcare workers who are severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset, or for those who were asymptomatic throughout their infection, the date of their first positive viral test. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy for determining when these healthcare workers may return to work could be considered.[4]

Contingency 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.
- Identify additional staffing resources such as staffing agencies. Investigate emergency waivers or changes to licensure requirements for select categories of healthcare workers, such as students and retired healthcare workers.
- Implement a temporary hold on new admissions until staffing is such to safely accommodate additional residents.
- If staffing shortages persist despite the above strategies, the length of quarantine may be reduced for unvaccinated healthcare workers. Workers who have remained asymptomatic and tested negative may return to work as soon as Day 7. The test must be a PCR conducted no sooner than Day 5 (see Appendix A). The following are still advised through Day 14:
    - Continuous self-monitoring and daily facility screening for signs or symptoms of COVID-19 infection, 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, 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, fully vaccinated, or tested positive for COVID-19 infection 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.

Crisis Capacity Strategies

Only when staffing shortages persist despite other mitigation strategies should long-term care facilities use crisis capacity strategies allowing unvaccinated, asymptomatic healthcare workers to end quarantine prior to Day 7. Should this be implemented, all above mitigation strategies should be observed through Day 14.

As a last resort, healthcare workers with suspected or confirmed COVID-19 infection who are well enough and willing to work may resume work before meeting all return to work criteria. This strategy may only be utilized as a temporary, emergency measure while alternatives are actively sought. 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 infection to perform job duties where they do not interact with others, such as teleworking.
- Allow healthcare workers with confirmed COVID-19 infection to provide direct care only for residents with confirmed COVID-19 infection, preferably in a cohort setting.
- Allow healthcare workers with confirmed COVID-19 infection to provide direct care for residents with suspected COVID-19 infection.
- As a last resort, allow asymptomatic healthcare workers with confirmed COVID-19 infection to provide direct care for patients without suspected or confirmed COVID-19 infection.

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.

Definitions

Mild 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.[4]

Moderate Illness: 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.[4]

Severe 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%.[4]

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.[4]

Severely Immunocompromised: Individuals who suffer from conditions, such as chemotherapy for cancer, being within one 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 healthcare personnel work restrictions.

Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunodeficiency and not clearly affect occupational health actions to prevent disease transmission.[4]

Appendix A

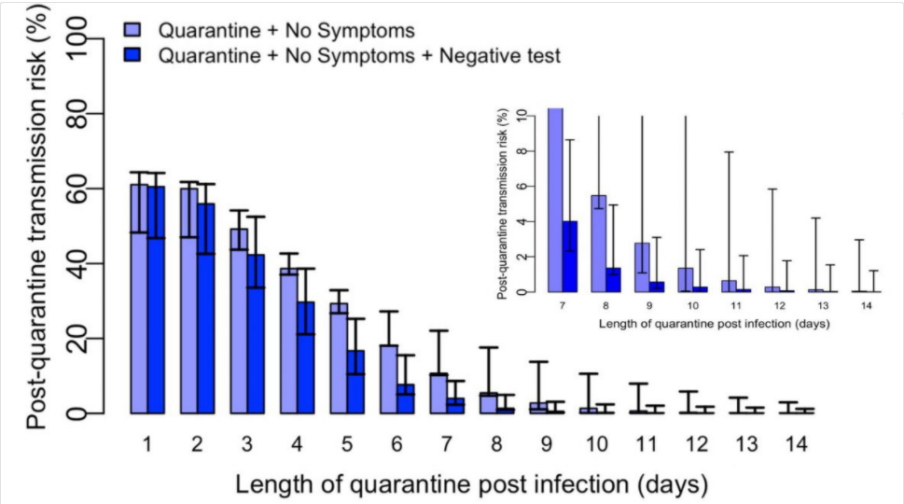

Figure. Modeled estimates of post-quarantine transmission risk quarantine duration. The light blue bars indicate the daily post-quarantine transmission risk if there is no clinical evidence of COVID-19 elicited during daily symptom monitoring. The dark blue bars indicate the post-quarantine transmission risk with the addition of a negative RT-PCR result from a specimen collected 24-48 hours prior.

~This model from the Centers for Disease Control and Prevention (CDC) estimates what occurs in a person who was infected in terms of how likely the person would be to infect others if quarantine was discontinued.[2]

References

[1]CDC. Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.

[2]CDC. Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing. https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-options-to-reduce-quarantine.html.

[3]CDC. Strategies to Mitigate Healthcare Personnel Staffing Shortages. https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html.

[4]CDC. Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance). https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html.

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