UTAH DEPARTMENT OF HEALTH

Preparing to Care for Residents with COVID-19 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 developing protocols for isolation as well as maintaining supplies of personal protective equipment (PPE), educating staff on proper PPE use and disposal, as well as ensuring adequate cleaning and disinfecting practices are in place. This guidance includes information on 1) establishing an infection prevention and control program; 2) maintaining an inventory of PPE; 3) correct use and disposal of PPE; 4) establishing an OSHA/NIOSH respiratory protection program; and 5) creating a COVID-19 isolation unit.

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 one 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 one 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.
- Request an Infection Control Assessment and Response (ICAR) from HAI or your local health department.
- CDC has created an online training course that can orient individuals to this role in nursing homes.

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.
- Requirements for different PPE depend on a variety of factors including community prevalence of SARS-CoV-2, procedure being performed, and whether a person is in isolation or quarantine.
    - Utilize this PPE table to help identify what is necessary in different scenarios.
    - 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.
- Identify health department contacts for getting assistance with PPE supplies as needed.
- 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 SARS-CoV-2 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 N-95 mask available at the facility.
    - Staff should be aware of the model and size of N95 for which they are fit-tested.
- Ensure 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. 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 ensure 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 90 days.

Residents with close contact to a person infected with COVID-19

- Residents who are up to date on COVID-19 vaccination do NOT need to quarantine following close contact with a person infected with SARS-CoV-2.
- Residents who are not up to date on vaccination, regardless of prior vaccination, should quarantine for 10 days (7 days with a negative test on days 5-7) following close contact with an individual infected with SARS-CoV-2.
- Patients should be quarantined in a private room with its own bathroom.
- Staff caring for patients under quarantine should wear a fit-tested N95 mask or higher-level respirator, gown, gloves, and eye protection.

Residents with suspected COVID-19 infection or persons under investigation (PUI)

- Residents who are suspected to have COVID-19, regardless of vaccination status, should isolate in a private room and be placed on contact/droplet precautions until infectious status has been determined.
- Residents should not be transferred to a dedicated COVID-19 area or unit until infectious status has been determined. Refer to the testing algorithm to assist in the determination or confirmation of infection.

Residents with confirmed COVID-19

- Place residents with confirmed COVID-19, regardless of vaccination status, in the dedicated COVID-19 isolation area and place on contact/droplet precautions.
- Restrict residents in isolation from transferring from or to another facility until 24 hours after fever resolves and symptoms improve, unless transfer is needed for medical care or to ensure isolation from other residents.

    - If transfer is required, the facility should clearly communicate the resident's infection status to the accepting healthcare facility prior to transfer. Use the Infection Control Transfer Form to assist with this process.
- Residents with confirmed COVID-19 may go home with family during their isolation period.
    - Educate the resident's family on the risk of COVID-19 transmission before transferring the patient home.

Dedicated patient care staff

- Enlist a dedicated staff team to care only for patients in the isolation area.
- Limit movement of designated staff between different parts of the facility to decrease the risk of staff spreading COVID-19 to other parts of the facility.
- If a dedicated team is not possible, prioritize staff who are fully vaccinated or have fully recovered from COVID-19 in the last 90 days.
- Consult CDC guidance for strategies to mitigate staffing shortages.

Dedicated medical equipment

- Maintain an adequate supply of medical equipment that is dedicated to the isolation area (Hoyer lifts, medication/treatment carts, monitoring equipment).
- If dedicated medical equipment for COVID-19 positive residents is not possible, ensure proper disinfection of shared medical equipment using cleaning and disinfecting agents from the EPA N List.

Environmental cleaning/disinfection

- Establish staff responsibilities and a schedule for cleaning and disinfecting patient care areas, equipment, frequently touched surfaces, and common areas with cleaning agents from the EPA N List.
- Develop an auditing tool for monitoring and assessing cleaning/disinfection practices.
- Establish plans for collection of trash and soiled linen, along with a process for the delivery of clean linen, dietary services, medication pass, and supplies.

Definitions

Close Contact: A cumulative time period of 15 minutes or more in a 24-hour period within six 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.

Up to date on vaccination: means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.