
COVID-19 Prevention and Response in Long-Term Care

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OREGON Public Health Division

Thank you for joining us today

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Goals

- Introduce process for public health outreach to long-term care facilities in Oregon
 - COVID-19-specific guidance for skilled nursing facilities, assisted living facilities, and memory care centers
- Review infection prevention and control recommendations for COVID-19
- Review recommendations for COVID-19 outbreak response
- Answer questions and provide consultations

Epidemiology update

- As of 4/9/20, 1,321 cases and 44 deaths in Oregon
- Long-term care facilities (LTCFs) are at high risk for poor outcomes related to COVID-19 (congregate settings, high-risk individuals).
 - 28 (4%) LTCFs currently reporting confirmed COVID-19 among residents or healthcare personnel (HCP). Many more facilities are testing suspect cases. See [DHS website](#) for details.
- High-risk of COVID spread in LTCF if strict infection control measures are not taken.
 - Washington Department of Health [report](#) from a LTCF outbreak early in the epidemic documented high levels of transmission among residents, HCP, and visitors.

Transmission of COVID-19

- According to current evidence, COVID-19 virus is transmitted between people primarily through respiratory droplets and contact
 - Close enough contact that viral droplets from coughing or sneezing could enter the mucous membranes (eyes, nose, mouth)
 - Contact with contaminated objects or surfaces and touching of the eyes, nose, or mouth
- Airborne transmission of COVID-19 has not been documented to date and is not believed to be a major driver of transmission, but possible that it could occur when aerosol-generating procedures are conducted.
 - CDC information about aerosol-generating procedures:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#take_precautions
 - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html>

Key opportunities for facility-led prevention and response

- Tried and true infection prevention and control strategies are effective against COVID-19, including
 - Hand hygiene
 - Avoiding touching your face
 - Wearing appropriate personal protective equipment (PPE)
 - Screening HCP, residents, and visitors
 - Cleaning and disinfection
- Facilities already have experience and expertise implementing these measures

Assessing your facility's readiness

- Visitor restrictions
- HCP screening
- Resident screening
- PPE and other needed supplies
- Environmental infection control
- Cohorting and HCP/resident movement
- Communication and education
- Hand hygiene

Visitor restrictions

- Notify families of residents of visitor restriction policy and post signage at entrances
- Limit access points and screen all visitors
- Establish exceptions to visitor restrictions (e.g., end-of-life scenarios)
 - Healthy visitors must wear a facemask and stay in designated location
 - Visitors with fever, cough, or shortness of breath must be restricted
 - Visitors perform hand hygiene and visiting areas disinfected immediately after use
 - Visitors self-monitor for 14 days after visit
 - Visits are scheduled in advance for designated period of time
- Provide alternative (e.g., remote) opportunities for visitation

Healthcare personnel (HCP) screening

- Restrict all non-essential HCP including volunteers, barbers, etc.
- Keep a list of symptomatic HCP, including date of onset and date(s) worked while symptomatic
- Screen all HCP at the start of each shift
 - Fever (measured temperature >100.0 using thermometers) – *only 44% of individuals present with a fever*
 - Respiratory symptoms (cough, sore throat, shortness of breath). Consider using broader definition (include nonspecific symptoms like fatigue, dizziness, diarrhea, malaise)

Healthcare personnel (HCP) screening

- Ill HCP should not come to work. HCP developing symptoms at work should be immediately masked and sent home
 - Return when at least 3 days (72 hours) have passed *since recovery* (defined as resolution of cough and fever without the use of fever-reducing medications)
- HCP returning to work after illness should
 - Wear a facemask at all times while in the healthcare facility until 14 days after illness onset
 - Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
 - Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
 - Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Resident screening

- Keep a list of symptomatic residents, including date of onset, list of symptoms, and date placed on precautions
- Screen residents on admission and each day
 - Fever (measured temperature >100.0 using thermometers) – *only 44% of individuals present with a fever*
 - Respiratory symptoms (cough, sore throat, shortness of breath). Consider using broader definition (include nonspecific symptoms like fatigue, dizziness, diarrhea, malaise)
 - Use objective signs for residents, particularly where communication is challenged: temperature, O2 saturation, respiratory rate
 - Assess change from baseline status where possible
- Isolate symptomatic residents appropriately
 - HCP must wear appropriate PPE when interacting with them

Personal protective equipment (PPE)

- Use PPE to protect eyes, nose, and mouth and to prevent contamination of clothing and hands
- Minimum PPE for care of residents with respiratory illness (suspect or known COVID-19) includes
 - Gown
 - Gloves
 - N95 respirators or masks
 - Eye protection (goggles or face shields)
- Ensure PPE available in all resident care areas
- Assess current supply of PPE
 - If shortages are identified or anticipated, make requests through healthcare partnerships, corporate owners, or local public health authority (LPHA)

Personal protective equipment (PPE)

- Train HCP to don and doff PPE correctly using posters, signage, just-in-time training, or observation/buddy system
- Develop plan to implement PPE optimization strategies (e.g., reserve N95s for essential aerosol-generating procedures)
- When COVID-19 is identified in the facility or when there is sustained transmission in the community, consider implementing all recommended PPE for HCP for the care of all residents regardless of symptoms as supplies allow.
- As tolerated, residents who leave the facility regularly for care should wear masks when outside of their rooms

Putting on (donning) PPE

- Identify and gather the proper PPE to don
- Perform hand hygiene using alcohol-based hand rub
- Put on isolation gown and tie all ties (assistance is helpful)
- Put on N95 or mask
 - Fit nosepieces to the nose with both hands, do not pinch, bend, or tent
 - Ensure it extends under the chin and protects both nose and mouth
 - Do not wear under the chin or put in pockets
 - Top straps/ties should be secured/placed on crown of head and bottom straps/ties at base of neck. If loops are used in place of ties, hook them around your ears. If using N95, perform a seal check every time
- Put on face shield or goggles
- Perform hand hygiene
- Put on gloves (should cover the cuff/wrist of gown)
- Enter the patient room

Taking off (doffing) PPE

- Remove gloves avoiding additional contamination of hands
- Remove gown, gently undoing or breaking all closures.
 - Reach up to shoulders and carefully pull down and away from body
 - Place immediately in laundry or trash receptacle
- Exit patient room
- Perform hand hygiene
- Remove face shield or goggles by pulling the strap upwards and away from head. Do not touch front of face shield or goggles
- Remove and discard N95 respirator or face mask
 - Mask: Carefully untie or unhook from ears and pull away from face without touching front of mask
 - Respirator: Grasp bottom strap only and bring carefully over head. Grasp top strap and bring carefully over the head. Pull respirator away from face without touching front of respirator
- Perform hand hygiene

Other needed supplies

- Ensure hand hygiene supplies available in all resident care areas, including alcohol-based hand rubs, paper towels, soap, warm water, accessible sinks
- Assess current supply of alcohol-based hand rubs, disinfectants, tissues, testing supplies (swabs, transport media, and items for transport)
 - If shortages are identified or anticipated, make requests through healthcare partnerships, corporate owners, or LPHA
- Ensure tissues are available for respiratory hygiene/cough etiquette and are used only once before discarding

Environmental infection prevention

- Use appropriate EPA-registered, hospital-grade disinfectants with a claim against COVID-19
 - EPA List N: <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>
 - Ensure contact time is achieved (may be up to 10 minutes)
- Prepare, label, store, and use EPA-registered disinfectants in accordance with instructions
- Clean and disinfect non-dedicated, non-disposable resident-care equipment after each use (hygiene, medical, recreational)
- Enhance schedules and protocols for disinfection of entire facility including resident rooms, common areas/breakrooms, high-touch surfaces, nursing stations, and medical equipment

Cohorting and HCP/resident movement

- Cancel group activities and communal dining
- Create plans and protocols for
 - Closing units or the facility to new admissions
 - Cohorting ill residents and dedicating HCP to their care
- When COVID-19 is identified in the facility or there is sustained community transmission:
 - Restrict residents to rooms except when medically necessary
 - Residents outside of rooms should wear a facemask, perform hand hygiene, limit movement, and practice social distancing
 - Implement protocols for cohorting residents and dedicating HCP to their care

Communication and education

- Educate residents about COVID-19 symptoms and mode of transmission, self-monitoring and how to report, how to protect themselves, and what the facility is doing to keep them safe
- Educate HCP about COVID-19 symptoms and modes of transmission
- Train HCP regarding new and existing infection prevention and control measures and processes (e.g., collecting specimens, doffing PPE, using new disinfectants)
 - Observation
 - Audits

Communication and education

- Notify other facilities and medical transport
 - Communicate information about known or suspected COVID-19 cases in residents before transfer as needed (e.g. transport personnel, receiving facility)
- Notify your LPHA in the following situations:
 - COVID-19 is suspected or confirmed in a resident or staff
 - A resident has a severe, acute respiratory infection *leading to death or requiring hospitalization*
 - Two (2) or more new-onset respiratory symptoms among residents or staff

Hand hygiene

- Soap and water handwashing
 - **Wet** your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
 - **Lather** your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
 - **Scrub** your hands for at least 20 seconds. Need a timer? Hum the “Happy Birthday” song from beginning to end twice.
 - **Rinse** your hands well under clean, running water.
 - **Dry** your hands using a clean towel or air dry them.
- Use alcohol-based hand sanitizer if soap and water is not available
 - Apply the gel product to the palm of one hand (read the label to learn the correct amount).
 - Rub your hands together.
 - Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds.

COVID-19 outbreak response

- Frequent and thorough screening of residents and HCP is the best way to identify new cases and outbreaks as soon as possible
- Once this has occurred it is crucial to
 - Act quickly
 - Implement all recommended interventions as soon as possible
 - Consider all respiratory illness to be COVID-19 unless testing or other information indicate otherwise
- A single case of acute respiratory illness in HCP or residents should prompt action
 - Review resident and HCP illness logs regularly to ensure new onsets trigger action

Known or suspect COVID-19 outbreaks

(more details in following slides)

- Communication
- Testing
- Active surveillance
- PPE
- Respiratory etiquette
- Hand hygiene
- Bundle care
- Cohort residents and HCP
- Cleaning and disinfection
- Resident admissions

Challenges in COVID-19 outbreaks

- Long incubation periods (up to 14 days) mean new cases will likely arise even after an intervention has been implemented - *this does not represent a failure of the intervention*
- Multiple modes of transmission (droplet and contact) mean that there are many infection control interventions to implement
- Variations in clinical presentation (including mild and asymptomatic infections) make screening and isolation challenging
- These challenges make it necessary to implement additional infection control measures for COVID-19 outbreaks immediately

Outbreak response: Communication

- Notify LPHA
 - Start of outbreak
 - Report new known or suspected cases on a daily basis
- Notify HCP, volunteers, residents, and families
- Post signage at facility entrances, outside affected units, and outside resident rooms
- If a resident's medical condition requires transfer, ensure that interfacility communication takes place and that the receiving facility and emergency transport are notified in advance so they can take appropriate steps to transport and receive the resident safely

Outbreak response: Testing

- If the cause of respiratory illness is unknown prioritize testing for COVID-19 and consider testing for other respiratory viruses
- Train HCP to collect specimens safely, including donning/doffing appropriate PPE during specimen collection (gloves, gown, respirator/mask and eye protection)
- Maintain an adequate supply of testing materials
- Determine where you will send specimens for testing
 - First five specimens can be tested at OSPHL for rapid identification
 - Subsequent tests may be sent to commercial labs at the provider's discretion

Outbreak response: Active surveillance

- New cases must be identified rapidly so they can be managed appropriately
- Aggressively screen all residents, HCP, and visitors at least daily (for asymptomatic residents) and at the start of each shift (for HCP)
 - Screening for residents should include clinical symptoms, changes from baseline status, and objective measures

Outbreak response: PPE

- Ensure availability of respirators/masks, gowns, gloves, and eye protection
 - Monitor stocks and re-order as needed
 - Contact healthcare partners or LPHA if needed
- Prioritize N95 masks for potential aerosol-generating procedures
- Train HCP to don, doff, and dispose of PPE properly
 - Avoids self-inoculation and wastage of supplies
- PPE must be worn when
 - Interacting with residents with undiagnosed respiratory illness or with confirmed COVID-19
 - Collecting specimens for testing
- Mask ill residents if they require transfer

Outbreak response: Respiratory etiquette

- Ensure followed by all residents. Those with signs/symptoms of a respiratory infection should
 - If necessary to leave room, resident should wear facemask if tolerated
 - Cough/sneeze into elbow
 - Cover nose and mouth with tissue when coughing/sneezing, dispose of the tissue in the nearest waste receptacle, and perform hand hygiene
- Ensure materials for respiratory etiquette are available throughout the facility, including tissue and no-touch waste receptacles

Outbreak response: Hand hygiene

- Ensure materials for hand hygiene are available throughout the facility
 - Alcohol-based hand rub (AHBR) containing least 60% alcohol
 - Soap
 - Disposable paper towels
 - Accessible sinks supplied with warm water

Outbreak response: Bundle care

- Bundle care to preserve PPE and reduce contact between ill and asymptomatic individuals
- Limit room entry to HCP needed for resident medical care (e.g., have HCP caring for the resident provide all clinical care, bring in meals, and wipe down high-touch surfaces)
- Limit the degree to which HCP interact with multiple residents.
- If HCP provide essential services to multiple residents (e.g., wound care)
 - Bring only minimal items into resident rooms; leave supply carts in the hall
 - Screen these HCP daily and implement PPE and frequent hand hygiene

Outbreak response: Cohort residents and HCP

- Group ill residents together and keep apart from others
 - Assign to single-resident rooms with private bathrooms
 - If no private bathrooms available, consider commodes and bed baths
 - If multiple residents are lab-confirmed cases with the same organism, can room together or place in units/rooms close to one another
 - Do not transfer ill residents or contacts of known cases to unaffected units
 - Restrict ill residents to rooms. If they must leave, have them wear a mask or cover mouth and nose with tissue

Outbreak response: Cohort residents and HCP

- Dedicate specific HCP to treat residents with the same infection
- Discontinue floating of HCP between affected and unaffected units, facilities, or residents
- Discontinue group activities, including communal dining
- During an outbreak caused by confirmed COVID-19, restrict all residents to rooms and practice social distancing
- Develop plans for where your facility will
 - Place residents with confirmed COVID-19
 - Place symptomatic residents who are awaiting testing or will not be tested (suspect COVID-19)

Outbreak response: Cleaning and disinfection

- Enhance cleaning and disinfection already taking place
 - Focus on high-touch surfaces (railings, door handles, nursing station areas, mobile computer stations, phones, light switches)
- Ensure that an appropriate disinfectant is being used and that the correct contact time is achieved

Outbreak response: Resident admissions

- If COVID-19 has been confirmed in two or more individuals (any combination of residents and HCP), close the facility to new admissions, and stop non-essential transfers. This should remain in effect until the LPHA and DHS have approved lifting of these restrictions.
- In consultation with DHS and the LPHA, develop an infection control plan to prepare for readmission of clinically stable residents with COVID-19 after discharge from the hospital setting
 - LTCFs can accept a resident diagnosed with COVID-19 that still requires the use of PPE as long as the facility can follow relevant guidance (e.g., has sufficient PPE to care for this resident)

Conserving PPE

- PPE helps prevent spread of infection between residents and HCP
- Shortages of PPE may impact your facility's ability to purchase adequate supplies and adhere to PPE recommendations
- PPE can easily become contaminated and is often worn near mucous membranes which it is meant to protect
- Major strategies of conserving PPE include
 - Limiting use
 - Reprocessing
 - Extended use (without removing or touching between resident encounters)
 - Limited reuse

Conserving PPE: Limiting use

- Dedicate PPE in short supply to highest-priority needs (e.g., N95s for essential aerosol-generating procedures, to treat confirmed cases of COVID-19)
- Delay non-essential care and procedures
- Bundle care
 - Limit resident room entry to only essential HCP
 - Limit the number of HCP entering a resident room

Conserving PPE: Reprocessing

- Use PPE that can be cleaned, disinfected, or sanitized
 - Washable gowns
 - Goggles and face shields that can be disinfected
 - Powered air-purifying respirators (PAPRs)
- Follow guidance for reprocessing in the manufacturer's guidelines
- There are currently no widely-accepted procedures for reprocessing N95 respirators or procedure masks

Conserving PPE: Extended use

- Wear the same PPE (particularly eye protection and N95 respirators or masks) by one HCP for repeated encounters with several residents without removing or touching it between resident encounters
- Use for multiple residents cohorted together with the same infectious disease diagnosis (e.g., confirmed COVID-19)
- Extended use of a face shield can prolong the use of the underlying mask as the shield protects the mask to some degree from surface contamination

Conserving PPE: Limited reuse

- Wear the same N95 respirator or mask and/or eye protection (goggles or face shield) by one HCP for multiple encounters for different residents, removing it and replacing it periodically
- Consider only in crisis levels of PPE shortages
 - Limited reuse involves touching potentially contaminated PPE and may pose a risk of self-inoculation for HCP
 - Care must be taken when donning, doffing, and storing PPE that is being reused

Staffing challenges

- Many facilities are seeing staffing levels impacted by turnover and work restrictions
- Urgent staffing challenges should be discussed with your local public health authority
- High levels of stress have been reported among HCP exposed to COVID-19. Educate HCP about mental health and self-care resources including:
 - [CDC Guidance for Stress and Coping](#)
 - [Disaster Distress Helpline](#)
 - [American Medical Association Managing Mental Health During COVID-19](#)
 - [American Psychiatric Nurses Association Guidance for Managing Stress and Self-Care](#)

OHA LTCF Toolkit

- [OHA: LTCF Response Toolkit](#)
 - About COVID-19
 - LTCF Infection Prevention Readiness Assessment Tool
 - LTCF COVID-19 Outbreak Response Tool
 - Strategies for PPE Conservation During COVID-19 Pandemic

 - LPHA Numbers in Oregon
 - Visitor Restriction Signage
 - Facility Entry Log
 - COVID-19 Illness Case Log
 - Links to Important Resources
- Expected updates: New FAQ section

Resources for LTCFs

- [CDC: Strategies to Prevent the Spread of COVID-19 in LTCFs](#)
 - Additional, more detailed guidance to build on OHA toolkit
- [OHA: Provisional Guidance: Clinical Care and Healthcare Infection Prevention and Control for COVID-19](#)
 - Additional, more detailed guidance by facility type covering:
 - Visitor policies
 - HCP monitoring, work exclusions, and return-to-work
- [CMS March 23, 2020 Announcement](#)
 - Symptom screening for all
 - PPE use
 - Designation of physical locations and staffing to care for suspect and known COVID-19

Infection Control Outreach

- The OHA Healthcare-Associated Infections Program, in collaboration with local county health departments, Department of Human Services and CDC, is providing infection control assessment and consultations to LTCFs in our state.
- Providing infection control consultations to priority LTCFs
 - Presence of outbreaks
 - Geographic “hot spots”
 - Facility infection control capacity
- Goal is not to add work but to support prevention and response activities
- If you would like to request an urgent telephone-based infection control assessment, please contact Rebecca Pierce at rebecca.a.pierce@dhsoha.state.or.us with subject line “Infection Control Assessment Request”

Who's Who for COVID-19 response

- Local Public Health Authority: disease investigation including monitoring the situation in the county, investigating cases, tracking outbreaks and using data to inform the response. **Suspect or confirmed COVID-19 should be reported to your LPHA.**
- Oregon Health Authority: In collaboration with LPHAs, conduct case and outbreak investigations, provide guidance to contain disease spread, and monitor the course of the outbreak to ensure containment measures are effective.
- Department of Human Services (Safety, Oversight, & Quality): Assist licensed health facilities with state and federal resources, guidance and support. SOQ provides daily COVID 19 response and guidance to LTCFs. In coordination with OHA, surveyors will be reaching out to facilities to complete an infection control assessment and provide guidance as needed. **Suspect or confirmed COVID-19 should be reported to DHS.**

Who's Who for COVID-19 response (cont.)

- Oregon Health Care Association (OHCA): association represents more than 1,000 organizations and 90 percent of licensed long term care providers in the state, including skilled nursing, assisted living, residential care, and memory care communities as well as licensed in-home care agencies and independent senior housing. OHCA is working to coordinate efforts with OHA and the DHS related to preventing, containing, and managing COVID-19. OHCA is also supported by its national affiliates, the American Health Care Association/National Center for Assisted Living, and Argentum.
- LeadingAge Oregon: statewide association of not-for-profit and other mission-directed organizations dedicated to advancing quality aging services in Oregon. COVID-19 actions include daily communication of the latest state/federal guidance, reliable resources and tools, creating virtual communities for sharing of resources/best practices, Q&A, seeking regulatory relief and responding to requests for assistance. Members include federally subsidized housing for low-income seniors, nursing homes, residential care, assisted living, continuing care retirement communities, home care agencies, adult day services and other community service providers.

Frequently Requested COVID-19 Resources

(Enter) DEPARTMENT (ALL CAPS)
(Enter) Division or Office (Mixed Case)

Donning and Doffing PPE Resources

- [NETEC: Personal Protective Equipment for COVID-19](#) (training video)
- [CDC: Protecting Healthcare Personnel](#)
 - PPE donning and doffing posters/training materials
- [CDC COVID-19: Use of Personal Protective Equipment](#)
 - COVID-19 specific PPE resources

Safe Use of N95 respirators

- OR-OSHA resources for COVID-19
 - Facilities with respiratory protection programs: <https://www.osha.gov/memos/2020-04-08/expanded-temporary-enforcement-guidance-respiratory-protection-fit-testing-n95>
 - Voluntary use of respirators: <https://osha.oregon.gov/OSHAPubs/factsheets/fs05.pdf>
 - OR-OSHA provides free and confidential consultation services and are currently prioritizing COVID-19 calls: <https://osha.oregon.gov/consult/Pages/index.aspx>
- A seal check should be performed each time an N95 mask is donned.
 - OSHA training video: <https://www.youtube.com/watch?v=pGXiUyAoEd8>
- Note: if masks are being re-used, the surface of the mask may become contaminated, care should be taken when donning the mask or when performing a user-seal check to avoid contaminating hands or face. A clean pair of gloves should be used to don mask and conduct seal check and should be removed after completion and followed by hand hygiene.

Personal Protective Equipment Optimization

- [Oregon Guidance for Healthcare Personnel on Use of Personal Protective Equipment in Resource Constrained Settings](#)
 - Tiered system for implementing PPE conservation and contingency strategies
- [CDC Strategies to Optimize the Supply of PPE and Equipment](#)
 - Contains strategies for all elements of PPE necessary for care of residents with suspect and confirmed COVID-19
- Supplies should be carefully monitored and shortages that could interrupt safe care of residents with suspect or confirmed COVID-19 should be reported to your local public health authority.
 - For questions regarding ongoing challenges related to PPE, consider requesting urgent infection control assessment with our team (previous slide)
 - See ‘Managing PPE Supply Issues’ in [OHA Clinical and Infection Control Guidance](#).

Discontinuation of transmission-based precautions for residents with COVID-19

Recommendations (adapted from CDC Guidance):

- *Test-based strategy (preferred)*
 - Resolution of fever without the use of fever-reducing medications **and**
 - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
 - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart
- *Non-test-based strategy (if testing not readily available)*
 - At least 3 days (72 hours) have passed *since resolution of respiratory symptoms (cough, shortness of breath) and fever without the use of fever-reducing medications*; **and**,
 - At least **14 days** *since symptoms first appeared**

**As consistent with CDC guidance, this extends the typical period of isolation due to the vulnerable resident population*

Frequently Asked Questions