

Recommendations for Responding to Long Term Care Facility Outbreaks of Coronavirus Disease 2019 (COVID-19) August 3, 2020

Background

The New Hampshire Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS) COVID-19 Cluster Investigation team will work closely with you if COVID-19 is identified in your facility. This guidance is intended to assist long term care facilities to respond to outbreaks of COVID-19. This guidance supplements but does not replace recommendations included in New Hampshire's [Guidance for Long Term Care Facilities](#).

All facilities should adhere to current CDC [infection prevention and control recommendations](#), including universal source control measures; visitor restrictions; communal dining and group activity restrictions; screening of residents and staff; and [promptly notifying the health department](#) about any suspected/confirmed COVID-19 or cluster of new-onset respiratory symptoms among staff or residents.

Immediate Actions

Policies and Procedures

- Cancel communal dining and all group activities, such as internal and external group activities.
- Close the affected unit(s) to new admissions. Current residents should be accepted back into the facility if they leave to receive care.
 - If disease transmission to other units/floors/wings occurs, BIDC will advise whether all admissions to the facility should be restricted.
- Cancel all visitation. Any facility visitors allowed in for compassionate circumstances should wear a surgical facemask and be screened before entering the facility.
- All staff are required to wear a surgical facemask while in the facility. This includes healthcare personnel, administrative staff, environmental service workers, and any other individual entering the facility.
- Notify staff, residents, and families [promptly \(within 12 hours\) notify HCP, residents, and families about identification of COVID-19 in the facility](#)
- Reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning).
- See CDC Guidance for "[Responding to COVID-19 Outbreaks in Nursing Homes](#)".

Isolation, Quarantine & Resident Movement

- A resident with new-onset suspected or confirmed COVID-19 should be isolated and cared for using [all recommended COVID-19 PPE](#). Place the resident in a single room with a private bathroom if possible pending results of COVID-19 test.
- If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.

- If any resident is suspected or confirmed to have COVID-19, staff should use [all recommended COVID-19 PPE](#) for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents.
- If a staff member worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset, then the facility should:
 - Prioritize these staff for COVID-19 testing. Exclude staff with COVID-19 from work until they have met all [return to work criteria](#).
 - Determine which residents received direct care from and which staff had unprotected exposure to the staff member who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset.
 - Residents who were cared for by these staff should be restricted to their room and be cared for using [all recommended COVID-19 PPE](#) until results of HCP COVID-19 testing are known. If the staff member is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
 - Exposed staff should be [assessed for risk and need for work exclusion](#).
- Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).
 - Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.
- Restrict all residents to their own rooms. If a resident must leave their room, they should wear a facemask, perform hand hygiene, and limit their movement in the facility
- In the event an ill resident must leave the facility, notify transport personnel and the receiving facility about the suspected diagnosis prior to transfer. Place a facemask on the ill resident if tolerated.

Transmission Based Precautions & Personal Protective Equipment (PPE)

- Follow CDC's COVID-19 infection prevention and control [recommendations](#), which include information on recommended personal protective equipment (PPE). We recommend the following for healthcare personnel:
 - For management of persons under evaluation for COVID-19, or persons confirmed with COVID-19, providers should wear gown, gloves, eye protection (face shield or goggle), and a surgical facemask or N95 or higher-level respirator as outlined below.
 - For evaluation of patients with suspect COVID-19, including for sample collection for COVID-19 testing, we recommend surgical face masks for healthcare provider protection in addition to other recommended PPE. There is no current laboratory or epidemiologic evidence that COVID-19 is routinely spread through airborne routes of transmission.
 - If available, consider using an N95 or higher-level respirator when evaluating patients with confirmed COVID-19, or for symptomatic suspect patients who may be at higher risk of aerosolizing respiratory droplets (e.g., patients with significant frequent coughing, sneezing, etc.).
- During an outbreak, personnel should use all recommended PPE for the care of all residents in affected areas (or facility); this includes both symptomatic and asymptomatic residents.
- If PPE shortages exist, implement [strategies to optimize PPE supply](#) on the unit, such as:
 - Bundle care activities to minimize the number of HCP entries into a room.

- Consider extended use of respirators (or facemasks if respirators are not available), eye protection, and gowns. Limited reuse of PPE may also be considered.
- [Consider prioritizing gown use](#) for high-contact resident care activities and activities where splash or spray exposures are anticipated.
- Ensure that staff have been trained on infection prevention measures, including the use of and steps to properly [put on and remove recommended personal protective equipment](#) (PPE).
- Monitor hand hygiene and PPE use in affected areas.
- Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions and DPHS has closed the outbreak.

Cohorting & Establishing a Dedicated COVID-19 Care Unit

- Residents with confirmed or suspected COVID-19 should be roomed in cohorts with dedicated healthcare personnel.
- Determine the location of the COVID-19 care unit and create a staffing plan before residents or staff with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify staff to work on this unit.
 - Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected).
- Ideally the COVID-19 care unit should be physically separated from other rooms or units housing residents without confirmed COVID-19. This depends on facility capacity (e.g., staffing, supplies) to care for affected residents. The COVID-19 care unit could be a separate floor, wing, or cluster of rooms.
 - Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit).
 - If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission
- Dedicate personnel to work only on affected units and do not float personnel. If possible, do not use personnel who work in multiple institutional settings. This practice has been a significant contributing cause of introduction and spread of viruses within long-term care settings.
 - At a minimum dedicated staff should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. Staff working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
 - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
 - Assign environmental services (EVS) staff to work only on the unit.
 - If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to [mitigate staffing shortages](#), restrict their access to the unit. Also, assign HCP dedicated to the COVID-19 care unit (e.g., NAs) to perform cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from [List N](#) into the room and wipe down high touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.

- Place signage at the entrance to the COVID-19 care unit that instructs staff to wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms.
- Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.

Hand Hygiene, Social Distancing & Environmental Decontamination

- Remind residents and staff to practice social distancing (maintain a distance of at least 6 feet from each other) and perform frequent hand hygiene.
 - Ensure staff practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break).
- The infection control practitioner should review proper hand hygiene with residents and staff
- Conduct frequent environmental cleaning and disinfection, including of shared medical equipment like vital sign machines.
 - Healthcare facilities should make sure that EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. Refer to [list N](#) for disinfectants that are effective against SARS-CoV-2.
- Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
- Maximize facility ventilation by opening windows as appropriate.

Screening Residents & Staff

- Screen all residents at least three times daily (e.g., on every shift) and include assessment of symptoms, vital signs, and pulse oximetry.
 - Include temperature, heart rate, blood pressure (as needed), and oxygen saturation. For ill residents, include respiratory exam.
 - Look to identify residents with a temp ≥ 100.0 F or repeated low-grade temps (>99 F) or symptoms.
- Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. In residents with impaired baseline cognitive functioning, symptom history may not be able to be reliably obtained, hence the need for more frequent vital sign and temperature checks.
- Maintain a line list of all residents and staff who are ill, illness onset dates, and symptoms
- Vital sign equipment should be cleaned and disinfected between each patient.
- Educate staff about the potential for rapid clinical deterioration in residents with COVID-19
- [Screen all personnel](#) at the beginning of their shift and take their temperature.
 - Immediately send home any personnel who are symptomatic or have a temperature ≥ 100.0 F and prioritize for testing.
 - Addition of a second mid-shift symptom check should be considered.
 - For return to work criteria, utilize CDC's symptom based strategy outlined in their return to work [guidelines](#) for healthcare personnel.

Testing Residents and Staff

- If one resident tests positive for COVID-19, place the entire unit on full droplet precautions, and work with DHHS to coordinate testing and cohorting for staff and other residents in the unit/facility
 - Submit laboratory testing for confirmation of organism identification. The Public Health Lab will do COVID-19 testing without cost to the facility.
- After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and [HCP](#) and that transmission has been terminated as described below. Repeat testing should be coordinated with NH DHHS.
- Continue repeat viral testing of all previously negative residents, generally every 7 days, until the testing identifies no new cases of COVID-19 among residents or [HCP](#) for a period of at least 14 days since the most recent positive result. This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.
- Outbreaks are closed by the DPHS team after 14 days have passed without new cases and 14 days have passed since the last date of exposure at the facility, whichever is longer.
- For additional information on testing in response to COVID-19 in nursing homes please refer to [Considerations for Use of Test-Based Strategies for Preventing SARS-CoV-2 Transmission in Nursing Homes](#).

Coordinate with the Cluster Investigation Unit

Please prepare the following for the COVID-19 Cluster Investigation Unit:

1. A current list of all ill residents and staff using the attached COVID-19 case line list. (Include the total number of staff and residents at your facility).
2. A daily update of all newly ill residents and staff using the line list form. Separate list for staff vs. residents. The line list should reflect new symptoms, resolution of symptoms, hospitalizations, or deaths.
3. A facility floor plan that includes all units/wings/floors.

This data should be sent using encryption to protect privacy and confidentiality. In order to ensure encryption, DHHS will provide you with instructions via email.