

Recommendations for Long-Term Care Facilities during COVID-19 Pandemic



The New Jersey Department of Health (NJDOH) has developed this guidance to assist long term and residential care facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. Given the congregate nature of long-term care facilities (LTCF) and residents served (e.g., older adults often with underlying chronic medical conditions), this population is at an increased risk of serious illness when infected with COVID-19. LTCF have experience managing respiratory infections and outbreaks among residents and healthcare personnel (HCP¹) and should apply those outbreak management principles, in addition to heightened measures within, to COVID-19. **Please note this is a rapidly evolving situation and as more data become available this guidance may change.** Additional resources on how LTCF can prepare for and manage COVID-19 can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>.

Identify Plan and Resources

Review and update your CMS “all -hazards emergency preparedness program and plan” which includes emergent infectious diseases.

- If you do not have a plan, a template can be found at https://www.ahcancal.org/facility_operations/disaster_planning/Documents/EID_Sample_Policy.pdf.
- Review CDC’s COVID-19 Preparedness Checklist for Nursing Homes and other LTCF at https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf.
- Review OSHA’s [Guidance on Preparing Workplaces for COVID-19](#).

Identify public health and professional resources.

- Locate a local health department contact using the NJDOH – Local Public Health Directory at <http://www.localhealth.nj.gov/>.
- Contact NJDOH at https://www.nj.gov/health/cd/topics/covid2019_questions.shtml or via phone during regular business hours at (609) 826-5964 for questions, and after hours/weekends at (609) 392-2020 for emergencies.
- Connect with state long-term care professional/trade association resources.
- Assign one person to monitor public health updates from federal, local, and state entities: _____

Identify contacts at local hospitals in preparation for the potential need to hospitalize facility residents or to receive discharged patient from the hospital.

- If a resident is referred to a hospital, coordinate transport with the hospital, local health department, and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the facility.
- **Opening bed capacity in hospitals is vitally important as the outbreak spreads.**
- A list of New Jersey State hospitals can be found at <https://healthapps.state.nj.us/facilities/acFacilityList.aspx>.

Protecting Residents, Visitors, and HCP

Provide education about respiratory infections, including COVID-19.

- Educate on potential harm from respiratory illnesses to nursing home residents, and basic prevention and control measures for respiratory infections such as influenza and COVID-19.
- Include the following topics in education:
 - Hand hygiene: <https://www.cdc.gov/handhygiene/providers/index.html>
 - Respiratory hygiene and cough etiquette: <https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>
 - Use of Personal Protective Equipment (PPE): <https://www.cdc.gov/hai/prevent/ppe.html>
- CDC COVID-19 Print Resources: <https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html>

Develop criteria and protocols for screening and/or restricting entrance to the facility.

- Ill visitors and HCP are the most likely sources of introduction of COVID-19 into a facility. **CDC recommends aggressive visitor restrictions and enforcing sick leave policies for ill HCP**, even before COVID-19 is identified in a community or facility.
- **On March 13, 2020 the Center's for Medicare & Medicaid Services (CMS) instructed that Facilities should restrict visitation of all visitors and non-essential HCP, except for certain compassionate care situations, such as an end-of-life situation.**
- Communicate with families to advise them of visitor restrictions and consider using alternative methods for visitation (e.g., video conferencing) during the next several months.
- Consider creating list serve communication to update families, assigning staff as primary contacts for families for inbound calls and conducting regular outbound calls to keep families up-to-date, offering a phone line with a voice recording updated at set times each day with the facilities general operating status such as when it is safe to resume visits.
- When allowed (e.g., end of life situations), visitors should be screened for fever or respiratory symptoms. Those with symptoms (fever, cough, shortness of breath, or sore throat) or unable to demonstrate proper infection control techniques should not be permitted to enter the facility.
- Any visitors that are permitted and screened should wear a facemask while in the building, perform frequent hand hygiene, and restrict their visit to a designated area.

Review, implement, and reinforce an infection control plan for preventing communicable disease among residents, visitors, and HCP. The plan should include:

- Enact a policy defining what PPE should be used by visitors.
- Before visitors enter the designated area, staff will provide instructions to visitors on hand hygiene, limiting surfaces touched, and appropriate use of PPE.
- Maintain a record (e.g., a log with contact information) of all people who enter the room. If a common area is used, cleaning and disinfection should be performed between visits.
- Ensure visitor movement is limited within the facility (e.g., avoid the cafeteria and other gathering areas).
- Review the CMS Quality, Safety & Oversight (QSO) Group memo Ref: QSO-20-14-NH at <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf> for expanded recommendations.
- A policy for when HCP should use Standard, Droplet, and Contact Precautions for residents with symptoms of respiratory infection unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
 - **For suspect or confirmed COVID-19 case(s) Standard and Transmission-based Precautions including use of a N95 respirator or facemask if unavailable, gown, gloves, and eye protection is recommended.**
 - CDC guidance states that **facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand**. During this time, available **respirators should be prioritized for procedures that are likely to generate respiratory aerosols, or care activities where splashes and sprays are anticipated** which would pose the highest exposure risk to HCP.
 - Use respiratory protection as part of a **comprehensive respiratory protection program** that meets the requirements of the Occupational Safety and Health Administration or OSHA's Respiratory Protection standard ([29 CFR 1910.134](https://www.cdc.gov/niosh/publications/2019-10-134)) and includes medical exams, fit testing, and training.
Consider implementing this program, if not already in place.
 - If there are shortages of gowns, they too should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of the HCP.
- Implementing and/or maintaining a respiratory hygiene program throughout the facility.
- Cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units, using one or more of the following strategies: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html> (see 3. Patient Placement)
- Collection of specimens. Specimens for COVID-19 should not be collected in the facility unless proper infection control precautions can be followed. This includes:

- Use of a respirator or facemask if unavailable, gown, gloves, and eye protection.
- Performed in an Airborne Infection Isolation Room (AIIR) (e.g., negative pressure room) or in an examination room with the door closed. Ideally, the resident should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.

Surveillance and Tracking

Perform surveillance to detect respiratory infections, including COVID-19.

- Maintain and/or implement protocol(s) for daily monitoring of residents (upon admission and throughout their stay) and HCP for fever and other symptoms of COVID-19 (e.g., gastrointestinal [GI] upset, fatigue, sore throat, dry cough, shortness of breath).
 - For tracking residents, McGeer criteria for respiratory tract infections can be found at <https://spice.unc.edu/wp-content/uploads/2017/03/Respiratory-Tract-Infection-Worksheet-McGeer-SPICE.pdf>
 - For tracking residents, McGeer criteria for GI tract infections can be found at <https://spice.unc.edu/wp-content/uploads/2017/03/All-GI-Infection-Worksheet-McGeer-SPICE.pdf>
 - NJDOH Respiratory Surveillance Line List can be found at <http://nj.gov/health/forms/cds-11.dot>
 - CDC's LTC Respiratory Surveillance Line List can be found at <https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf>
- Remember that older adults may manifest symptoms of infection differently and that other symptomology should also be assessed at minimum, daily. Vital signs should include heart rate, blood pressure, temperature, pain and pulse oximetry.
- For incoming residents, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room).
- **If symptoms are detected, clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.** Verify the diagnosis using clinical, epidemiological and lab test information, considering seasonal disease occurrence. Co-infection with COVID-19 is possible and should be considered.

Report any known or suspect communicable disease outbreak, by phone to the local health department with jurisdiction over the facility.

- Refer to NJDOH Guidelines for the Control of Respiratory Virus Outbreaks in LTCF and Other Institutional Settings at https://www.nj.gov/health/cd/documents/flu/outbreak_prevention.pdf
- Your local health department will help assess the situation and provide guidance for further actions, including laboratory testing.

Person Under Investigation (PUI) and Positive COVID-19 Case(s)

Determine appropriate placement of PUI and positive COVID-19 Case(s) and infection control precautions.

- Residents with known or suspected COVID-19 do not need to be placed into an AIIR (e.g., negative pressure room) but should ideally be **placed in a private room with their own bathroom, with the door closed.**
- Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario.
- For suspect or confirmed COVID-19 case(s), Standard and Transmission-based Precautions including use of a **N95 respirator or facemask if unavailable, gown, gloves, and eye protection is recommended.**
- Consider universal use of facemasks for HCP, if possible.
- **In the event of an outbreak, cohort residents, HCP, equipment and supplies as possible.**
 - Identify three cohort groups: 1.) "Ill" 2.) "Exposed" (not ill, but potentially incubating) and 3.) "Not ill/not exposed".
 - Dedicate resident specific equipment and supplies. If not possible, restrict dedicated equipment within

- a specific cohort with routine cleaning and disinfection between resident use.
- Close the facility to new admissions if the physical set-up does not allow for complete separation between “not ill/not exposed” and “ill”/“exposed” cohorts.
- HCP assigned to affected unit(s) should not rotate to unaffected units. This restriction includes prohibiting HCP from working on unaffected units after completing their usual shift on the affected unit(s).
- Public health authorities can assist with these decisions, during an outbreak.

Implement environmental infection control measures.

- Conduct routine cleaning and disinfection of frequently touched surfaces and shared medical equipment using an EPA-registered, hospital-grade disinfectant on List N (<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>). Adhere to internal environmental cleaning protocols to ensure appropriate measures are being taken to clean and disinfect throughout the facility. Consider increasing the frequency of routine cleaning.
- Dedicated medical equipment should be used when caring for a resident with known or suspected COVID-19, when possible.

Restrict the movement of residents throughout the facility.

- Cancel communal dining and all group activities such as internal and external group activities (e.g., physical therapy, beauty shop).
- If there is confirmed COVID-19 in the facility, encourage residents to remain in their rooms. Restrict all confirmed cases and any residents who may have been exposed to their assigned rooms except for medically necessary purposes.
- If they leave their room, residents should wear a facemask (as tolerated) or use tissues to cover their mouth and nose, preform hand hygiene, and preform social distancing (i.e., stay at least 6 feet away from others).

Inform receiving facilities when transferring residents.

- Transfer notification applies to all residents of the facility. If possible, limit transfers to medical necessity.

Enhance active surveillance.

- When a confirmed COVID-19 case is identified at the facility, monitor residents **twice daily**, at minimum, for fever and other symptoms of COVID-19 (e.g., gastrointestinal (GI) upset, fatigue, sore throat, dry cough, shortness of breath). Vital signs should include heart rate, blood pressure, temperature, pain and pulse oximetry.
- Residents that develop compatible symptoms should be tested for COVID-19.
- Seek out additional cases of respiratory illness among residents and HCP. Be alert for new onset of illness among exposed persons, and review resident and HCP histories to identify previous onsets of illness that may not have been correctly recognized as being part of the outbreak.

Perform HCP exposure risk assessment for staff who cared for COVID-19 case(s)

- To help facilities document and assess HCP risk and exposure, NJDOH has developed the below series of tools and checklists based on CDC guidance, available at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml:
 - NJDOH Monitoring and Movement Guidance for HCP Exposed to Confirmed Cases of COVID-19
 - NJDOH HCP Exposure to Confirmed COVID-19 Case Risk Algorithm
 - Retrospective Assessment Tool for HCP Potentially Exposed to COVID-19
 - NJDOH COVID-19 HCP Exposure Checklist
 - NJDOH COVID-19 Fever and Symptom Monitoring Log for HCP
 - HCP Exposure Line List

Implement procedure for monitoring HCP working within the facility.

- Screen all HCP at the beginning of their shift for fever and other symptoms of COVID-19 (e.g., gastrointestinal (GI)

upset, fatigue, sore throat, dry cough, shortness of breath). Actively take their temperature and document absence of symptoms. If they are ill, have them put on a facemask and leave the workplace.

- **HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.**
- Identify HCP who may be at higher risk for severe COVID-19 disease and attempt to assign to unaffected units.

HCP Health and Contingency Planning

Evaluate and manage HCP with symptoms of illness.

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health measures that allow ill HCP to stay home.
- As part of routine practice, ask HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of COVID-19 (e.g., gastrointestinal (GI) upset, fatigue, sore throat, dry cough, shortness of breath). Remind HCP to stay home when they are ill.
- If HCP develop fever or symptoms of COVID-19 while at work, they should immediately put on a facemask, isolate, and inform their supervisor.
- Consult occupational health on decisions about further evaluation and return to work.
- When there are cases in the community, but none in the healthcare facility consider implementing universal use of facemask for HCP while in the facility, depending on supply. With sustained community transmission consider having HCP wear all recommended PPE for the care of all residents, regardless of presence of symptoms.
- When transmission in the community is identified, LTCF may face staffing shortages. Facilities should develop (or review existing) plans to mitigate staffing shortages.

Develop contingency staffing and resident placement plans.

- Identify minimum staffing needs and prioritize critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.
- Contact your healthcare coalition for guidance on altered standards of care in case residents need acute care and hospital beds are not available.
- Strategize about how your facility can help increase hospital bed capacity in the community.
- Establish memoranda of agreement with local hospitals for admission to the LTCF of lower acuity residents to facilitate utilization of acute care resources for those more seriously ill.
- Identify facility space that could be adapted for use as expanded inpatient beds.

Develop strategies for optimizing the supply of PPE.

- Implement protocols for the extended use of PPE. Review CDC's Strategies to Optimize PPE Supply at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>.
- During times of limited access to respirators or facemasks, facilities could consider having HCP remove only gloves and gowns (if used) and perform hand hygiene between residents with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator or facemask (i.e., extended use). Risk of transmission from eye protection and facemasks during extended use is expected to be very low.
- Review CDC's FAQ about PPE at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html>.

¹For this guidance, CDC defines HCP as all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

Acknowledgment

NJDOH thanks and acknowledges the Washington State Department of Health for its assistance in developing the above guidance materials.