Long Term Care and Post-Acute Care COVID-19 Planning and Prevention Guidance

Wyandotte County Kansas City Kansas Unified Government Health Department
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General Guidelines

- Transparency at every juncture is imperative.
- Extensive and flexible testing with detailed contact tracing and robust education for all contacts must be prioritized.
- Ongoing supervisor-Health Care Worker (HCW) interactions to train and document staff compliance are crucial.
- Documentation of all plans, procedures, and daily operations will improve outcomes for the facility, HCWs and staff, residents/patients and community at large (including other similar facilities that could be at risk and underprepared).

COVID-19 poses the highest level of risk to residents and patients who live in or receive care in Long-term Care (LTC), post-acute and residential facilities. We believe many of these facilities are currently basing their infection control and COVID-19 prevention protocols on directives they receive from their corporate leadership, independent Medical Directors, and on-site Infection Control Nurses. This has led to wide variability in the interpretation and application of evidence-based guidelines and CDC guidance. Recent Centers for Medicare and Medicaid Services (CMS) documentation (4.2.2020) recommends LTC facilities turn to their State and local leaders for guidance on their response to COVID-19. For this reason, it is critical to provide education and prevention strategies based on CDC and CMS recommendations to limit disease spread. In addition, all facilities should work immediately to create detailed response plans especially if they detect even low levels of exposure to COVID-19 disease among health care workers (HCWs) or residents/patients. These plans should focus on adherence to appropriate hand hygiene as set forth by CDC (https://www.cdc.gov/handhygiene/providers/guideline.html), symptom monitoring protocols for all staff/residents/patients, systematic and monitored protocols for use of Personal Protective Equipment (PPE) by staff as well as residents/patients, and should include back-up and crisis mitigation strategies should staffing, leadership or facility inadequacies be detected. CMS has issued extensive COVID-19 infection control guidance, including a self-assessment checklist that long-term care facilities can use to determine their compliance with crucial infection control actions. Facilities should refer to CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) for long-term care facilities as they develop their plans. Plans should also consider CDC guidance on conservation of personal protective equipment (PPE) depending on local and regional resource availability.
Facilities should refer to their local county and state plan for re-opening at different phases of the COVID-19 pandemic, when available. Given the high vulnerability of the long term care and post-acute population as well as all persons in congregate living, it will be critical to maintain commitment to the guidelines until vaccine is widely available. We strongly recommend routine review of these recommendations even as other sectors of the community resume prior function.

LTC Planning for Prevention

- All visitors should be restricted except for specific occasions to include compassionate care situations at the end of life.
  - If visitors do enter via controlled entrance access points, they should follow all required PPE recommendations and only move to the appropriate patient’s room for a time limited period. Visitors should be escorted by staff at all times to ensure PPE is used correctly.
- HCWs caring for ANY patients, including those who have tested positive or negative for COVID-19, should always utilize appropriate PPE during all facility activities.
  - For care of patients who have tested positive, are PUI, or who have symptoms, HCWs should use an N95 or higher-level respirator/face shield/goggles, gown, and gloves during patient care activities. If an N95 is unavailable, a surgical mask is an acceptable substitution. Refer to current CDC guidance on PPE conservation strategies.
  - It is recommended that Wyandotte County be considered an area of sustained transmission at this time. Per current CDC guidelines, full PPE should be used for all patient care in this situation.
  - Cloth masks should NOT be worn by HCW as PPE.
- All staff must be trained on proper procedures to don and doff PPE including a completed competency to demonstrate understanding by each staff member with a supervisor signature (https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf). Procedural compliance should be documented on a checklist for all staff each day.
- At least one staff member for every ten residents/patients should be trained and should have documented supervisor sign off that they are using proper technique for nasopharyngeal swab COVID-19 sample collection.
- Plans should be in place for ordering adequate supplies of nasopharyngeal swabs, tubes, viral transport medium, or 0.9% normal saline prepared in tubes under sterile conditions. Protocols for refrigeration and storage of collected specimens should be in place, including materials for transport and cooling of multiple specimens to local laboratories at least once daily.
● Plans should be in place for courier service or transport of NP COVID-19 specimens to a local laboratory with contracts in place and a system for transmission of test results with back-ups.

● Protocols should specify how, where and when HCWs don and doff PPE and how discarded PPE is to be handled by janitorial staff. Detailed instructions for dirty linens and daily hygiene items utilized by HCWs caring for residents/patients should be included in plans and training materials. ([https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html))

● Protocols should be in place that allow for telemedicine support by Physicians and Advanced Practice Providers and include plans for at least one provider to be dedicated for each facility in case of an outbreak. Providers should limit their routine on-site care to one facility whenever possible.

● All HCWs, staff and visitors under end-of-life exceptions should be screened at both facility entrance and exit with documentation of any COVID-19 symptoms (fever, cough, shortness of breath, sore throat, headache, fatigue, aches, chills, loss of smell/taste or nausea/diarrhea) and temperature.

● All residents/patients should be screened at least twice daily with results recorded on a centralized log. Screening should include the following:
  ○ Full vital signs, including an oral temperature and oxygen saturation (document at least once daily – preferably twice daily)
  ○ Assessment for new/changed cough, shortness of breath, sore throat, headache, loss of smell, fatigue, aches, chills, or nausea/diarrhea.
  ○ NP COVID-19 testing should be collected on any staff member or resident/patient with a fever or 100.0 degrees F, a sustained drop in oxygen saturation of 3% from baseline, a new persistent cough, sore throat, headache, loss of smell, body aches, chills, fatigue or nausea/diarrhea. These symptomatic staff members or residents/patients should be considered for repeat testing should their initial tests come back negative but their symptoms persist.
  ○ Patients considered a Person Under Investigation (PUI) or probable case (fever greater than 100.0 degrees F or any other symptoms listed above) should be isolated in a private room with the door closed immediately upon suspicion until COVID-19 test results are available. Some who test negative should continue to be isolated based on presence of continued symptoms as they may require repeat testing every 2-3 days as clinically appropriate.

● If possible, all staff should be employed at only one facility (and no other essential place of employment) during the current crisis. Weekly documentation that all HCWs have been asked and responded to these questions should be maintained. This will limit spread between staff and other facilities.
  ○ Documentation should include any other facilities that staff have worked at in the past 14 days and dates of employment. Work at multiple facilities should be avoided as much as possible.
- Essential outside healthcare workers, such as laboratory personnel, x-ray technicians, and hospice agency employees, who are screened and wearing full PPE should be admitted on a case-by-case basis as is medically necessary for the resident/patient.

- All HCWs and staff should be encouraged to report illness prior to their shift and to stay home if they are ill without punitive repercussions.

- All staff should be screened at the beginning and completion of their shift with the results recorded on a centralized log.
  - Screening must include a temperature check documented at the beginning and completion of each shift in addition to assessment for cough, shortness of breath, sore throat, fatigue, aches, chills, changes in taste or smell, or nausea/diarrhea.
  - Any staff who has a positive screen should be referred to their personal health care provider, a local safety-net clinic or the local health department. They should report their work at a long-term care/post-acute care facility to ensure coordination and collaboration between providers going forward.

- A review of all advance care planning (ACP) documentation should be completed to ensure that each patient’s code status documentation is up-to-date and all appropriate documents are available, including:
  - Outside the Hospital Do Not Resuscitate forms, TPOPP forms, etc.
  - Power of Attorney paperwork or identified Surrogate Decision Maker with contact information.
  - Documentation with regularly updated dates for these conversations with providers

- These documents are critical for transport via EMS and arrival in the Emergency Department and must accompany the resident/patient.

- Protocols and updated plans outlining criteria for calling EMS based on resident/patient clinical condition should be in place. This should include plans for when to engage Medical Director, invoke vital sign driven decisions, or clinical criteria with input and decisions based on team-based clinical evaluations of patients on an urgent or emergent basis.

- All calls to 911 or ambulance dispatch line should include information about the patient’s COVID-19 status, when known.

- Residents/patients being transferred out of the facility by EMS should be delivered to the ambulance entrance by staff in order to minimize the number of EMS providers entering facility unnecessarily. Movement of resident/patient by staff to designated ambulance entrance should only occur if the criteria following can be met:
  - Patient is stable and not in extremis or requiring emergent resuscitation
  - Patient is able to be moved safely without worsening patient condition
  - Patient wears a face covering while being transported to ambulance entrance
  - Staff can safely accomplish the move to the ambulance entrance

- EMS access should not be limited in a true, time-critical emergency (ex. cardiac arrest, choking, uncontrolled hemorrhage). In these cases, EMS providers should wear appropriate PPE.
A packet of information should be prepared for EMS to include the following:
  ○ Routine transfer packet including at least face sheet, medication list
  ○ DPOA paperwork and name/contact information of surrogate decision maker
  ○ DNR, if applicable
  ○ Recent labs, including copy of COVID-19 testing, if applicable
  ○ Documentation of any provider Advance Care Planning conversations

An individual or team of individuals in the facility should be identified as the control person(s) for supplies and ordering of PPE. Par levels need to be set for daily cares as well as supplies needed in case of an outbreak requiring extra PPE.

Outbreak

An outbreak is defined by CMS as “the occurrence of more cases of a particular infection than is normally expected, the occurrence of an unusual organism, or the occurrence of an unusual antibiotic resistance pattern.” For this reason, one positive case of COVID-19 diagnosed in a LTC facility is considered an “outbreak” and requires immediate intervention and initiation of outbreak protocols.

Isolation (for those considered PUI or probable cases) – Initial Response

- All residents meeting these criteria will be placed under strict isolation with PPE usage by all healthcare workers and with PPE usage by the resident/patient as much as possible.
- All symptomatic staff will be prevented from entering the facility or will be sent home to quarantine for 14 days past last exposure to a PUI or test-positive case.

Notify local Health Department, of suspected cases. Isolation—after positive test results received

- All residents will remain under strict isolation with PPE utilized by HCWs and residents/patients as much as possible.
- Residents should be separated by COVID-19 status using different wings or units, where possible. Residents can be moved from their normal room for this action.
- Put a hold on new admissions until evaluation by and in consultation with the health department.
- For any HCWs or staff that test positive and are outside the parameters listed below- if asymptomatic, care for residents that are known to be COVID-19 positive may continue but all must continue to wear masks and PPE at all times.
- Those staff that remain asymptomatic and/or have tested negative should care for patients that have remained asymptomatic or have tested COVID negative. All HCWs and staff even in these circumstances should continue to wear respirators and/or masks at all times while in the facility.
- Notify local Health Department, state Health Department, and CDC of positive cases as required.
- Notify residents/surrogate decision makers of COVID-19 case per CMS requirements.
Staffing

- Identify the following positions in the facility
  - Internal Communications Liaison: responsibilities include, but are not limited to, communication to facility staff about care of the residents, PPE
  - External Communications Liaison: responsibilities include, but are not limited to, communication with families of residents
  - PPE Stakeholder: regular review of available PPE, burn rate reporting, coordination on restocking

- It is known that staffing shortages due to illness or anxiety surrounding COVID-19 may occur. It is reasonable in the setting of an outbreak to seek staffing from
  - Local agencies
  - Other facilities, from the same corporation or otherwise, through novel partnerships
  - Local organizations
  - National organizations

- Local and state health departments may be able to provide contact information in addition to resources suggested by local and state emergency management directors as well as the National Guard and other resources.

- If a staff member tests positive, that staff should stay home on self-isolation until 14 days after symptoms began. Put a hold on new admissions until evaluation by and in consultation with the health department (alternatively, until 10 days after the staff member's symptoms have resolved).

Advance Care Planning

- See above. All required documentation must accompany resident/patient for all Emergency Department transfers.

- Encourage physicians to complete a second review of ACP in the setting of COVID-19 outbreak.

Reporting

- Facilities are required to maintain a spreadsheet on all staff and residents/patients that are suspected to have COVID-19 based on symptoms of exposure. [https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf](https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf)

- Spreadsheet should be maintained and updated as new cases are identified and submitted to the local health department and appropriate state agencies daily.

Under emergency and crisis circumstances a **Drop Team** (a team providing emergency support with both facility and local public health department coordination)

- Facility will provide the following:
○ The number of symptomatic and known positive residents/patients and staff
○ Name and contact information for a primary point of contact for the facility
○ Information about availability of supplies needed for testing, PPE, etc.

● Drop team provides to facility:
  ○ Additional testing supplies, if available
  ○ Additional PPE, if available
  ○ Triage support, if available
  ○ Logistical support, typically via remote technology

● Regular communication between the affected facility and the health department will occur to include information about staffing, testing, changes in numbers of affected persons, etc.

Care of the Patient Post-Hospitalization

Post-acute care facilities are encouraged to admit patients per their normal standards. It is critical that post-acute levels of care work across the continuum in order for hospitals to continue caring for the sickest of patients. Extensive CMS guidance exists for skilled nursing facilities recommending patients be identified as COVID-19 positive, COVID-19 negative, and COVID-19 unknown based on previous testing (https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf)

● COVID-19 positive patients should remain in isolation in a designated area of the facility until the following criteria are met:
  ○ At least 10 days without fever, defined as >100 degrees Fahrenheit, without the use of fever-reducing medications and until 10 days after the patient’s symptoms have resolved.
  ○ At least 14 days since initial COVID-19 postive test.

● COVID-19 unknown patients and patients who tested negative should be isolated in a designated area for 14 days whenever possible.
  ○ Patients who are considered unknown or who tested negative can be cohorted with patients of the same status, if needed. Whenever possible, these patients should be cohorted based on date of admission to the facility within 48 hours.

● A negative COVID-19 test is not required for admission to a facility following hospitalization.

● Patients who were sent to acute care from a facility should, whenever possible, be accepted for admission back into that facility. All efforts should be made to prevent patients from moving to and from multiple facilities and hospitals throughout this pandemic. Facilities will be required to maintain some continuity of care for individuals to assure this occurs.


Suspected COVID-19 patient

- Place patient in room by themselves and close the door. If patient has a roommate, move to private room. Do not put another patient in the current room as that patient potentially has been exposed.
- Notify supervisor and attending physician of possible COVID-19 patient.
- Begin using full PPE for patient care of this patient. This includes gown, gloves, facemask, and faceshield.
- Collect full vital signs every 4-6 hours, including oral temperature and oxygen saturation. Report changes in vital signs to attending physician.
- Initiate testing for COVID-19 using facility protocol.
- Patient to remain in isolation at least until test results are available. If patient is negative, but has persistent symptoms including fever, cough, body aches, change in taste or smell, consider testing again.

Positive COVID-19 patient diagnosed in facility

- Patient should be moved to previously designated COVID-19 area in isolation.
- Persons entering the room should be limited to designated staff who will only care for patients that are known to be positive.
- PPE should be initiated in entire facility to include gown, gloves, mask, and faceshield. If available, N95 or higher respirators should be used. Usage of respirators should be prioritized for patients who have tested positive. Fit testing for N95s should be completed when possible. If an N95 is unavailable, a surgical mask is an acceptable substitution.
- All patients should be placed on isolation and remain in their rooms, wearing masks whenever possible.
- Local and state health departments should be notified, as should CDC per requirement. The health department will provide consultation and guidance on testing procedures.
- Patient should be evaluated on a regular basis to identify clinical changes, including decrease in oxygen saturation, decrease in blood pressure, and increase in pulse. Vitals should be taken at least every 6 hours.
- Supportive care should be initiated. This may include IV or subcutaneous fluids or supplemental oxygen.
- The facility should work with the Medical Director to determine clinical stability and ability to remain in the facility for clinical care. Only patients who are clinical unstable should be sent to the Emergency Department.
- All patients in the facility who have not tested positive should have vital signs tested at least twice daily in addition to a symptom check for COVID-19 (body aches, change in taste/smell, etc.)

Positive Patient Requiring Hospitalization

- Notify EMS of the patient's COVID status.
- Create an EMS packet that includes routine items such as face sheet, medication list, and also includes:
  - DPOA paperwork and name/contact information of surrogate decision maker
  - DNR, if applicable
  - Recent labs, including copy of COVID-19 testing, if applicable
- Documentation of any provider Advance Care Planning conversations
- If the following conditions are met, transport patient to the ambulance entrance for EMS to assess. If any of these conditions are not met, EMS is to enter the facility per usual protocol and wearing appropriate PPE.
  - Patient is stable and not in extremis or requiring emergent resuscitation
  - Patient is able to be moved safely without worsening patient condition
  - Patient wears a face covering while being transported to ambulance entrance
  - Staff can safely accomplish the move to the ambulance entrance