Managing COVID-19: A Guide for Skilled Nursing Facilities and Assisted Living Settings

About this guide

The information in this guide is current as of April 15, 2020.

The Minnesota Association of Geriatrics Inspired Clinicians (MAGIC) developed this comprehensive guide to managing Coivd-19 in our facilities to provide concise guidelines with up to date information. We recognize there are many guidelines and articles that have been released, and it is difficult to stay up to date with all of the information being published on the novel Coronavirus, specifically what is pertinent to facility-based care settings. Therefore, MAGIC has thoroughly reviewed publishing's from the Center for Disease Control and Prevention (CDC), Minnesota Department of Health (MDH), and AMDA The Society for Post-Acute and Long-Term Care Medicine and developed this comprehensive guide to provide concise information for managing COVID-19 in our facilities.

MAGIC is the state chapter of AMDA The Society for Post-Acute and Long-Term Care Medicine (PALTC). AMDA is the only medical specialty society in the U.S. representing the community of medical directors and providers working in post-acute and long-term care (PALTC) settings. MAGIC is an organization whose purpose is to support its members as they advocate for, and serve those, with complex medical needs. During this pandemic, MAGIC has created a MAGIC COVID Taskforce to address community advocacy needs. They have advocated for COVID Cohort SNFs and clarification on regulatory visits to this date. MAGIC website: https://www.minnesotageriatrics.org/

The Clinical Practice Alliance Committee (CPAC, fka Metro Alliance) is the clinical workgroup within MAGIC. CPAC is a collective group of geriatric primary care organizations serving residents in facility-based settings, with the purpose to create common, evidenced-based approaches to care from our collective wisdom and practices. During the COVID-19 pandemic, we have created the CPAC COVID-19 Taskforce to review the evolving information regarding COVID-19 from AMDA, CDC and MDH, address best practices for our medical groups and provide guidance to our facility partners. We have distributed several guidelines from CPAC to our facility partners and will continue to provide guidance to effectively and safely care for our residents together. All guidelines are posted on the MAGIC website.

The following Frequently Asked Questions page from AMDA was used throughout this document. Please refer to this document and several other listed sources for additional information. Of note, this document is not specifically listed in each section to reduce the redundancy of listing this resource.
http://paltc.org/sites/default/files/COVID%2019%20QA%20Community%20Spread%20March%2031%20with%20hylerlinks%20and%20Rx%20Final.pdf

If any of these guidelines and recommendations are inconsistent with your facilities procedures, please follow your procedures and review these updated guidelines for potential updates to your facility procedures.

The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Facilities should be prepared for guidance from CMS and other agencies (ie: MDH) to change. Please monitor the relevant sources regularly for updates. MAGIC will continue to provide guidance as changes are made or guidance is requested.

Please share these guidelines with anyone who may find them pertinent and helpful.

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Clinical Presentation of COVID-19

Incubation Period

The incubation period for COVID-19 is thought to range from 2 to 14 days, with a median time of 4-5 days from exposure to symptoms onset.

Transmission

Current data suggest person-to-person transmission most commonly happens during close exposure to a person infected with the virus that causes COVID-19, primarily via respiratory droplets produced when the infected person speaks, coughs, or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. Transmission also might occur through contact with contaminated surfaces followed by self-delivery to the eyes, nose, or mouth. The virus can persist on some surfaces for up to 72 hours. During aerosol-generating procedures, the virus can also become aerosolized and pose a greater transmission risk. The virus is highly contagious, with the number of persons infected by each infected person thought to be somewhere between 2 and 6.

Typical and Atypical Symptoms

Atypical symptoms often present before fever and/or respiratory symptoms.

Typical Signs and Symptoms	Atypical Signs and Symptoms
Cough	Diarrhea, nausea, vomiting, abdominal pain
Shortness of Breath	Muscle aches, headache
Hypoxia	Sore throat, runny nose
Fatigue, lethargy	Loss of taste and/or smell
Loss of appetite	Confusion, change in mental status, delirium (often hypoactive)
Fever (>= 99.5 degrees or subjective fever fever may be intermittent or absent in elderly, specifically those on scheduled Acetaminophen)	Chest pain
fever may be intermittent or absent in elderly, specifically those on scheduled Acetaminophen)	Exacerbation of Chronic Diseases (ie: CHF, COPD)

Risk Factors

Risk Factors for Developing Severe COVID-19 Infection	
Increasing age	Cardiovascular Disease
Respiratory Disease	Diabetes
Hypertension	Cancer
Renal Disease	Obesity
Multiple Comorbidities	Dialysis

Potential Courses and Illness Severity of COVID-19

- Indolent/Convalescent- mild: have mild typical or atypical symptoms with uneventful recovery
- Indolent/Convalescent- moderate/severe: initial 1-2 days of fever with severe respiratory symptoms. Stabilization around 4-6 days, followed by an improvement around days 5-7, but can take 1-3 weeks for recovery.

- Indolent/Fatal: initial 1-2 days of high fever, severe respiratory symptoms. Stabilization for several days with sudden worsening and death despite maximum symptomatic treatment with mechanical ventilation.
    - Among residents who developed severe disease, the median time to dyspnea ranged from 5 to 8 days, the median time to acute respiratory distress syndrome (ARDS) ranged from 8 to 12 days, and the median time to ICU admission ranged from 10 to 12 days. Clinicians should be aware of the potential for some residents to rapidly deteriorate one week after illness onset. Of note, this data is not specific to facility-based residents.
- Acute Respiratory Distress: Onset of symptoms to death < 24 hours (often 6-12 hours). High fever, severe respiratory symptoms and hypoxia. Most common in very frail population.

The case fatality rate for COVID-19 for nursing home residents in Kirkland, WA was around 33%.

Clinical Presentation Sources

CDC: Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html

To view the data regarding the COVID-19 pandemic in Minnesota, visit the Minnesota Department of Health Situation Update for Coronavirus Disease 2019 (COVID-19). Data is for cases that were tested and returned positive. Numbers are cumulative since Jan. 20, 2020. Not all suspected cases of COVID-19 are tested, so this data is not representative of the total number of people in Minnesota who have or had COVID-19. https://www.health.state.mn.us/diseases/coronavirus/situation.html

CDC: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

Symptom Screening/Early Detection and Tracking

Symptom Screening

Staff should conduct active surveillance of residents for signs and symptoms of acute respiratory illness, as well as the atypical symptoms which often occur prior to fever and respiratory symptoms. They should be systematically marked on the facility map for identification of clusters of respiratory illness. There should also be a log recording symptom surveillance.

Tracking

The CDC's Respiratory Surveillance Tool Kit provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness. https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf

Screening and Tracking Source

CDC: Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html

Asymptomatic/Pre-symptomatic Transmission

Asymptomatic and Presymptomatic Study

Significant findings from a study at a LTC facility in King County, Washington: On March 13, CDC performed symptom assessments and COVID-19 testing for 76 (93%) of the 82 facility residents to evaluate the utility of symptom screening for identification of COVID-19 in SNF residents. Of the 76 residents evaluated, 23 residents had positive test results, 10 (43.5%) were symptomatic, and 13 (56.5%) were asymptomatic at the time of testing. Of the 13 residents who had positive test results and were asymptomatic on the date of testing were reassessed 1 week later; 10 had developed symptoms and were recategorized as pre-symptomatic at the time of testing. Three residents with positive test results remained asymptomatic.

Sixteen days after introduction of COVID-19 into the facility, facility-wide testing identified a 30.3% prevalence of infection among residents, indicating very rapid spread, despite early adoption of infection prevention and control measures. Approximately half of all residents with positive test results did not have any symptoms at the time of testing, suggesting that transmission from asymptomatic and pre-symptomatic residents, who were not recognized as having COVID-19 infection and therefore not isolated, might have contributed to further spread.

This analysis suggests that symptom screening could initially fail to identify approximately half of facility residents with COVID-19 infection. Unrecognized asymptomatic and pre-symptomatic infections might contribute to transmission in these settings. During the current COVID-19 pandemic, facilities should take proactive steps to prevent introduction of COVID-19 and once a facility has a case of COVID-19, broad strategies should be implemented to prevent transmission. Once COVID-19 is introduced in a communal living setting, rapid transmission can occur.

Asymptomatic and Presymptomatic Source

Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility—King County, Washington, March 2020 https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm

Prevention of COVID-19 from entering the facility

Covid-19 Prevention

All facilities should follow these guidelines to prevent and minimize the risk of COVID-19 in the facility:

- Restrict visitation of all visitors and non-essential staff, except for certain compassionate care situations, such as an end-of-life situation
  - o If a visitor is permitted, notify them if they develop an acute respiratory illness or COVID-19 within 14 days of visiting a facility they should report that to the facility
- Restrict vendors who access the facility, including delivery of food, linens, and supplies
  - o Those who deliver should not enter the facility if possible. Instead, as part of social distancing, they should be instructed to leave their delivery at an appropriate location well away from residents and, if possible, staff. Post signs at the doors and entrances used by vendors that remind individuals about cough etiquette. Provide alcohol hand rub and direct vendors that must enter the facility to sinks with soap and water if needed.
- Screen all staff and anyone entering the facility for typical and atypical signs of symptoms of COVID-19. This includes health care workers (lab/radiology services, providers, hospice workers, EMS personnel, home care/therapy staff, etc). Those with symptoms should not be permitted to enter the facility (even in end-of-life situations).

- - - o Limit entrances available for visitors to enter to ensure screening is completed on everyone
- Advise visitors, and any individuals who entered the facility to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility that they visited. Facilities should immediately screen the individuals reported to have had contact and take all necessary actions.
- Facilities should identify staff that work at multiple facilities—actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19. It is recommended that staff do not work at more than one facility during the pandemic.
- Staff and visitors must wear a facemask while in the facility and perform frequent hand hygiene
- Avoid provider/specialist visits outside of the facility
  - It is recommended that the staff call the outside consultants and delay non-urgent visits or procedures. If there is a pressing medical need for the appointment, explore options such as electronic consults or other telehealth modalities to limit exposure of the resident to other healthcare settings.
  - It is also recommended to suspend all nonemergent dental visits either in or out of the facility. Limit procedures that involve manipulation of mucosal cavity, e.g., dental cleaning, denture fitting, fiberoptic evaluation of swallowing. If the procedure is thought to be urgent, the need should be weighed against the elevated risk of transmission due to these procedures.
- Residents should not be taken out of the facility by family or friends unless medically necessary
- If a resident must leave the facility, the following procedures should be followed:
  - Residents should wear a facemask for the entire time they are out of the LTC facility
  - Upon the resident's return, staff should assist the resident with thorough hand washing and changing of clothes
  - Place these residents in a single room with standard, contact, and droplet precautions
  - Staff should give special attention to surveillance for influenza-like illness and should have high level of suspicion for COVID-19 in these residents
  - The facility should communicate with the healthcare provider if one of its residents is suspected or tested positive for COVID-19
- No communal dining or feeding, or group activities. CMS guidance on staff assistance with meals:
  - For residents, not having an active or suspected case of COVID-19, facilities are able to use dining rooms for feeding assistance purposes. In these limited situations, social distancing and other infection prevention practices should be implemented. Specifically, facilities should maintain social distancing of at least 6 feet per CDC guidelines, practice good hand hygiene between contact with each resident, carefully clean the table before and after the resident eats, and ensure there is a nursing assessment that includes the need for monitoring or assistance while eating.
- Staff should clean the frequently touched surfaces like handrails, doorknobs and door handles, and surfaces at the nurses' stations at least twice daily and more frequently as needed
- If a visitor is allowed for end of life care visitation (no respiratory symptoms or illness), the visitor should limit contact to the residents' room or a place the facility has specifically dedicated for visits rather than common area. Visitor should be directed to frequently perform hand hygiene, follow proper cough etiquette, avoid touching surfaces, and use a mask for the duration of the visit.
- Social distancing should be maintained by everyone

Residents Receiving Dialysis Treatment

Residents receiving dialysis are at high risk for acquiring the COVID-19 virus. This is likely due to both inherent immunocompromise in this population as well as possible exposures encountered during transport to/from as well as within the dialysis center itself. There should be a preemptive communication of the plans for how dialysis centers are handling the COVID-19 residents from the community. The following recommendations are for residents receiving dialysis treatments:

- Residents who are going to dialysis should wear a facemask for the entire time they are out of the facility
- Upon the resident's return, staff should assist the resident with thorough hand washing and changing of clothes
- These residents should be in a single room with standard, contact, and droplet precautions. Staff should give special attention to surveillance for signs and symptoms and should have high level of suspicion for COVID-19 in these residents.
- The LTC facility should communicate with the dialysis facility if one of its residents is suspected or tested positive for COVID-19

Prevention Resources

MN Department of Health: Interim Enhanced Respiratory Outbreak Surveillance for Long-term Care Facilities
https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcsurv.pdf

CMS Guidance for Infection Control and Prevention of Coronavirus Disease 2019 in Nursing Homes (Revised)
https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

How to prepare for an outbreak

Covid-19 Outbreak Preparedness

Preparing for the first resident with COVID-19 and a facility outbreak is critical for the safety of all residents and staff members. This preparation will directly relate to how well a facility can contain the virus.

- Identify an area for cohorting residents with COVID-19—ideally this will be an area that can be closed off from other parts of the facility, an entire hallway or at least rooms at the end of a hallway
    o Clear 4 rooms in this designated area to have readily available for residents when the need arises
- Establish a plan for moving residents with COVID-19 to these areas on any shift or day of the week, and identify who can be trained to safely move these residents
- There should be no sharing of equipment and supplies
- Increase the availability and accessibility of alcohol-based hand rubs (ABHRs), reinforce strong hand-hygiene practices, tissues and no touch receptacles for disposal. Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Extra equipment like medication carts and wound care supplies should be planned for and available
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.)
    o The virus is transmitted through respiratory droplets; the risk of transmission by fomites is also a concern. Respiratory droplets that land on surfaces near an individual and are later touched by a healthcare worker may lead to transmission.
- In addition to following standard infection control practices on cleaning common equipment to assess residents, like thermometers or pulse oximeters, staff should be asked to clean personal equipment, such as stethoscopes before and after examining an individual, and to clean their personal devices, like cellphones, frequently
- Isolation carts and PPE supplies should be made available
- To minimize the exposure and optimize use of PPE, only essential clinical staff enter the rooms of resident with COVID-19.
- Staff movement should be minimized, and assignments should be adjusted
- Work with environmental services (EVS) to adjust their schedule to be available on-call if possible
- SNFs: Oxygen concentrators and contingency arrangements should be made
- SNFs: Have medications meant to provide comfort, including at the end of live, available. These include morphine, lorazepam, and similar agents.

- Keep a log of all visitors who enter the facility—they must leave their name and contact information in case the facility needs to notify them about a possible exposure
- Consider a "clean entrance" and "dirty exit" for the facility
- Remove fingernail polish from resident's nails to obtain pulse oximetry readings quickly and accurately
- Have extra supplies of cleaning products to clean common surfaces and equipment on a frequent basis
- Minimize contact between the resident and staff to decrease the risk of transmission risk. Providers and nursing staff should reduce resident procedures and monitoring to what is necessary for each resident and avoid any unnecessary contact. This should include per provider orders:
  - Decrease the frequency of vital signs and blood sugar monitoring to what is necessary
  - Stop the routine monitoring of labs, unless necessary for resident safety
    - Anticoagulation: Consider changing from Warfarin to a Direct Oral Anticoagulant (DOAC) when appropriate for individual patients, after discussing with patient or decision maker
  - Stop nebulizers that are non-essential, change to inhalers when able
  - Discontinue or hold non-essential medications, and reduce the number of medication passes when able

Advanced Care Planning Discussions

It's recommended to have Advanced Care Planning(ACP) discussions with any residents/families who have not already indicated Do Not Hospitalize/Comfort Cares. COVID-19 can be fatal for the elderly and specifically those with multiple comorbidities. Residents and families should make informed decisions regarding their care wishes related to COVID-19. Changes to ACP/Provider Order for Life Sustaining Treatment (POLST) forms can be temporary during the pandemic. Providers should lead these discussions and facility staff can also support these efforts.

Resource: AMDA Managing Acute Respiratory Distress During the COVID-19 Pandemic—Advance Care Plan Tool
http://paltc.org/sites/default/files/AMDA%20COVID19%20Advance%20Directive%20Final_4_14_20.pdf

Patient Management Resources

MAGIC: Patient Management Recommendations for all Patients during COVID-19 Crisis (reduce patient contact recommendations) https://www.minnesotageriatrics.org/COVID-19.html

Optimizing Medication Management during COVID- 19 Pandemic: Implementation Guide for Post-Acute and Long-Term Care https://www.pharmacy.umaryland.edu/media/SOP/wwwpharmacyumarylandedu/centers/lamy/covid19-med-mgmt/complete-guide.pdf

Resource: Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf

Testing

Testing for COVID-19 is changing rapidly based on the availability of tests and this varies region by region as well as over time. The decision to test for COVID-19 is based on MDH guidelines for testing, clinician's judgment, prevalence of disease in the community and is subject to the availability of tests.

Who should receive testing?

Follow MDH guidelines for evaluating, testing and reporting COVID-19 in Minnesota. Ill individuals (residents or staff) in congregate living settings are prioritized for COVID-19 testing. Please visit the MDH website for up to date guidelines on the testing process: https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html

Facility staff should call the primary provider for any patient with a change in status that is concerning for possible COVID-19 disease based on the symptoms and signs listed above. The decision to test and order for the test will come from the primary provider, or in some cases the medical director. Facilities should be in communication with their medical director if there are patients with concerting symptoms, particularly if there are clusters of patients with concerning symptoms, or concern about an outbreak.

Follow these steps for obtaining COVID-19 testing supplies

- Obtain an order to test for COVID-19 from the provider (order could also come from medical director)
- Contact the facility's lab company to request and initiate lab testing for COVID-19
- Complete the MDH test request form (this may be provided by the lab) and indicate that the specimen is from a congregate living setting
- Lab will supply the swab and testing supplies. Coordinate with the lab for courier transportation of the specimen once collected.
- Lab results will go directly to MDH and the CDC, as well as the facility
- Can also contact MDH if lab companies are unable to provide testing supplies
- Can also check with the resident's provider group to see if they have any additional testing options

MDH COVID-19 Testing Form: https://www.health.state.mn.us/diseases/coronavirus/hcp/COVIDtestform.pdf

Limited Testing Supplies

Given the limited availability of tests, as well as the prolonged period for results, other testing strategies may be necessary. Consider testing only the initial 2-3 residents on a unit that develop symptoms suggestive of a respiratory viral infection. Once one person is positive, assume others with a similar presentation are also positive. Testing several residents may consume a limited supply of tests. If residents in another unit or floor also develop respiratory symptoms, it may be reasonable to test 1 or 2 of those individuals as well. It would also be reasonable to assume that COVID-19 is now widespread in the facility. Monitor availability of testing and further guidance from MDH as accessibility to testing evolves. Follow MDH guidance regarding how many and which residents to test when there are questions.

Collecting a Sample

Collect samples using a nasopharyngeal swab. The individual collecting the sample should wear an N-95 mask (or facemask if a N-95 is not available), eye protection, gloves, and a gown as there is risk of the resident coughing or sneezing. Those present during the collection should be limited to those essential for procedure support. Visitors should not be present. The door should remain closed during the procedure. Clean and disinfect the room surfaces promptly.

The specimen must be adequately labeled with all resident identifying information to ensure processing of the specimen.

New England Journal of Medicine: Collection of Nasopharyngeal Specimen with the Swab Technique (Video) https://www.youtube.com/watch?v=DVJNWefmHjE

Test Results

A positive result does not rule out co-infection with bacterial or viral infections. A negative result does not guarantee the patient does not have COVID-19 and should not be used as the sole basis for patient management decisions (false-negative result). Negative results must be combined with clinical observations, patient history, and epidemiological information. Test accuracy will vary with the specific test, lab, collection, and handling technique. These interpretations and management decisions should come from the patient's primary care provider.

Testing Resources

MN Department of Health: Coronavirus Disease 2019 Laboratory Guidance
https://www.health.state.mn.us/diseases/idlab/labCOVID19.html

MN Department of Health: Rapid IgM/IgG SARS-CoV-2 Tests
https://www.health.state.mn.us/diseases/coronavirus/hcp/sarscov2test.pdf

Resident management while Covid-19 test results are pending

COVID-19 Test Results Pending

Management of typical and atypical symptoms could be caused by several different illnesses including COVID-19. Follow these recommendations before COVID-19 testing is resulted:

- Continue to follow the guidelines to prevent COVID-19 from entering the facility
- Isolate the resident. Implement standard, contact, and droplet precautions. Do not move a resident with unconfirmed COVID-19 to a COVID-19 specific unit.
- Notify the primary provider
- Assess the resident for severity of illness in conjunction with goals of care. Residents with acute respiratory symptoms should be placed on an active monitoring protocol. Active monitoring includes checking vital signs as appropriate, measuring pulse oximetry, and assessing for common and less common signs and symptoms of COVID-19 every 6 to 8 hours.

Source: CDC: Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html

What to do when get first positive

Facility-specific actions to minimize spread of infection to other residents and staff

- Continue to follow the guidelines to prevent COVID-19 from entering the facility
- Call the MDH COVID-19 hotline with all cases: 651-201-5537 or 1-877-676-5414
  - MDH will assign a COVID Case Manager (CCM) who will be in close contact with the DON
- Maintain a Respiratory Surveillance List for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a facility. MDH will request updates of this tracking.
- Strict cohorting of COVID-19 residents in a separate unit if able, otherwise isolate as best as possible
- During the physical transfer of the resident, personnel should wear gloves, gown, and a face shield or facemask with goggles. The resident should have a facemask if tolerated, otherwise tissues covering their mouth and nose.
- Residents should be placed in a private room with their own bathroom if able and keep 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. Public health authorities can assist with decisions about resident placement.
- All residents on the unit should be carefully screened for typical and atypical symptoms of COVID-19
- Restrict healthcare personnel movement between affected and unaffected residents/areas of the facility
- Prioritize the use of PPE in this area of the facility
- No sharing of equipment, including medicine carts and wound care supplies, between the units

- Practice adherence to infection control practices—strict, complete, and correct use of PPE
- Dedicate equipment for the care of COVID-19 residents and leaving that equipment in the designated area
- Rehabilitation services should be suspended for the COVID-19 residents/units to avoid staff-based transmission
- Facilities should only cohort COVID-19 confirmed residents and not cohort suspected cases on respiratory isolation pending testing results
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly
- Restrict visitors or non-essential staff to these units
- Notify visitors of the facility in the past 2 weeks of the potential exposure to COVID-19 in the facility. Instruct them to self-isolate and to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure. If they become ill, they should contact their healthcare provider.
- No communal dining or feeding. No group activities.
- Encourage all residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If a resident must leave their room, the resident should wear a facemask, perform hand hygiene, limit their movement in the facility and perform social distancing (stay 6 feet away from others).
- There are no special recommendations for management of laundry, food service utensils, and medical waste. Follow routine procedures.
  - It is not recommended that family members continue to do laundry during the pandemic. The risk of transmission of COVID-19 outweighs the potential benefit.
- If staffing becomes an issue, focus VS monitoring to temperature, oximetry/pulse, and respiratory rate. Forego BP monitoring (except on resident with BP issues).
- An outbreak is defined as two or more residents and/or staff with a recent onset of respiratory illness within the same unit or ward within 72 hours

Resident-specific actions

Residents who are COVID-19 positive can deteriorate very quickly. These residents often need increased nursing services. Follow these resident-specific actions:

- Goals of care should be reestablished (if not already reviewed during this pandemic), including the decision to hospitalize and placement on ventilator/life support, or the decision to treat in place should be based on care goals and medical necessity. This will often be provider led, but facility staff can also support these discussions.
- COVID-19 residents should be frequently monitored with pulse oximetry
- Staff should be vigilant for signs that signal quick deterioration; this includes respiratory distress. This could present as a drop in the resident's oxygen saturation being the only clue.

Minimizing the Spread Sources

AMDA Frequently Asked Questions Regarding COVID-19 and PALTC
http://paltc.org/sites/default/files/COVID%2019%20QA%20Community%20Spread%20March%2031%20with%20hylerlinks%20and%20Rx%20Final.pdf

Optimizing Medication Management during COVID- 19 Pandemic: Implementation
https://www.pharmacy.umaryland.edu/media/SOP/wwwpharmacyumarylandedu/centers/lamy/covid19-med-mgmt/complete-guide.pdf

Personal Protective Equipment (PPE)

Universal Source Control

As part of source control efforts, everyone should wear a facemask at all times while they are in the healthcare facility. When available, facemasks are generally preferred over cloth face coverings for staff as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are anticipated shortages of facemasks, facemasks should be prioritized for staff and then for patients with symptoms of COVID-19 (as supply allows). Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.

Staff whose job duties do not require PPE (e.g., clerical personnel) might continue to wear their cloth face covering for source control while in the healthcare facility. Staff in patient areas might wear their cloth face covering for part of the day when not engaged in direct patient care activities, only switching to a facemask when PPE is required. To avoid risking self-contamination, staff should consider continuing to wear their respirator or facemask instead of intermittently switching back to their cloth face covering.

When caring for residents with COVID-19 or an undiagnosed respiratory infection use **Standard, Contact, and Droplet Precautions** with eye protection (gloves, gown, mask and eye protection). This includes restricting residents with respiratory infection to their rooms. If they leave the room, residents should wear a facemask (if tolerated) or use tissues to cover their mouth and nose.

MN Department of Health: Interim Guidance for Facemask Use in Health Care Facilities during the COVID-19 Pandemic
https://www.health.state.mn.us/diseases/coronavirus/hcp/facemaskguide.pdf

Using PPE Appropriately

- PPE effectiveness is highly dependent on proper fit and correct, consistent use
- Staff should have received job-specific training on PPE and demonstrated competency with selection and proper use (e.g., putting on and removing without self-contamination).
    - It's recommended to train and practice proper donning (putting on), doffing (taking off), and disposal of PPE. Use a buddy system to help catch common errors.
    - Employers should select appropriate PPE and provide it to staff in accordance with OSHA PPE standards. Staff must receive training on and demonstrate an understanding of:
        - when to use PPE
        - what PPE is necessary
        - how to properly don, use, and doff PPE in a manner to prevent self-contamination
        - how to properly dispose of or disinfect and maintain PPE
        - the limitations of PPE
- Post signage about proper precautions and use of PPE
- Hand hygiene should be performed before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
- Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses

Correct order for donning and doffing PPE

Donning PPE (putting on) Sequence:
1. Gown
2. Facemask or Respirator (N95)—a respirator must be donned before entering the room

3. Face shield or goggles
4. Gloves

Doffing PPE (removing) Sequence while in the resident's room:
1. Gloves
2. Face shield or goggles, unless wearing with extended use guidelines (wearing throughout the shift)
3. Gown
4. Facemask or Respirator (N95)—do not remove respirator until out of the resident's room, unless wearing with extended use guidelines
5. Hand Hygiene

Donning and Doffing Resources

The CDC has posters that show how to put on and take off (don and doff) PPE that can be displayed:
https://www.cdc.gov/niosh/npptl/pdfs/PPE-Sequence-508.pdf

Donning and Doffing PPE: University of Nebraska Videos https://www.youtube.com/watch?v=oxdaSeq4EVU

Donning and Doffing PDF Instructions: University of Nebraska
https://www.nebraskamed.com/sites/default/files/documents/covid-19/donning_stepbystep_03062020.pdf
https://www.nebraskamed.com/sites/default/files/documents/covid-19/covid-19-personal-protective-equipment-doffing-step-by-step.pdf

N95 Respirators

A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard. Facility staff should be medically cleared and fit tested if using respirators with tight-fitting facepieces (i.e.,: a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.

OSHA: Respiratory Protection Program https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134

Source: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

User Seal Check of N95 Mask ("fit check", not fit test)

A user seal check should be completed each time the respirator is donned (put on) by the user to determine if the respirator is properly sealed to the face. The user seal check can be either a positive pressure or negative pressure check. Check the manufacturer's instructions, but generally are based on covering the surface of the respirator with the user's hands so that air is prevented from passing through the filtering facemask.
- The positive pressure user seal check is where the person wearing the respirator exhales gently to see if the facepiece bulges slightly.

- The negative pressure user seal check is where the person wearing the respirator takes a quick, deep breath to see if the facepiece collapses slightly.
- During either test, if air leaks out between your face and the respirators face seal, the respirator may not fit your face properly. One way to identify leakage is if you feel air blowing through the seal onto your face or eyes.
  - If the user feels leakage, readjust the fit of the respirator and check the seal again. If the user cannot achieve a proper seal, they are not protected and should not enter an area where the respirator is needed.

User Seal Check Resource

OSHA: How to Perform a User Seal Check with an N95 Respirator (Video)
https://www.youtube.com/watch?v=pGXiUyAoEd8

PPE while collecting samples for COVID-19

Collecting samples to test for influenza, RSV, and COVID-19 carry a high risk as there may be droplet exposure at very close range when residents cough or sneeze (often induced by testing). The person collecting the COVID-19 testing must follow strict contact and droplet precautions including a facemask and eye protection.

PPE during an Aerosol-Generating Procedure (AGP)

The COVID-19 virus is transmitted via respiratory droplets and fomites, so aerosol-generating procedures are associated with a high risk of transmission. These procedures must be avoided with residents who have confirmed or suspected COVID-19. If it must be performed for a chronic condition, it should be completed very cautiously for the safety of staff and other residents. The following MAGIC guidelines are intended to ensure safe, and effective care of residents with confirmed or suspected COVID-19 and keep staff who care for these residents safe.

Significant risks of COVID-19 transmission include the following AGPs: nebulizers, high flow oxygen, CPAP/BiPAP, open suctioning of airways and sputum induction. MAGIC has provided specific guidelines for these AGPs, including oxygen per nasal cannula should be kept under 6 L, nebulizer therapies should be avoided, and not using CPAP/BiPAP if able. If the resident must receive an AGP, staff should follow strict precautions for safety. To review these guidelines in detail, please visit: https://www.minnesotageriatrics.org/uploads/1/1/8/4/118442543/cpac_COVID-19_aerosol-generating_procedure_guidelines_pdf.pdf

Preserving PPE

We recommend that facilities adopt stewardship practices for PPE in accordance with CDC guidance on strategies to optimize PPE supply. Immediate steps you can take to preserve PPE are:

- Minimize face-to-face interactions when able
- Minimize the number of staff who need to use PPE, specifically N95 masks (limit staff caring for residents with suspected or positive for COVID-19 to a specific group of staff if able)
- Facilities participating in universal masking initiatives will wear different facemasks, depending on their potential exposure to residents with COVID-19 and their job responsibilities. Those with patient-facing responsibilities must wear surgical masks for PPE, while staff with no close or direct contact with residents might wear alternative facemasks, which are not meant for medical care and are not PPE.
- Make use of telehealth visits whenever possible, for primary provider and any specialists
- Limit laboratory studies and radiology imaging to only those that are medically necessary
- Change from nebulizer to metered dose inhalers and consider oral albuterol
- Limit or eliminate point of care blood sugar monitoring and routine monitoring of vital signs

- Decrease the frequency of medication administration
- Allow staff to wear one face mask for several shifts/days
  - Facemask may be worn throughout an entire shift and does not need to be changed when going from resident to resident. If a facemask becomes soiled, wet, torn, or no longer covers the nose and mouth, it should be discarded.
- Staff can use the same gown when caring for several individuals with the same illness following CDC guidelines
- Prioritize use of N-95 masks during respiratory procedures with a possible respiratory viral infection that likely to result in aerosolization of viral particles. During all other lower-risk care, surgical masks should be utilized.

Reusing Facemasks

A removed mask can by hung from a peg with the patient-facing side toward the wall. If there is not enough area to hang the masks, then it can be placed, patient-facing side down, on a paper towel placed on a counter. The towel is discarded after the mask is re-donned. A mask can also be placed in a paper bag—not plastic bag due to moisture. The patient-facing side will face the bottom of the bag which will then be contaminated; the bag should be discarded after one use.

Another option is to store the mask in a small box that keeps the mask suspended in the box when the straps are wrapped around the box (patient facing side will be faced into the box). Using the box option, the box can be held up to the face when donning and doffing the straps between the user's head and box. The box can then be stored in a paper bag or gift-type bag with an open top and handles.

Staff can consider using a face shield or facemask over the N95 mask to reduce/prevent contamination. Staff re-using an N95 respirators should use a clean pair of gloves when donning or adjusting a previously worn N95 respirator. It is important to discard gloves and perform hand hygiene after the N95 respirator is donned or adjusted.

The facemask should be removed and discarded if soiled, damaged, or hard to breathe through. Masks contaminated with blood, respiratory or nasal secretions, or other bodily fluids from residents should be discarded. The wearer must take care not to touch their facemask. If they touch or adjust their facemask, they must immediately perform hand hygiene. Staff should leave the resident care area if they need to remove the facemask.

Reusing Eye Protection or Face Shield

When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields or eye protection, consider the following steps for disinfecting these PPE items:

1. After removing gown and gloves and performing hand hygiene, don clean gloves
2. Remove the face shield or eye protection by the strap and do not touch the front (patient-facing side)
3. Place the item face-down on a clean paper towel
4. While wearing gloves, carefully wipe the *inside* of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe (ie: Sani-wipes or other approved cleaners). Allow to air dry for at least one minute.
5. Carefully wipe the *outside* of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution. Allow to air dry for at least one minute.
6. Remove gloves and perform hand hygiene
7. Wipe the outside of face shield or goggles with clean water or alcohol to remove residue from cleaning solution
8. Fully dry (air dry or use clean absorbent towels)
9. Hang to dry in designated clean location
10. Perform hand hygiene

Mask Shortages

To preserve the current supply, staff members can write their name on the outside of the mask. If no surgical masks are available, cloth masks sewn and donated by community members can be used. To preserve the life of an N95 mask, it can be covered by a surgical or cloth mask.

Cloth face covering are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer. Guidance on design, use, and maintenance of cloth face coverings is available.

Gown Shortages

In situation of severely limited or no available isolation gowns, the following pieces of clothing can be considered as a last resort for care of COVID-19 residents as single use. However, none of these options can be considered PPE, since their capability to protect staff is unknown. Preferable features include long sleeves and closures (snaps, buttons) that can be fastened and secured. Options that could be considered: rain ponchos, coveralls, laboratory coats, washable patient gowns, disposable aprons with disposable sleeve covers, or garbage bags in place of gowns. Reusable options should be laundered according to routine procedures. Disposable options can be wiped down if appropriate. Processes should be established to routinely inspect, maintain and replace these additional options for safe use.

PPE Shortage Requests

PPE can be requested through the State of Minnesota https://mn.gov/mmb/ppe/request/

PPE Resources

World Health Organization (WHO): When and how to use masks (Videos)
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/when-and-how-to-use-masks

CDC: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

CDC: Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html

CDC: Strategies to Optimize the Supply of PPE and Equipment https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fhealthcare-supply-ppe.html

CDC: Strategies to Optimize the Supply of PPE and Equipment https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

Isolation post-hospital discharge and discontinuing transmission-based precautions

Residents admitted to the facility should be put on standard, contact and droplet precaution for observation.

Residents with confirmed or suspected COVID-19

Residents with confirmed or suspected COVID-19 who still require transmission-based precautions for COVID-19 can be transferred to congregate living facilities as long as the facility can follow the infection prevention and control recommendations of the Centers for Disease Control and Prevention (CDC) for the care of COVID-19 residents.

- Hospital discharge planners must provide advanced notice to the facility for any transfer of a resident with confirmed or suspected COVID-19
- For residents who are symptomatic and under transmission-based precautions who do not have access to transitional sites or dedicated COVID-19 facilities, hospital discharge planners should follow a tiered approach.
  - Transfer residents to a receiving facility with a separate unit dedicated to COVID-19 residents, including dedicated staff and PPE
  - Transfer residents to a receiving facility that has private rooms with private bathrooms or can cohort positive or suspect COVID-19 residents with dedicated staff and PPE
- If transmission-based precautions have been discontinued, residents with persistent symptoms should be placed in, and restricted to, a private room in the facility and wear a medical-grade facemask during care activities until symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- If transmission-based precautions have been discontinued and symptoms have resolved, residents can be discharged back to their facility of origin, regardless of the facility's ability to adhere to infection prevention and control recommendations for the care of COVID-19 residents and the residents pending or completed test results

Persons under investigation (PUI) for COVID-19, with test results pending

A PUI (someone who has symptoms suggestive of COVID-19) should not be transferred to a congregate living setting until test results are available, unless the facility is experienced and able to handle residents with COVID-19. Clear communication about the pending COVID-19 test must be provided to the receiving facility.

Residents investigated for possible COVID-19 with negative test

Residents investigated for possible COVID-19 with a negative COVID-19 test can be discharged from a hospital to a congregate setting.
- Hospital discharge planners should communicate test results and any indication for continuation of transmission-based precautions to the receiving facility.
- Residents should be admitted to a private room with private bathroom and monitored at least twice daily for 14 days to determine whether symptoms develop that could be consistent with COVID-19. Residents should stay isolated in the room for the 14-day period. The resident may be moved out of a private room if they remain asymptomatic after the 14-day period. Staff should follow standard, contact and droplet precautions.

Residents with no clinical concern for COVID-19

At this time, residents with no clinical concern (e.g. no presence of symptoms consistent with COVID-19), can be discharged from a hospital to a congregate living setting following normal procedures. However, residents should be quarantined and monitored for the development of symptoms. Recommendations are as follows:
- Congregate living settings should not require a negative COVID-19 test result as criteria for admission or re-admission of residents hospitalized with no clinical concern for COVID-19.

- Hospitals are not required to perform COVID-19 testing on residents solely for discharge considerations unless they develop new respiratory symptoms.
- Residents should be admitted to a private room with private bathroom and monitored at least twice daily for 14 days to determine whether symptoms develop that could be consistent with COVID-19. Residents should stay quarantined in the room for the 14-day period. The resident may be moved out of a private room if they remain asymptomatic after the 14-day period. Staff should follow standard, contact and droplet precautions.
- Receiving facilities should maintain a low threshold of suspicion for COVID-19 disease and consider COVID-19 testing and implementation of transmission-based precautions immediately if a resident develops symptoms (see guidance below on confirmed or suspected COVID-19 residents).

Discontinuation of Transmission-based Precautions

- Because of limited COVID-19 diagnostic testing supplies and potentially long delays between specimen collection and results, discontinuation of transmission-based precautions should be guided by clinical conditions using CDC's non-test-based strategy.
- For immune-competent individuals with confirmed or suspected COVID-19, transmission-based precautions should be maintained until both of the following criteria are met:
  o At least 7 days have passed since symptom onset AND
  o 3 days have passed since recovery, which is defined as resolution of fever without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).
  o Residents with persistent symptoms should be placed in, and restricted to, a private room in the discharge facility and wear a facemask during care activities until symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- For residents 75 years of age and older, the period of isolation should be at least 14 days since symptom onset with 3 days of resolution of fever without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).
- For residents with immunocompromising conditions the period of isolation should be at least 21 days since symptom onset with 3 days of resolution of fever without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).

Hospital Discharges and Discontinuing Precautions Resources

MN Department of Health: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions
https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf

CDC: Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance) https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

Environmental Cleaning

Environmental Cleaning

- CDC recommends that daily cleaning of frequently touched surfaces inside the resident's room (such as door handles, bedrails, tabletops, light switches, elevator buttons [inside and out], computers, remotes, phones etc.) with an EPA-registered, hospital-grade disinfectant that has an emerging viral pathogens claim for use against SARS-CoV-2 (COVID-19). Staff assignment should account for extra services that the staff is providing to allow effective care of the residents.
- If a resident discharges or expires, environmental service staff should observe contact and droplet precautions when cleaning residents' rooms. Educate staff on proper use of PPE and appropriate choice of disinfectant. A

facemask and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated. Standard practices using an EPA-registered, hospital-grade disinfectant with an emerging viral pathogens claim are recommended for use against SARS-CoV-2 (COVID-19).

Disinfection procedure for reusable medical equipment (i.e., stethoscope, BP cuff, etc.)

1. After removing gown and gloves, perform hand hygiene
2. Don clean gloves
3. Place equipment to be disinfected on clean paper towel
4. Wipe all surfaces with approved disinfecting wipe for 1 minute and allow to fully air dry
5. Remove gloves and perform hand hygiene

List of Disinfectants for Use Against COVID-19

https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

Treatment/Goals of Care

Treatment

No vaccine or specific treatment for COVID-19 is available; care is supportive. Several potential agents are under investigation with many studies underway.

Supportive care measures include acetaminophen to reduce fevers, oxygen, and comfort medications for respiratory symptoms. Inhalers may ease respiratory symptoms, but nebulizer treatment should absolutely be avoided due to significant risk of transmission. For residents with significant respiratory illness and symptoms, symptom relief with opioids, and potentially other comfort medications, will likely be required for end of life care. Residents can decline rapidly and require higher doses or more frequent dosing of opioids for symptom management, than typically prescribed. Oxygen can also be applied and titrated for comfort based on the patient's symptoms up to 5 liters (6 liters and above increases the risk of aerosolization).

Position changes can also help with oxygenation of different parts of the lung and relieve dyspnea/hypoxia in COVID-19. This can be done in conjunction with supplemental oxygen via nasal cannula. Residents who can move independently (or with minimal assistance) can be instructed or assisted to change positions every 1-2 hours, rotating between left side, upright with bed at 60 degrees, right side, and prone (face-down with the face rotated to the side). Those who can't tolerate the prone position can rotate between the other three positions. Staff can provide assistance with pillows to support and add comfort in each position, adjust bed settings to the correct position, check to make sure oxygen tubing is not obstructed, and ensure that in each position, patients can move themselves to a different position or seek help if needed. Limited assistance can be provided for patients to move into different positions, but these positions are likely best suited for patients who have fairly independent bed mobility.

SNFs: Facilities can consult with their partnering pharmacy to ensure there is a process in place for procuring timely access to emergency kit (E-kit) medication and sufficient quantities. Each pharmacy can check with the Board of Pharmacy regarding best practice during the pandemic given a potential increased need for comfort medication quantities.

Treat in place

Due to the high mortality rate in our frail elderly, it's often in their best interest to treat in place when the facility can continue to provide the appropriate level of care. Nursing will work with providers to order necessary treatment regimens, including comfort medications.

Resource: AMDA Managing Acute Respiratory Distress During the COVID-19 Pandemic—Advance Care Plan Tool
http://paltc.org/sites/default/files/AMDA%20COVID19%20Advance%20Directive%20Final_4_14_20.pdf

CPR with COVID-19

All clinicians and staff should be aware that the efficacy of CPR is generally low in the nursing home population. CPR creates significant additional risk of contracting coronavirus due to virus aerosolization. Therefore, additional precautions are required when performing CPR during this pandemic. Early discussion of code status can help ensure that residents' goals are met, without creating unnecessary risk and exposure to staff during CPR.

Recommended modifications for CPR in full-code patients with COVID-19 known or suspected include donning full PPE with N95 respirator mask before entering the room, spreading a clear plastic sheet over the patient and utilize a bag-valve mask.

For additional information refer to AMDA's CPR Guidance During the COVID-19 Pandemic:
https://paltc.org/sites/default/files/01_Intro/CPR%20Guidance%20During%20the%20COVID-19%20Pandemic.pdf

AMDA Statement on Hydroxychloroquine [Plaquenil]

AMDA develops trusted clinical practice guidelines for health care professionals in the post-acute and long-term care (PALTC) settings that are based on scientific evidence. There is currently no evidence in the PALTC population, beyond anecdotal, that hydroxychloroquine (HCQ) is effective for treating persons infected with the COVID-19 virus, and there is also no data to recommend the use of HCQ as prophylaxis for COVID-19.

AMDA Statement on the Current Use of Hydroxychloroquine in Persons with COVID-19
http://www.paltc.org//sites/default/files/01_Intro/Guidance%20on%20HCQ%20revised%2008APR2020.pdf

Telehealth

Telehealth during the COVID-19 Pandemic

The Centers for Medicare and Medicaid (CMS) has expanded access to telehealth services in response to the COVID-19 pandemic. CMS has also broadened acceptable platforms to perform telehealth by waiving enforcement of HIPAA health privacy law violations. In addition to current telehealth platforms, providers are now able to utilize common communication tools such as FaceTime and Skype. If audio-visual applications are unavailable, telehealth visits can occur without the video component and only use the telephone.

MAGIC is recommending all providers practice telehealth and limit time spent on-site to essential visits that cannot be completed via telehealth. An essential visit would be one that would avoid an ED visit or hospitalization. We acknowledge providers are vectors of transmission and we must make every attempt to protect our residents and facility staff. CDC acknowledges that healthcare personnel and ill visitors are the most likely sources of introduction of COVID-19 into a facility. Telehealth will also help preserve the limited supplies of PPE. Recommendations for providers being on-site at facilities will evolve over time within this pandemic, as COVID becomes more widespread and PPE hopefully becomes more readily available.

MAGIC acknowledges the extra stress the on-site nursing teams are facing and our provider teams want to support facility efforts to deliver the right care to each resident. These virtual visits will be collaborative, and timing will most often be directed by nursing or facility staff. Many facilities who are successful at supporting telehealth have identified staff to implement a process with designated technology and times that it can be completed with the providers. Facilities can support telehealth with non-nursing roles that could include activities staff, chaplains, nursing assistants, facility administrative staff, as examples.

Telehealth equipment/process in a COVID-19 positive room

- Have a dedicated portable device, such as a tablet (e.g., iPad) for smartphone for COVID-19 positive or persons under investigation (PUI) if possible. The device can be covered with a water-resistant covering so that it can be wiped down after use.
- Have a staff member in appropriate personal protective equipment (contact and respiratory precautions) carry the device into the room and hold it so the resident does not have to touch the device. After completion of the visit the staff can wipe down the device.

Review MAGIC guidelines on Telehealth for additional information (3/25/20):
https://www.minnesotageriatrics.org/COVID-19.html

Hospice

Hospice Services

It is acceptable to continue allowing hospice personnel to enter the facility, at the discretion of facility staff. These are trained healthcare personnel and may be able to help reduce the burden on the staff in the facilities. Facilities should work with those individuals and agencies to limit the number of individuals going into multiple facilities. Ideally, each staff member would only visit one facility or would only visit one facility each day. Hospice staff should be screened upon entry and comply with the policies and procedures related to preventing the spread of COVID-19.

AMDA Frequently Asked Questions
http://paltc.org/sites/default/files/COVID%2019%20QA%20Community%20Spread%20March%2031%20with%20hylerlinks%20and%20Rx%20Final.pdf

Nursing Facility Staff Member Information

How do I protect myself and others?

- **Hand-washing**. The number one way to protect yourself and others is to wash your hands often and per guidelines when at work! Please use gloves when indicated AND wash your hands after removing the gloves.
- **Wear a facemask**. Do not touch the front of the facemask and remember to take it off carefully, laying the "dirty side" (the side facing outward) face down. If reusing a mask, store it in a paper bag, not plastic, to allow it to dry. If there are no facemasks available, the last option is to wear a homemade mask made of cloth. The masks are intended to help prevent you from transmitting the virus to residents. Most people with COVID-19 show symptoms 2-14 days after exposure, with generally healthy persons averaging 4-7 days before showing symptoms. During these 4-7 days you can still transmit the disease, and this is how COVID often enters a nursing home – by staff who do not show signs or symptoms.

- **Social distancing**—this is extremely important. Continue these practices even when not in the presence of residents and among staff members. Limit your travel to work and home and nowhere else except briefly to the store for food and supplies. This is the BEST way to prevent spread in the community and entry into our homes!

Should I Come to Work?

Please, yes, UNLESS you are sick, on immunosuppressive drugs, or have been advised to self-quarantine by a medical provider or have any chronic high-risk conditions that would make working in a congregate living setting unsafe even prior to Covid-19. If you are sick, please do not enter the nursing facility. Communicate with your leadership on the company procedure.

It is tempting to try to protect your family and take off work. Your residents need you now more than ever and taking off will hurt them and your co-workers. By protecting yourself with the right hygiene and equipment, and socially distancing yourself, you will be at a very low risk of getting COVID-19.

What to do if Possibly Exposed to COVID-19?

If you find out that a co-worker or resident at your facility has tested positive for COVID-19 you do not have to automatically self-quarantine or be tested right away, especially if you don't have symptoms. The employee should notify the company and monitor themselves for symptoms. They should wear a face mask for at least 14 days. Take your temperature several times a day if possible. Should you develop symptoms, stay at home and notify your company as you may need testing at that point.

What should staff do when they cared for a resident who tested positive for COVID-19 before the resident was placed on contact and droplet precautions?

Exposed staff should consult with their company and the MN Department of Health for assessment of the degree of exposure (website below). Please refer to the CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19). This interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for staff with potential exposure to COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

What if a staff member develops respiratory symptoms while at work?

Any ill staff should not be allowed to provide resident care. Sick leave policies should be non-punitive, flexible and consist with public health guidance. Any staff that develops signs and symptoms of a respiratory infection while on the job should:
- Immediately stop work, put on a facemask, inform the supervisor, and self-isolate at home
- Inform the facility's infection preventionist of contacts with individuals, equipment, and locations
- Contact and follow the local health department recommendations for next steps (e.g., testing).

Keep in mind early/atypical symptoms include muscle aches, headache and diarrhea.

When can a staff member who had a respiratory viral illness be allowed to return to work?

The CDC recommends that staff with suspected or positive COVID-19 should be excluded from work until at least 3 days (72 hours) have passed since recovery, is defined as:
- Resolution of fever without the use of fever-reducing medications
- Improvement in respiratory symptoms (e.g., cough, shortness of breath)

- At least 7 days have passed since symptoms first appeared.

All staff returning to work must wear a mask for 14 days after the onset of illness, practice hand hygiene and cough etiquette and self-monitor for recurrence of symptoms. If there is a recurrence, they should immediately stop working and report to the supervisor for guidance.

Nursing Facility Staff Sources

AMDA COVID-19 Update for the Nursing Home Worker
http://paltc.org/sites/default/files/01_Intro/Guidance%20for%20Nursing%20Home%20staff%2006APR2020.pdf

CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html

MN Department of Health: COVID-19 Recommendations for Health Care Workers (3.19.20)
https://www.health.state.mn.us/diseases/coronavirus/hcp/hcwrecs.pdf

Emotional Health/Self-care Resources

AMDA Strategies for Mitigating the Emotional Impact of COVID-19
https://paltc.org/sites/default/files/Strategies%20for%20Mitigating%20the%20Emotional%20Impact%20of%20COVID-19.pdf

MDH Managing Stress and the Threat of COVID-19
https://www.health.state.mn.us/communities/ep/behavioral/stress_covid19.pdf

University of Minnesota: Taking Care of Yourself in Isolation
https://extension.umn.edu/news/taking-care-yourself-isolation

The Substance Abuse and Mental Health Services Administration (SAMHSA): Tips for Social Distancing, Quarantine, and Isolation During an Infectious Disease Outbreak
https://www.samhsa.gov/sites/default/files/tips-social-distancing-quarantine-isolation-031620.pdf?mc_cid=87f848e562&mc_eid=00fda03ed

CDC: Stress and Coping https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html

Anxiety and Depression Association of America: Coronavirus Anxiety – Helpful Expert Tips and Resources
https://adaa.org/finding-help/coronavirus-anxiety-helpful-resources

Additional Resources

CDC Webinar: Preparing Nursing Homes and Assisted Living Facilities for COVID-19 (30 minutes, dated 4.1.20)
https://www.youtube.com/watch?v=p1FiVFx5O78

MN Department of Health: Situation Update for Coronavirus Disease 2019 (COVID-19). Provides case information for MN.
https://www.health.state.mn.us/diseases/coronavirus/situation.html

MN COVID-19 Public Dashboard
https://mndps.maps.arcgis.com/apps/opsdashboard/index.html#/f28f84968c1148129932c3bebb1d3a1a

AMDA Caring for PALTC Residents with Dementia During the COVID-19 Outbreak
https://paltc.org/sites/default/files/Caring%20for%20Residents%20With%20Dementia.pdf

Assisted Living Facilities Resource

AMDA The Society for Post-Acute and Long-Term Care Medicine & American Assisted Living Nursing Association (AALNA) Guidance & Resources for Assisted Living Facilities and Continuing Care Retirement Communities During COVID-19
http://paltc.org/sites/default/files/01_Intro/Guidance%20for%20Assisted%20Living%20Facilities%20and%20Continuing%20Care%20Retirement%20Communities%204-2-20.pdf

Additional Education: COVID-Certification

NextStep: National COVID-Ready Caregiver Certification for Healthcare Workers (Nurses, Nursing Assistants, Therapists) who support the elderly and people with disabilities in facility-based care settings https://covidcert.nextstep.careers/