Guidance and responses were provided based on information known on 5/21/2020 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates.

COVID-19 and LTC

May 21, 2020

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ICAP
Infection Control Assessment and Promotion Program

Questions and Answer Session

Use the QA box in the webinar platform to type a question. Questions will be read aloud by the moderator
If your question is not answered during the webinar, please either e-mail it to NE ICAP or call during our office hours to speak with one of our IPs

A transcript of the discussion will be made available on the ICAP website
https://icap.nebraskamed.com/coronavirus/
https://icap.nebraskamed.com/covid-19-webinars/

Panelists today are:

Dr. Salman Ashraf, MBBS	salman.ashraf@unmc.edu
Kate Tyner, RN, BSN, CIC	ltyner@nebraskamed.com
Margaret Drake, MT(ASCP),CIC	Margaret.Drake@Nebraska.gov
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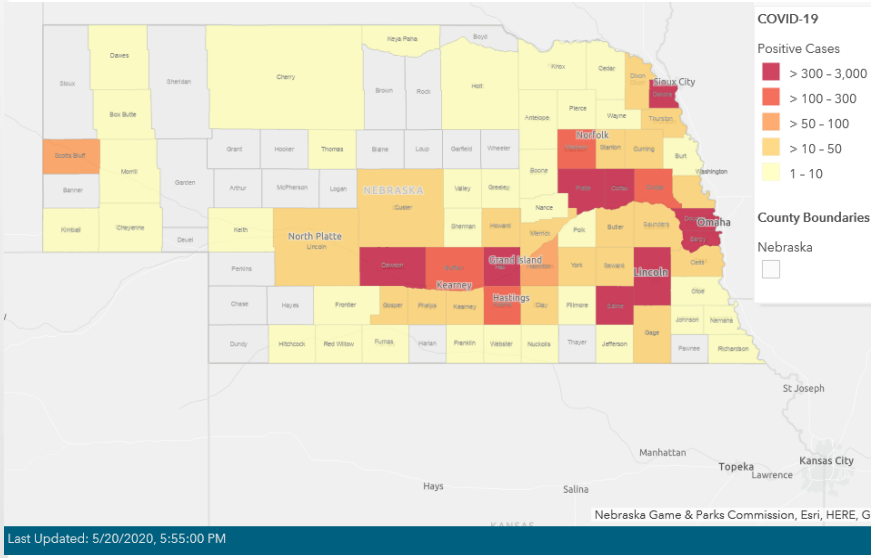
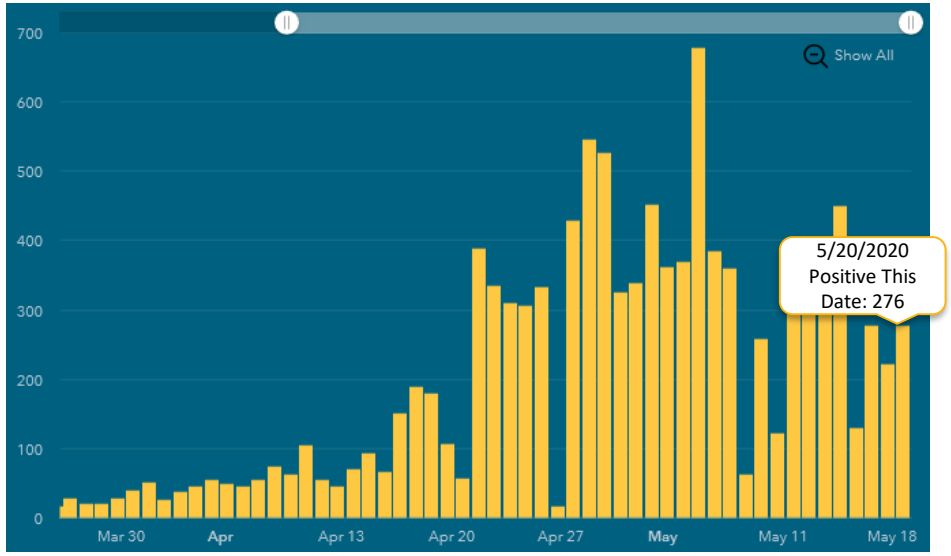
Nebraska Case Update

Coronavirus COVID-19 Nebraska Cases



New positive cases by date results were received



Total Positive Cases	Total Tested	Deaths
11,122	75,864	138

https://nebraska.maps.arcgis.com/apps/opsdashboard/index.html#/4213f719a45647bc873ffb58783ffef3

Staffing challenges

Staff who are diagnosed with COVID have to be off until they meet criteria for coming back to work.

If many staff members have been diagnosed, this can present staffing challenges.

Additional staffing options:

NE DHHS can assist with some ideas for staffing using this resource

- Email: Caryn.Vincent@nebraska.gov
- Phone: 402-471-1595 or 402-613-2377

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Return to Work Criteria for HCP with Suspected or Confirmed COVID-19

Symptomatic HCP with suspected or confirmed COVID-19

(Either strategy is acceptable depending on local circumstances):

Symptom-based strategy. **Exclude from work until:**

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 10 days have passed *since symptoms first appeared*

Test-based strategy. **Exclude from work until:**

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens)[1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

Updated 4/30/2020 https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

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HCP with laboratory-confirmed COVID-19 who have not had any symptoms

***Time-based strategy*. Exclude from work until:**

- 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

***Test-based strategy*. Exclude from work until:**

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Updated 4/30/2020 https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

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CDC also points out:

While this strategy can apply to most recovered persons, CDC recognizes there are circumstances under which there is an especially low tolerance for post-recovery SARS-CoV-2 shedding and risk of transmitting infection. In such circumstances, employers and local public health authorities may choose to apply more stringent recommendations, such as a test-based strategy, if feasible, or a requirement for a longer period of isolation after illness resolution.

Therefore, ICAP team usually suggest long-term care facilities to either use test-based strategy for clearing healthcare workers to return to work or extend the duration to 14 days from time of onset or 5 days from resolution of fever and symptoms improvement (whichever one is longer).

https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html.

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. **A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility.** After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.

- A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- Of note, N95 or other respirators with an exhaust valve might not provide source control.

Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Updated 4/30/2020 https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Discontinuation of Isolation for Nursing Home Residents with COVID-19

ICAP suggests the following strategy to make decisions in long-term care facilities on when to re-test residents with COVID-19 and discontinue isolation.

- Consider retesting the resident after at least 10 days have passed since the onset of the illness and 3 days have passed since symptoms resolution (whichever is longer).

- Residents with COVID-19 will need 2 negative tests (obtained more than 24 hours apart) before they can come out of isolation.

- If one of the two tests come back positive then wait 5 to 7 days before obtaining additional tests (will still need two negative test >24 hours apart for discontinuation of isolation).

- If the residents with COVID-19 were being managed in an isolation (red) zone within a facility, then upon confirmation of the two negative tests, they may be moved back to their own rooms (as long as they remains asymptomatic).

- It should be noted that COVID-19 PCR-tests may continue to be positive for a prolonged period of time (> 4 to 6 weeks) in some residents. It remains unknown whether these PCR-positive samples represent the presence of infectious virus. Among recovered patients with detectable RNA in upper respiratory specimens, concentrations of RNA after 3 days are generally in ranges where virus has not been reliably cultured by CDC.
    - Therefore, it may be reasonable to discontinue isolation for those residents who have been positive for more than 28 days and has remained asymptomatic for at least 7 days even if they continue to test positive.

PPE

Take precautions when extending the use of isolation gowns: Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridioides difficile*) among patients. If the gown becomes visibly soiled, it should be removed and discarded and hand hygiene should be performed after PPE removal. More information about optimization of isolation gown supplies can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html [cdc.gov].

PPE Request form link

https://form.jotform.com/NebraskaDHHS/PPERequestform.

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Gown Reuse concerns

NE ICAP advises against reuse of isolation gowns (could easily contaminate the healthcare workers' clothing).

Rather, for lower risk residents (asymptomatic, no known exposure) use a gown per standard precautions (high contact encounters and those with splash/spray risk)

Consider prioritizing gown use for the following activities only (in asymptomatic patients without diagnosis of COVID-19):

- During care activities where splashes and sprays are anticipated, which typically includes aerosol-generating procedures (such as nebulization, suction etc.)
- During high-contact patient care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care.

These gowns should be single use, that is laundered or disposed after each use. Here is the source document for the recommendation above:

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/PPE-use-when-a-LTCF-has-a-COVID-19-infection-ICAP-guidance-4.16.2020.pdf

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Crisis Strategies for Gowns

Contingency Capacity Strategies

- Shift gown use towards cloth isolation gowns.
- Laundry operations and personnel need to be augmented to facilitate additional washing loads and cycles

Crisis Capacity Strategies

- Extended use of isolation gowns (disposable or cloth)
    - the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort).
    - This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridioides difficile*) among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices.

- ~~Cloth gowns could potentially be untied and retied and could be considered for re-use without laundering in between.~~

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

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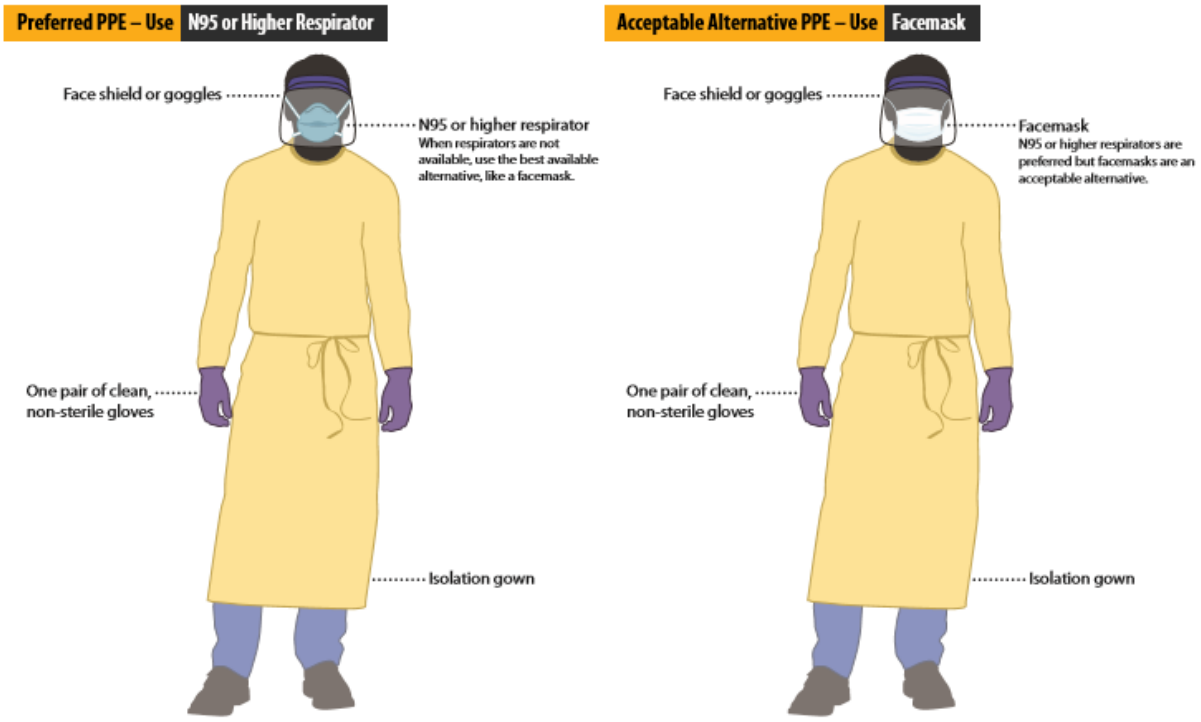
Appropriate PPE attire

https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf.

- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.



Masks should be medical grade and staff should not be wearing cloth masks

CS 316124-A 03/30/2020

www.cdc.gov/coronavirus

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Extended Use of N-95s

Extended use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several different patients, without removing the respirator between patient encounters.[2] Extended use is well suited to situations wherein multiple patients with the same infectious disease diagnosis, whose care requires use of a respirator, are cohorted (e.g., housed on the same hospital unit).

- Discard N95 respirators following use during aerosol generating procedures.
- Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients.
- Discard N95 respirators following close contact with, or exit from, the care area of any patient co-infected with an infectious disease requiring contact precautions.
- Consider use of a cleanable face shield (preferred[3]) over an N95 respirator and/or other steps (e.g., masking patients, use of engineering controls) to reduce surface contamination.
- Perform hand hygiene with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary for comfort or to maintain fit)

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Facilities with Disinfection Programs N95s –

University of Nebraska Medical Center | Nebraska Medicine

UV Light box locations in Nebraska

City of Lincoln Transportation & Utilities Municipal Service Center
901 West Bond
Lincoln, NE 68521
CONTACTS: Dave Thurber 402-326-2507 or Rod Hendrickson 402-441-7701

Regional West Medical Center
4021 Ave. B
Scottsbluff, NE 69361
CONTACT: Robin Buchammer 308-630-1545

Avera St. Anthony's Hospital
300 North 2nd Street
O'Neill, NE 68763
CONTACT: Deb Tejral 402-336-5287 or 402-340-6718 debora.tejral@avera.org

CHI Good Samaritan Hospital
10 E 31 Street
Kearney, NE 68848
CONTACT: JasonTaylor@catholichealth.net

Nebraska Ortho Hospital
Oakview Medical Building
2727 S. 144 St.
Omaha, NE 68144
CONTACT: Lori Jensen 402-699-7074 lori.jensen@OrthoNebraska.com

Chase County Community Hospital
600 W. 12 Street
Imperial, NE 69033
CONTACTS: hlwheeler@ymail.com
Kay Schmidt 308-882-7217 kschmidt@chasecountyhospital.com
Abby Cyboron ACyboron@ChaseCountyHospital.com

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/UV-Light-box-locations-in-Nebraska.pdf

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From the ICAP IP Team:

Some of our favorite resources

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N95 Respirator Decontamination Process Resources

N95 Respirator Decontamination and Re-Use Process Key Points

https://www.nebraskamed.com/sites/default/files/documents/covid-19/quick-education-n95-decontamination-and-re-use-process.pdf

UV Treated N95: Donning and Doffing (steps with pictures)

https://www.nebraskamed.com/sites/default/files/documents/covid-19/donning-doffing-uv-treated-n95-respirators.pdf

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https://repository.netecweb.org/files/original/f227e6c708549b770225b9883e686403.pdf

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Nebraska Medicine/ UNMC Universal Masking Guidelines Step-by-Step

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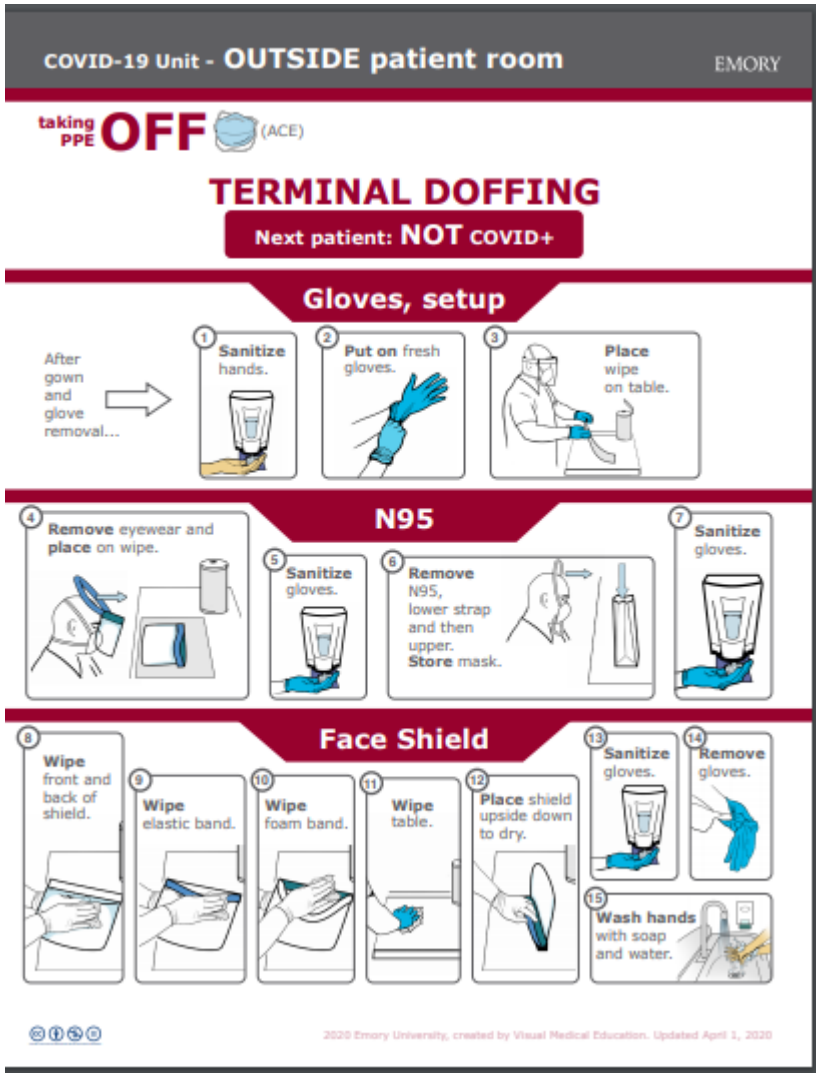
https://www.nebraskamed.com/sites/default/files/documents/covid-19/universal-masking-guidelines-step-by-step.pdf?date=05062020

Terminal Doffing

After Gown and Glove Removal…

1. Sanitize hands
2. Put on fresh gloves
3. Place wipe on table
4. Remove eyewear and place on wipe
5. Sanitize gloves
6. Remove N95, lower strap and then upper. Store mask
7. Sanitize gloves
8. Wipe font and back of shield
9. Wipe elastic band
10. Wipe foam band
11. Wipe table
12. Place shield upside down to dry
13. Sanitize gloves
14. Remove gloves
15. Wash hands with soap and water



https://repository.netecweb.org/files/original/903b6db9504582cc2a655f175aab905e.pdf

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Resources

Nebraska COVID cases LTC update
https://nebraska.maps.arcgis.com/apps/opsdashboard/index.html#/4213f719a45647bc873ffb58783ffef3
Return to work criteria for HCW CDC
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html.
Isolation gown use strategies
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html [cdc.gov].
Gown use recommendations
https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/PPE-use-when-a-LTCF-has-a-COVID-19-infection-ICAP-guidance-4.16.2020.pdf
Proper PPE attire poster
https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf.
N95 reprocessing centers in Nebraska
https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/UV-Light-box-locations-in-Nebraska.pdf

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Infection Prevention and Control Office Hours

Monday – Friday
7:30 AM – 9:30 AM Central Time
2:00 PM -4:00 PM Central Time
Call 402-552-2881

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Questions and Answer Session

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A transcript of the discussion will be made available on the ICAP website

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Dr. Salman Ashraf, MBBS
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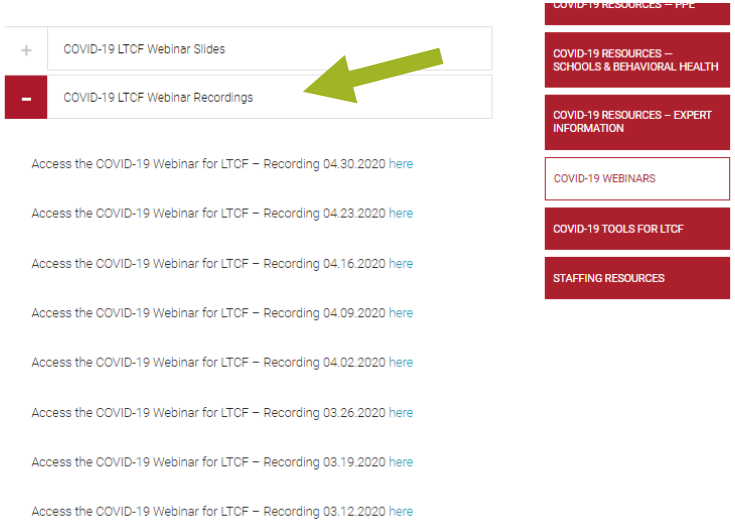
Margaret Drake, MT(ASCP),CIC
Teri Fitzgerald RN, BSN, CIC
Dr. Tom Safranek, NE DHHS

Moderated by Mounica Soma, MHA



https://icap.nebraskamed.com/resources/

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Nebraska DHHS HAI-AR and Nebraska ICAP
Long-term Care Facility Webinar on COVID-19 5/21/2020

1. **Our facility has had no COVID-19 cases and our county has very few cases. I know that CMS is now allowing facilities to restart communal dining with 6 foot distancing. This is very difficult to accomplish, as most tables are only 4-5 foot square tables so that means one resident/table. Like everyone else, we are seeing weight loss and increased depression among residents. We are considering starting communal dining again but are struggling with how to accomplish this without having four separate dining times, which is not feasible. My question is can we have residents that are roommates sit together at the same table since they share the same bedroom and bathroom?**
   No. Even in a shared room, there are curtains that provide some kind of source control between residents, but that isn't possible at a small dining table unless you have a Plexiglas barrier installed on the table. We understand the issue; one possible solution might be to some of the residents out for dinner and some out for lunch, so everyone gets out once a day but the 6-foot distance between people would be maintained. With current restrictions, that is the best option.

   Response from webinar viewer via email: In our teams discussion we have thought about adding a bedside table at each table (when moving in that direction), this makes the 6-foot distance between residents.

2. **Do you feel it is safe for dietary aides to enter into a room in a green zone to hand sanitize before entering, present/set up the residents food in the room and then sanitize hands and serve a resident in the next room? Or do you feel it should be the dietary aide staying outside the room and then the nurse or nurse aide presenting/ setting up the food for the resident in the room?**
   When possible, have as few staff members enter the room as you can. In a red or yellow time, the dietary aide entering the room would need PPE and that is in short supply. You might be able to use the dietary aid to remove the trays from the clean cart and hand them to the staff member in PPE to give to the residents. We have seen cases where dietary aides have been positive and residents positive, so we don't know who has transmitted the COVID. If you could eliminate the need to expose residents to that one additional worker, that's the best choice. This is true in the "yellow" zone, but in the "green" zone you could have the dietary worker take food into the room, so long as that worker is aware of using hand hygiene, etc.

3. **If a resident that tested positive and was in quarantine for 14 days and a repeat test on day 14 is still positive, what type of isolation does the patient need to in at this time? What PPE is necessary?**
   That person still needs to be in full COVID-level precautions. He needs to be in the red zone, using red zone PPE. You need to get two negative tests, or go the full 28 days with the patient asymptomatic for more than a week before you can take them out of isolation.

4. **With potential needs for testing for Nursing Facility residents and staff, what are ICAP's recommendations? I am hearing of some facilities where there are being teams deployed to do testing of the entire facility. Is that testing something that is being done through DHHS?**
   We have heard of some facilities choosing themselves to do a point prevalence study inside their facility, hiring a contractor and getting testing everyone. That was not the recommendation of the state DHHS. In other places where the National Guard has done testing in the whole community and a high number of COVID positive cases are found with a high rate of transmission, we have heard that the National Guard has gone into a few facilities and done that testing. There may be some situations in high-risk communities where that has happened, but at this point, there has not been wide-spread, large-scale testing across the state and there has not been a recommendation on that.

5. **I am hearing COVID positive staff in other facilities say they experienced fatigue and some gastrointestinal disturbances. Is this a symptom we should be focusing on, in addition to respiratory illness, as a strong indicator of suspicion of COVID?**
   We are continually seeing updated listings of symptoms to watch for with COVID. Here is a link to the latest guidance we have on our ICAP website: https://paltc.org/sites/default/files/Active%20Screening%20apr%2028_revised.pdf. This screening tool was written for residents but would also apply to staff. Fatigue, body ache, loss of taste and smell and even headache are all symptoms that have been added to the screening guidance since it was first written. If you see those symptoms in a staff member, you should stop them from working and test them.

6. **If half of the hallway of dementia residents tests positive would you consider the whole hall a red zone? The residents all have dementia and would not be compliant with isolation.**
   There are different ways to handle this. Some facilities were able to build some type of partition within that memory zone so the red zone patients are one side of the partition and yellow zone patients are on the other side of the partition. Making the whole unit as a red zone can make sense, but you need to be careful. In the red zone, we have suggested that someone working in the zone could wear the same gown going from room to room (i.e., dispensing medications). But if you have patients who have not tested positive for COVID living in that same red zone, you can't employ the same red zone strategy of using the same gown throughout the unit. If you call it a red zone, you might not be able to follow that same reuse of gowns strategy. You still want to try to establish the most separation as possible between the positive and negative residents in the unit. You are still trying your best not to have transmission of COVID between positive and negative residents. There is a guidance for memory care unit https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/caregivers-dementia.html, but remember that this red zone is not the same one we typically discuss on calls. It will require a modified strategy. You have to be careful in the hallway and wear your eye protection and N95 masks in the hallways at all time. For residents, still try to differentiate between the yellow and red zones.

7. **Is it acceptable to store a designated employee's cleaned/sanitized face shield(s) in a grey zone resident isolation room if it is near the entrance and more than 10 feet away from the**

resident care area? Do the face shields need to be brown bagged individually after they are cleaned?
If the question is if you can store clean patient care equipment in a resident room when the patient is there, you should not do that. If you are using a resident room with no patients in it as a clean storage room, you could do that. You still need to follow basic infection control principles of not storing clean and dirty items together. Even in a brown paper, the face shields should be stored in a break area away from patient care. Before you start your shift you put on your clean shield for the day.

8. **Why do you think that more facilities are not taking advantage of the UV light disinfection?**
The UV light disinfection is a very new process and not all facilities know it is available. Facilities also have to come up with a transport system, but that could still be a barrier. We want to know from facilities if there are other barriers to using the UV disinfection. Please email or call during office hours to give ICAP this information. (Chat box input was invited here).

9. **When are you considering to letting up on the lockdowns of facilities? What do you want to change to start considering this? Residents and families are asking this every day.**
CMS has announced a guidance that is currently being reviewed by Nebraska DHHS licensure staff. Part of the CMS guidance allows state authorities to make some of these decisions based on COVID cases in the state. Don't expect visitation to start tomorrow; it is listed in CMS guidance as coming in Phase 2. The state will be announcing that after consideration. There may be some phased in loosening based on testing strategies, etc., but that information is not available yet. We hope to add this information to the transcript after we contact the DHHS if they are ready for us to announce it.

10. **Leading Age developed the Post-Acute Transfer Covid 19 Assessment for residents transferring from hospitals to nursing homes. Are there guidelines for how often to test those patients who are in/out of hospitals frequently? If they are tested in hospital and are negative, come to the nursing home, then go back to hospital for a few days, then come back to the nursing home, should they be tested with every hospitalization even if it is in the same week as their first negative test?**
Testing depends on what symptoms are causing them to be hospitalized. Are they going in to be treated for a fall, or for symptoms that might come from COVID-19? If they are going in for COVID-19 like symptoms, then they need to be tested. If they are going in for a continuation of an earlier hospitalization or other issues, then they probably would not need to be tested. Even the Leading Age algorithm doesn't ask for testing all the time, just for certain symptoms.

11. **If we have someone from our staff doing the COVID-19 swabbing to obtain the baseline testing– what happens if someone they swab comes back positive? Will the staff member who did the testing be required to self-isolate because they have a known exposure? The employee would be in full, appropriate PPE when doing the swabs.**
If the person is using the appropriate N95 facemask, gown and gloves, there is no exposure you are considered fully protected and you should not be required to stay away from work. CMS guidance recommends that if you are in a two-patient room, only one of those patients should

be in the room during the testing procedure. The healthcare worker would be protected by PPE, but the other resident would not be predicted.

12. **In our independent and assisted living environments, we are experiencing challenges with a couple of things. People are being discharged from one health system while still testing positive and not notifying anyone in the community of the discharge or the situation. In other health systems, they are not discharging patients until two negative tests. What is the best practice that we can ask for to keep our residents and staff safe? In a recent situation, it involved two county health departments as well.**
    The best way to deal with that is to educate the patient who is being discharged home. Give them very clear guidelines about when they can come out of isolation. The local health department should always be informed. If the patients are being discharged to another local health care jurisdiction (while the discharging hospital is in a different local health department jurisdiction) that communication is essential to protecting everyone. There is no need to keep a patient in the hospital until there are two negative tests for COVID. The patient can be discharged safely and self-isolate so they don't need to stay in the hospital.

13. **I am not seeing the printouts on the website for this webinar – Sorry for the delay in posting; here is the link:** https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/05/COVID-19-and-LTC5.21.2020-FINAL.pdf