Guidance and responses were provided based on information known on 7/16/2020 and may become out of date.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

## July 16, 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 |
| Teri Fitzgerald, RN, BSN, CIC | TFitzgerald@nebraskamed.com |


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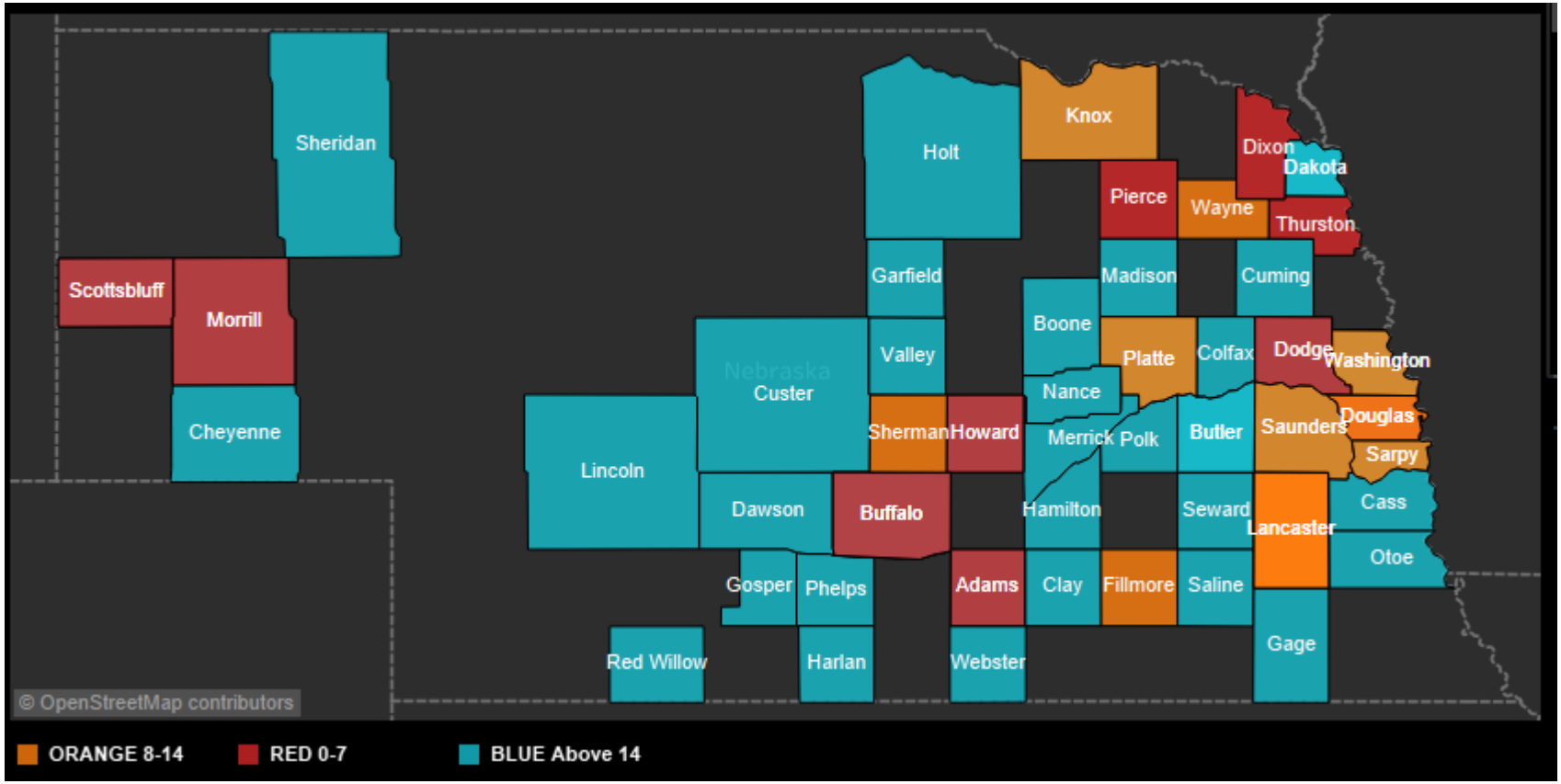
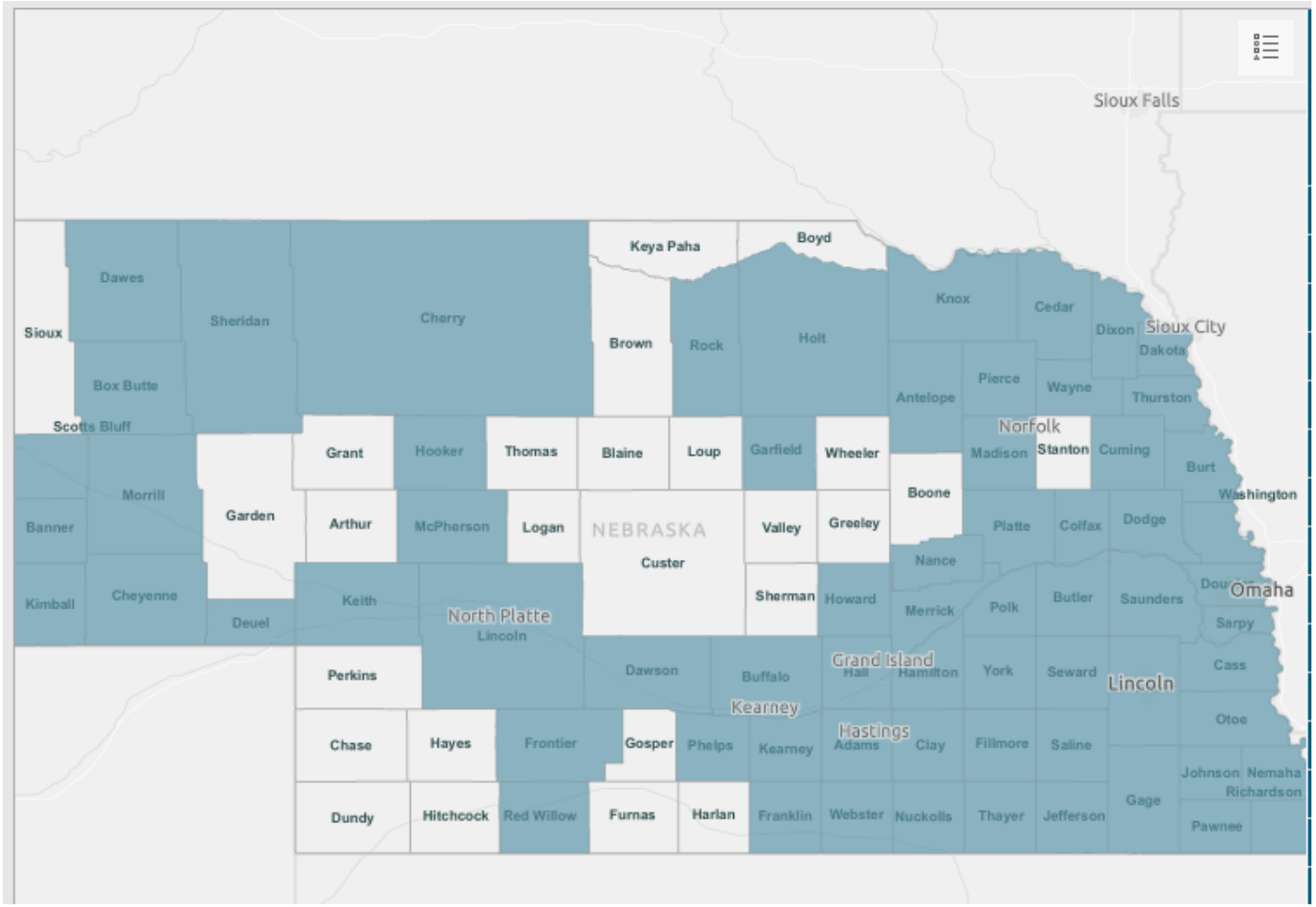
# Map showing Counties Categorized by Days Last Tested Positive Cases




Updated: 7/16/2020 8:00AM CST
Source: Unofficial Counts Compiled by Nebraska ICAP based on date reported by facilities; Actual Numbers may vary slightly

# Nebraska COVID-19 Cases DHHS




Last 14 day Positive Cases as of 7/15 3:40 pm

https://experience.arcgis.com/experience/ece0db09da4d4ca68252c3967aa1e9dd

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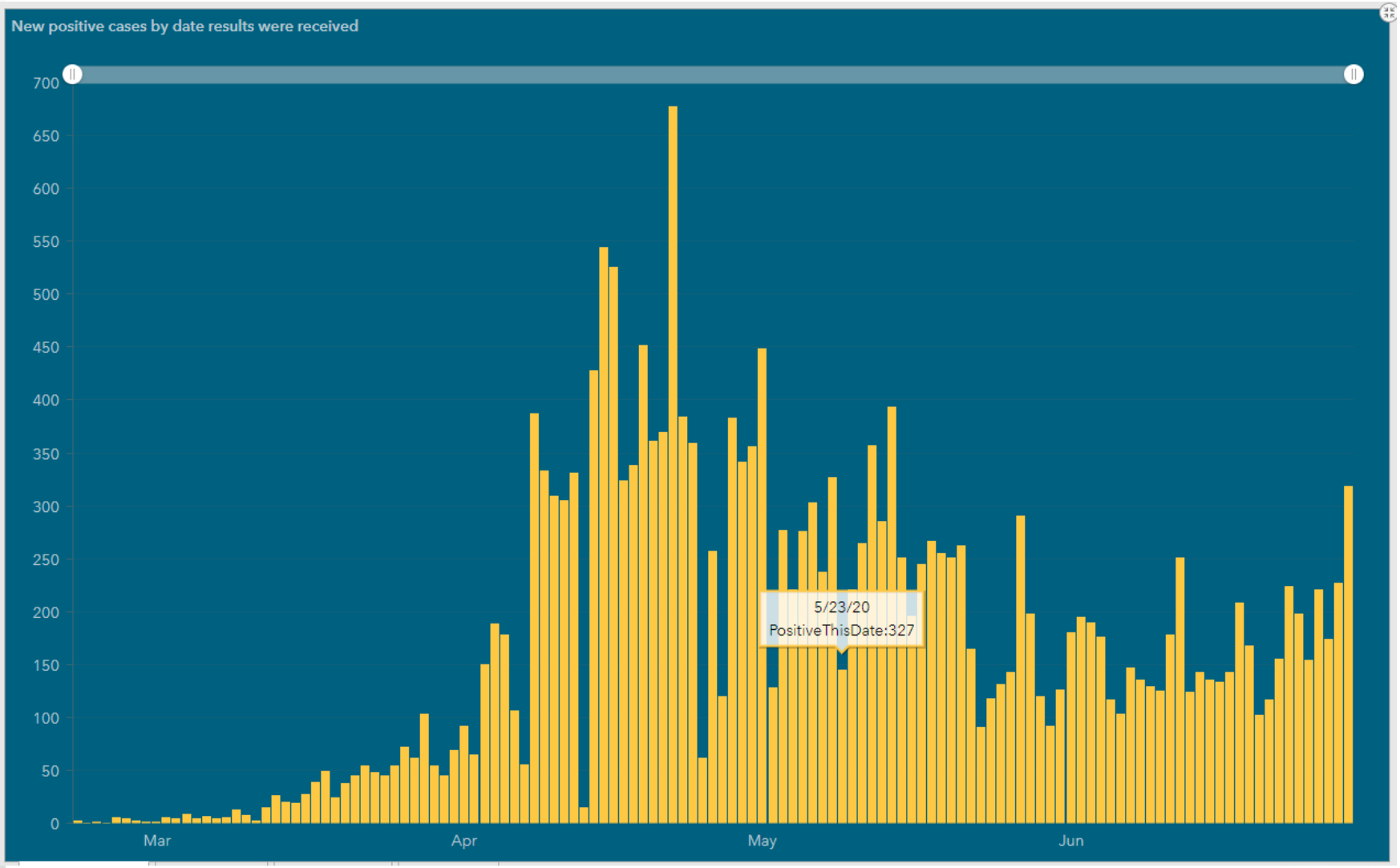
# Nebraska COVID-19 Cases DHHS




New positive cases by date as of 7/15 3:40 pm

https://experience.arcgis.com/experience/ece0db09da4d4ca68252c3967aa1e9dd

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# What's New?

New guidance or data in the past week

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# New CDC Guidance: Universal Eye Protection

**Changes to the guidance as of July 9, 2020:**

Clarified that the recommendations for universal use of eye protection (in addition to a facemask) for HCP working in facilities located in communities with moderate to sustained SARS-CoV-2 transmission is intended to ensure HCP eyes, nose, and mouth are all protected during patient care encounters

# Universal Source Control

HCP should wear a facemask at all times while they are in the healthcare facility, **including in breakrooms or other spaces where they might encounter co-workers**.

- When available, facemasks are preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others.
  - Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is needed.
- To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same respirator or facemask (extended use) throughout their entire work shift, instead of intermittently switching back to their cloth face covering.
  - Respirators with an exhalation valve are not recommended for source control, as they allow unfiltered exhaled breath to escape.
- HCP should remove their respirator or facemask, perform hand hygiene, and put on their cloth face covering when leaving the facility at the end of their shift.

Educate patients, visitors, and HCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth face covering.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

# What's hot?

Common questions heard at ICAP

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What if my staff members cannot get an adequate seal check on the N95 respirators that are provided?

*Image: Pixabay*

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# CDC Guidance

- HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection.
- When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring Airborne Precautions (e.g., tuberculosis, measles, varicella). Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

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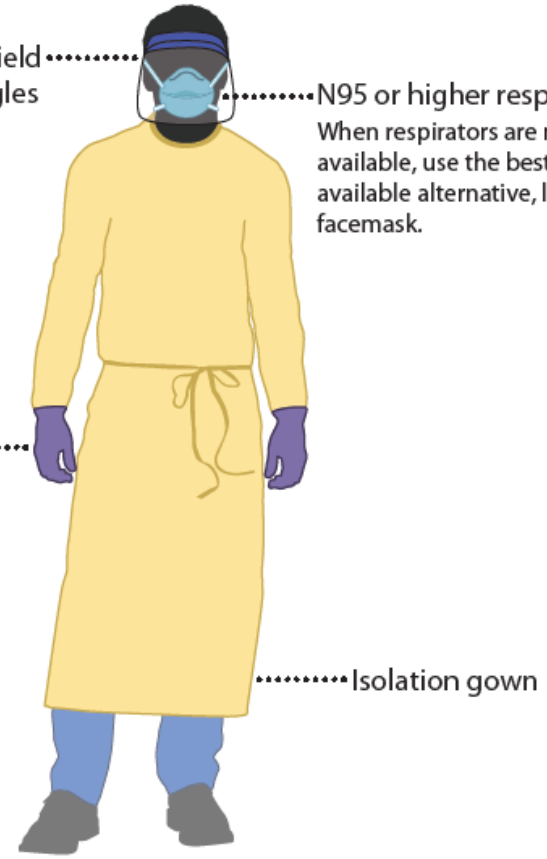
https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19_PPE_illustrations-p.pdf

# COVID-19 Personal Protective Equipment (PPE) for Healthcare Personnel

## Preferred PPE – Use N95 or Higher Respirator




## Acceptable Alternative PPE – Use Facemask




cdc.gov/COVID19

# Explore all options

- Normal vendor for supplies
- Shift equipment within corporation to high need buildings
- Nebraska DHHS PPE request program
- Continue efforts/ don’t give up

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# What is a user seal check?

A user seal check is a procedure conducted by the respirator wearer to determine if the respirator is being properly worn. The user seal check can either be a positive pressure or negative pressure check.

During a positive pressure user seal check, the respirator user exhales gently while blocking the paths for air to exit the facepiece. A successful check is when the facepiece is slightly pressurized before increased pressure causes outward leakage.

During a negative pressure user seal check, the respirator user inhales sharply while blocking the paths for air to enter the facepiece. A successful check is when the facepiece collapses slightly under the negative pressure that is created with this procedure.

A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on).

More info at this link
We often recommend this video
https://youtu.be/pGXiUyAoEd8

# If you cannot get a seal:

Option 1:

Do not work in a zone that requires it (transition/gray, yellow, or red)

Option 2:

Wear a regular surgical mask.

- An ill-fitting N95 is less protective than a surgical mask, which will filter 60-70% of particles

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# Additional considerations regarding N95

- Continue to make effort to procure the right size N95
- Consistently document the procurement issues and rationale for not using N95
- Staff at least one person on each shift that can wear an N95 for high risk procedures/ resident care

| Exposure | Personal Protective Equipment Used | Work Restrictions |
|---|---|---|
| HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 | HCP not wearing a respirator or facemask[4] | Exclude from work for 14 days after last exposure |
| | HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask | Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19 |
| | HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure[1] | Any HCP who develop fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. |

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

| Exposure | Personal Protective Equipment Used | Work Restrictions |
|---|---|---|
| HCP other than those with exposure risk described above | N/A | •No work restrictions<br>•Follow all recommended infection prevention and control practices, including wearing a facemask for source control while at work, monitoring themselves for fever or symptoms consistent with COVID-19[6] and not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19[6] at the beginning of their shift.<br>•Any HCP who develop fever or symptoms consistent with COVID-19[6] should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. |

Any healthcare worker who tests positive should not work. They should be is isolation and once completed their isolation then will return back to work.

**ONLY IN CRISIS MODE** the CDC suggest that positive asymptomatic healthcare worker can work in a COVID-unit. That should be a **VERY RARE OCCURRENCE (ALMOST NEVER).**

In short, if a facility has a positive staff member regardless of whether they have symptoms or not, they **should not** work until are done with their isolation.

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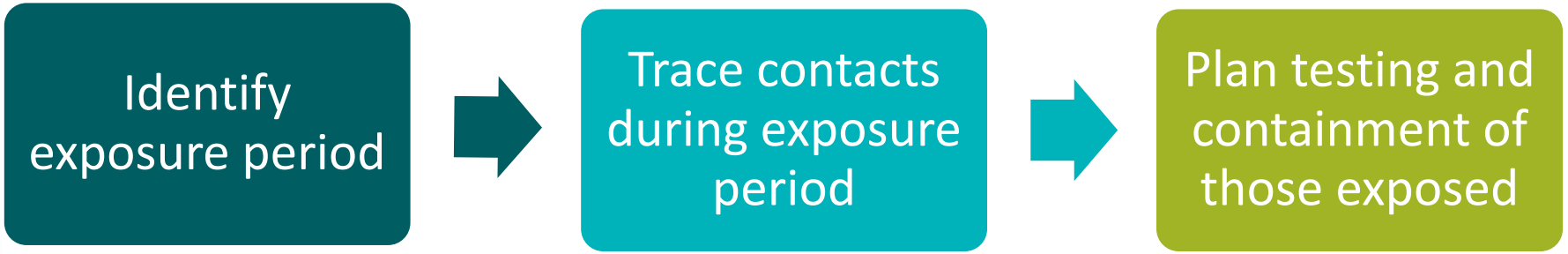
# Exposure Evaluation

- For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset
- If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

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After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. Repeat testing should be coordinated with the local, territorial, or state health department.

Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

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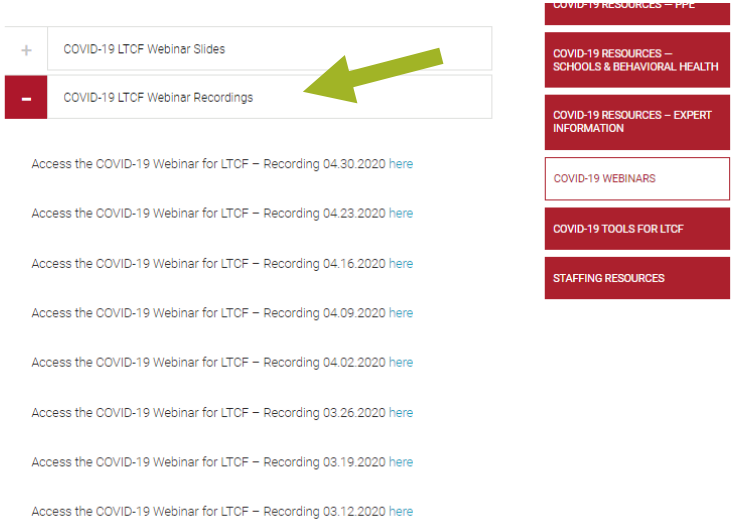
A transcript of the discussion will be made available on the ICAP website

Panelists:
Dr. Salman Ashraf, MBBS
Kate Tyner, RN, BSN, CIC
Margaret Drake, MT(ASCP),CIC
Teri Fitzgerald, RN, BSN, CIC

Moderated by Mounica Soma, MHA

Supported by Sue Beach




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

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Responses were provided based on information known on 7/16/2020 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates.

**Nebraska DHHS HAI-AR and Nebraska ICAP**
**Long-term Care Facility Webinar on COVID-19 7/16/2020**

1. **Once a facility enters Phase 3 and is able to allow limited visitation, are therapy dogs allowed?**
   The most recent guidance Kate has seen on therapy dogs is from the CDC where the guidance says to treat your dogs the way you treat your family. You don't want to take them around and expose them to more people than needed. We would advise dog owners not to do that. We have to remember that this virus has only been known about for seven months and we don't have a ton of data on how animals carry or are affected by COVID. Because of that gap in information, it isn't time to roll the dice because we don't know what that could do. Dr. Ashraf added that in general, Kate is right, the guidance is to avoid pets in the facility. If there is a medical or psychological need for therapy, then in those scenarios you will be extra careful and just limit the exposure to the person in need. Avoid the common areas and go only into the resident room who has a therapy need. It is not completely, absolute a "no", but any animal/pet there has to be a real psychological/mental/therapy need. For those purposes, it would be okay but limit the exposure to that resident who is in need as much as possible.

2. **I saw a news story last night that said when someone has a diagnosis of COVID and retests and still shows they are positive, that it is being counted as another case of COVID. Is this true?**
   If it is after two months (eight weeks) it can be true. Within the eight weeks, it is very hard to say that people have a new case. Even after eight weeks people can continue to have a positive PCR from their previous infection, but as of right now CDC guidance says you can retest, looking for the infection, after eight weeks. So if they are tested after eight weeks, then there can be a question. I am not 100 percent sure that anyone has a really good grasp if this is really a new infection, a reinfection, or just a continuation of the first positive infection. But if there is a really clear reasons to believe this a new infection and they are tested again after eight weeks, and there is a positive test result, then it is possible that it can be a reinfection. Kate Tyner said she thinks that some people seem to think that the data is not accurate because of factors like this. However, there are not a lot people who are lining up to be retesting after they had a positive test. She does not think even if that were happening that it would inflate the numbers very much. In long-term care, ICAP has advised that we don't retest people who are known positives unless they meet certain criteria and we have waiting periods for that discontinuation period. This is not a large amount of cases that would make us have any uncertainty about the data you would find on the DHHS website, for example.

3. **In non-transition units, do you feel it is okay to allow dietary personnel to enter into resident rooms to set up room trays? Do you know if there is a regulation stating that dietary**
   Dr. Ashraf said if we are talking about a green zone where no one is exposed, symptomatic or positive for COVID-19. In those units there is no restriction on a dietary person going in the room and delivering a tray. However, Dr. Ashraf recommends that these staff always perform good hand hygiene before entering a room and always wears a mask. Anyone with resident

interaction should be wearing a surgical mask and should be doing good hand hygiene going in and out of the room. Dr. Ashraf has seen situations where the dietary teams are going in and out of the rooms on a unit and not washing hands between the rooms. That should not be happening. You can have dietary staff going in and out of a room in the green zone, but be sure you instruct them about good hand hygiene between the rooms and always wearing their masks 100 percent of the time.

4. **The CDC guidance for universal eye protection for those facilities in areas of sustained transmission makes sense. The exposure guide mentioned for the employee would self-monitor though if they were not wearing the eye protection but wearing a mask when exposed to a COVID-19 positive resident without a mask. This seems confusing or contradicting; can you please clarify?**
   Kate asked the group to remember that the exposure guidance was written before the universal eyewear recommendation came out on July 9. People have been working towards this for some time. The need to have it on a table is important because many facilities did not have that in place. If the people are self-monitoring and are they in the building, they could work so long as they are screening for symptoms, etc. They would not be automatically excluded for not wearing a face shield. That is different from someone not wearing a mask. Not wearing a mask is an automatic exposure. The slide with the exposure guidance was reviewed again and Dr. Ashraf tried to clarify on the discussion point from that table. The first point on the table was that if the healthcare worker was not wearing a mask, then it is always an exposure. The other part discussed was about healthcare personnel not wearing eye protection. In the scenario shown, the person with COVID not wearing a cloth mask. If you are encountering a person who is COVID positive, you are wearing a mask and you are not wearing an eye protection and the person who is COVID positive is not wearing a mask, you can get exposed through the eyes. That is because this person's secretions are not contained. If the COVID positive person is talking droplets are probably going into the air. Even if you are wearing a mask, there is a good chance that your eyes can get exposed. In that situation, it is recommended that if you were not wearing eye protection, you might have been exposed and you might have to take 14 days off. The point is that even if you are wearing a mask you ask the other person to wear a mask to avoid exposure.

5. **Do you have any clarification as to what is meant when stating a resident has "diarrhea"? If a resident has one stool without any other symptoms and receives medication to prevent constipation do you recommend testing?**
   That is a different scenario. In that case, you have a reason to give the medication Is that one stool. This refers to someone who is given medication because they are constipated, and the medication triggers a bowel movement. This is an expected response of a medication and that is a totally different scenario. Dr. Ashraf would not count it as a symptom of COVID-19.

6. **We were told that our dialysis patients who were positive and are recovered did not need to remain in gray zone and could go back to their normal rooms. Has this thought changed?**
   A grey zone is for transitional people who are coming into a facility and doing their quarantine. Once quarantine is over, they can go into a green zone if they are okay at that point in time.

Kate asked Dr. Ashraf about the potential for reinfection among dialysis patients and if that would affect whether or not they would be moved into the green zone. Dr. Ashraf noted that his earlier advice was directed to the general population of long-term care facilities. Decisions about dialysis populations depends on which county you are in. If a facility is still in Phase 1 or Phase 2 of reopening, and there are still cases of COVID in your community, dialysis patients are still at high risk for exposure as they go in and out of the facility three times a week for treatment. In that scenario, you probably will still want to keep them in the grey zone, as long as the risk of community transition remains. Even if you go into Phase 3, you are not mandated to keep them (or anyone else) in a grey zone, but if you have specific If you are in Phase 3, and still seeing cases of COVID 19, your dialysis patient is still at high risk of exposure when they come in and go out. Want to keep them in the grey zone. Even in Phase 3, you are not mandated to keep anyone in the grey zone. But if you have specific risk factors in your community or in the dialysis facility, you may want to keep that person in a grey zone even after you have you have gone into Phase 3 and even after the 14 days are over. That is still in place if your community transmission warrants that. If the hospital cases, community cases, and/or dialysis facility is seeing cases you may want to continue the grey zone for those dialysis patients. But if your community is not seeing cases, your hospital is not admitting COVID-19 positive patients, nor is the dialysis facility is not seeing COVID-10 cases, especially if you are in Phase 3, then you don't have to keep that person in the gray zone, not even for the first 14 days.

7. **With the guidance for a face mask at all times, how should facilities handle break rooms for meals? Obviously staff cannot wear a mask to eat.**
   Kate said some facilities have handled this by opening up additional spaces for break to keep people socially distanced. That might allow for only having one or two people in a fairly large break room. Sometimes people can eat outside at picnic tables, distancing people wherever you can. We know people need a break to eat, etc., so facilities need to plan for that. You can also consider Plexiglas dividers or other things to put more precautions in place.

8. **What are the height guidelines for the Plexiglas?**
   The height guidance depends on what you are doing near the Plexiglas. If people are seated like in a place like a dining room table and they only take off their masks once people are seated, it would need to be a different height than if people are standing up. The height has to be above your head to be safe. If not, the droplets coming out of your mouth (if you are talking, sneeze or cough) could go above that Plexiglas barrier. A barrier your head is controlling the source. If it comes up to your chin, it is not going to give you the amount of source control you are looking for. Dr. Ashraf doesn't know if there is a written height somewhere we can share, but that is the general principal.

9. **An employee tested positive in April. She was retested in July and is now presumptive positive. Will this be an issue for all past positive residents and staff during baseline testing? What is the timeline to shed COVID from the body for elderly residents and middle-aged staff?**
   Retested to July. That is about three months into the disease process, which is highly unusual, but If we know the specific dates we can look into it further. Dr. Ashraf invited the questioner to contact ICAP after this webinar to go over the details further. Usually the CDC says that after

eight weeks you can retest. You should not be retesting someone who previously tested positive within e weeks of that first test. If a facility is doing a baseline testing, don't test anyone who was positive in the last three months. If it beyond the three months, Dr. Ashraf would be anxious to know whether the patient has a reinfection. Kate said that if a facility has that situation, ICAP would want to work with them one to one to sort out the details. So far, ICAP has not identified a reinfection case in any of our long-term care facilities.

10. **What should the temperature "number" on the resident and staff screening tools say? Do we go by the CDC/McGeer definition of a fever or is the temperature number lower when doing the COVID assessment? Just clarifying. Right now we are using 99.6.**
    The temperature definition in the McGeer is pretty good to use. The problem with resident testing is using a set number like 100 is not a sure thing (100 or above is a fever in an older person, or a repeated 99, also considered a significant issue.). If the temperature is two degrees F above the resident's baseline then that is also definitely a fever. For staff members you can use the CDC definition for a fever.

11. **If residents and family members are visiting outdoors, and there is 10 feet between them, would it be appropriate for the family member to wear a Faceshield instead of a mask so the resident can actually see their face? The resident would be wearing a mask.**
    Dr. Ashraf thinks the masks are more protective than the face shields. We don't have good scientific data on the protective nature of using a faith shield alone. Kate said that would be a risk she wouldn't want to take. Until we get more guidance, it is better if a mask is worn. Dr. Ashraf added that If you prolong the distance that is probably okay, but we don't have much concrete data on that right now. ICAP will continue to discuss this with its partners and pass along the information later.

12. **We purchased a Plexiglas drum shield that works great. Is also somewhat portable and looks better than something we can make. Drum Shield link:** https://www.amazon.com/Shield-Screen-Panels-DS6L-Living/dp/B01DJJJ78E/ref=sr_1_1?dchild=1&keywords=drum+shield+6+foot&qid=1594922102&sr=8-1