Long Term Care Outbreak Response Train-the-Trainer for Health Departments

Presented by Nebraska ICAP
In collaboration with
CDC Project Firstline

Housekeeping

Guidance and responses were provided based on information known on Feb. 16, 2021 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates.

Slides from this presentation will be available on the ICAP Website at:

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COVID-19 Containment In LTCF

Week 2

February 16, 2021

Monitoring Staff and Residents

CDC Firstline Video Resources

Training: Closely Monitor Residents for COVID-19 [Video – 7:16]

CNW1

Key point: The earlier we identify sick residents, the better we can prevent COVID-19 from spreading. Closely monitoring ill residents also allows early escalation of care (i.e. hospitalization) and better outcomes.

https://www.cdc.gov/infectioncontrol/projectfirstline/training/nursing-homes.html

Slide 5

CNW1 tweaked wording here
Cortes-Penfield, Nicolas W, 2/11/2021

CNW2

A case study:

Situation:

A resident has tested positive (2/8) for COVID-19.

Resident refused vaccination

Has a history of COPD

Has had visitation from family

Is currently inpatient at local hospital

Daughter reports that symptom onset was Friday 2/5, but resident did not report this to staff.

This is an assisted living facility. They had a serious outbreak of COVID-19 in early November, so any previously infected staff or residents are just now about 90 days post infection. They have used Abbott Binax Cards for rapid testing in the past and are prepared to resume this.

Slide 6

CNW2 Can we add some specific questions to guide discussion here, either on the same slide or a second slide?
Cortes-Penfield, Nicolas W, 2/11/2021

Case Identification

First Steps for a LTCF

- Inform Local Health Department of Positive COVID-19 case
- Inform Licensure (LTC-CMS Survey team)
- Notify facility leadership and activate Incident Command System if it has not already been activated.
- Identify a point person (IP, DON, ADON etc.) who will subsequently get in touch with Nebraska ICAP team for reviewing infection control measures on an ongoing basis in coming days.
    - ICAP will assist long-term care (including skilled nursing) and assisted living facilities with implementation of infection prevention strategies and may advise on testing, isolation, staff cohorting, PPE use and other infection control related issues
    - The introductory call will preferably include facility leadership, local health department and ICAP team, when possible and will be arranged by the local health department.

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

SS1
CNW3

Nursing Facility Versus Assisted Living

	Nursing Facility	Assisted Living
Operational Structure	Medical Model	Social Model
Nurse Availability	With a few exceptions, required to have 24-hour nurse coverage and have an RN onsite eight hours per day, seven days per week.	Only required to have a nurse consultant to oversee medication administration and medication aide training. Nurse consultant may only visit facility a few times per year.
Level of Care	May vary based on staffing. For example, if patient requires an RN service multiple times per day may not have the staffing to provide this level of care.	With a few limited exceptions, licensure prohibits the provision of "complex nursing care." Typical services provided are meals, emergency response, medication administration. May provide limited assistance with bathing, dressing, grooming, etc.
Population Served	Individuals requiring nursing care.	Individuals who are mainly independent but want or need limited (non-medical) assistance.
Medical Oversight	Required to have a Medical Director.	No requirement for a Medical Director.

Slide 9

SS1 I'm not sure where this slide fits into the presentation, but i thnk it's important information. THoughts?
Stream, Sarah, 2/11/2021

CNW3 I would put it after slide 9, and frame it as info you need to understand the setting and resources available for outbreak control at these diferent types of facilities
Cortes-Penfield, Nicolas W, 2/11/2021

Establishing Red, Yellow and Green Zones

Red Zone (Isolation zone)	Dark Red	Residents with Positive COVID-19 test
	Light Red	Symptomatic residents suspected of having COVID-19
Yellow Zone (Quarantine zone)		Asymptomatic residents who may have been exposed to COVID-19
Green Zone (COVID-19 free zone)		Asymptomatic residents without any exposure to COVID-19
Gray Zone (Transitional zone) We'll discuss Gray Zones next week during Prevention		Residents who are being transferred from the hospital/outside facilities (but have no known exposure to COVID-19) are usually kept in this zone for 14 days and if remains asymptomatic at the end of 14 day will be moved to Green zone

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Cohorting-Plan-for-LTCF-4.16.20.pdf.

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CNW4

Establishing Red, Yellow and Green Zones

- **If nursing home has space/rooms available** then it will be preferred to establish red, yellow and green zones in geographically distinct areas within the nursing homes.

- **If space is limited**, red and yellow zones can be established within the same unit/hallway/neighborhood.
  - If the resident in the above example have a roommate. The roommate should be transferred to a private room within the yellow zone. (Note: **Do not** transfer the roommate to green zone).

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

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Slide 11

CNW4 This slide is too busy, can we break it into two slides?
Cortes-Penfield, Nicolas W, 2/11/2021

Establishing Red, Yellow and Green Zones

- **If COVID-19 cases are identified in more than one units/hallway/neighborhood**, then some of those can become red zone and others yellow zone
- **If the resident identified has a roommate**, the roommate should be transferred to a private room within the yellow zone. (Note: **Do not** transfer the roommate to green zone).
  - If the resident with COVID-19 illness is being isolated in their own room then move the roommate to a private (single-bed) room within the yellow zone. If such a room is not available, then roommate will stay in the same room with the COVID-19 positive resident until a more suitable room has been identified.
  - Staff should change PPE after taking care of COVID-19 positive resident before taking care of the roommate in those scenarios.

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

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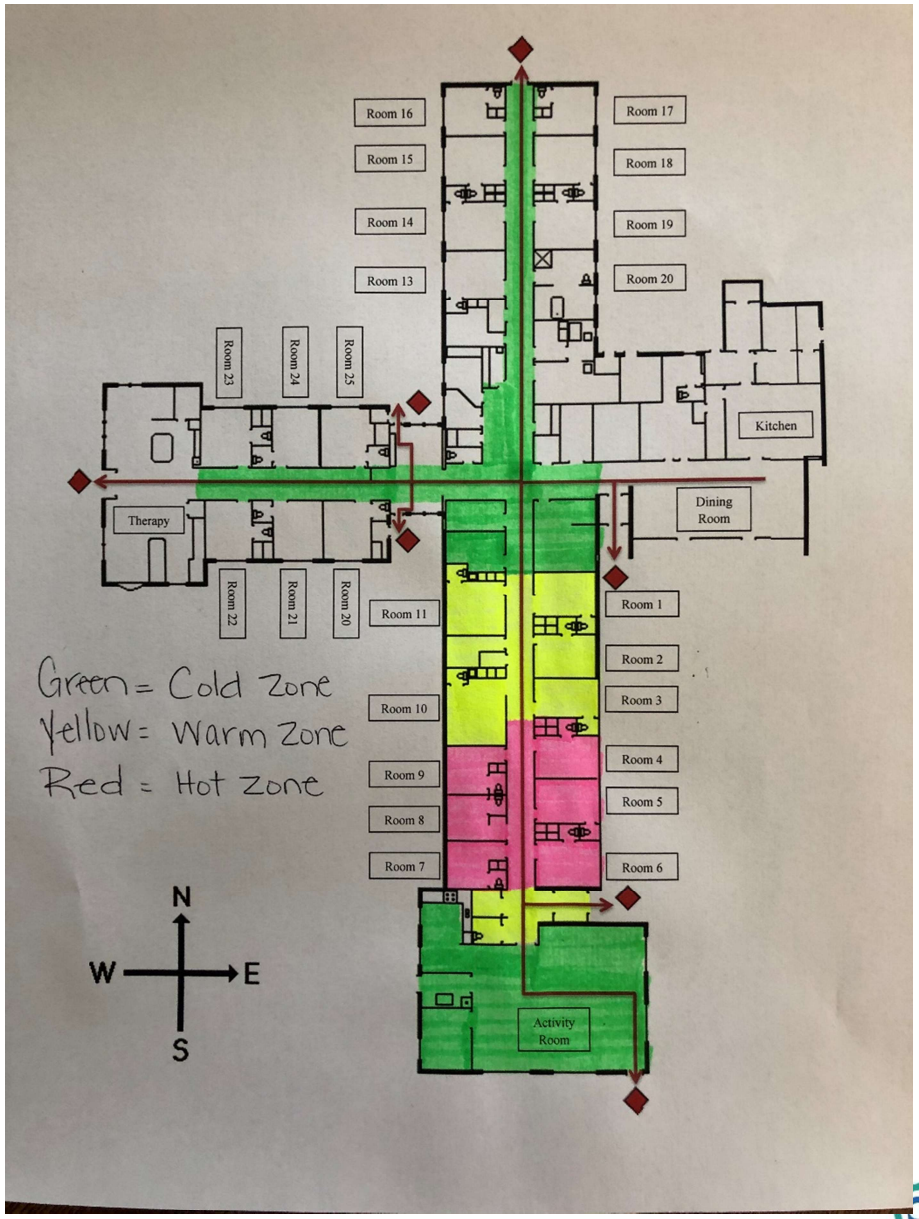
Example of a floor plan outlining the red, green and yellow zones



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Establishing Red, Yellow and Green Zones

Red Zone Considerations

- All residents that have **tested positive** for COVID-19 (**Dark Red Zone**)
- All residents who are **symptomatic and suspected** to have COVID-19 even if the test results are not back **These residents should remain in the Yellow Zone until confirmation of COVID-19 via test**. (**Light Red Zone**)
- Make sure to **cohort confirmed positive** (dark red) and **suspected positive** (light red) **separately** within the Red Zone.
- **Dedicate separate healthcare personnel** to work in Red Zone and preferably assign separate healthcare personnel to dark and light red zone, if possible.
- **Healthcare workers should wear full COVID-19 level PPE** (Gloves, Gown, Mask and eye protection) when taking care of these patients.

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

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Establishing Red, Yellow and Green Zones

Yellow Zone Considerations

- All **asymptomatic** residents who may have been exposed to COVID-19.

- Facilities should take into consideration suspected mode of COVID-19 acquisition (for the positive resident), movement of resident with COVID-19 infection within the facility prior to the diagnosis, facilities policies on universal masking and visitation, compliance of staff with infection control protocols and the number of residents with suspected or confirmed COVID-19 infection in a unit.

- **All residents in the yellow zone should be on COVID-level precaution** and healthcare workers should wear COVID-level PPE to take care of these residents.

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

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Establishing Red, Yellow and Green Zones

Green Zone Considerations

- All **asymptomatic** residents who are not considered to be exposed will be in green zone.

- If there are symptomatic residents suspected of having COVID-19 in many different units/hallway/neighborhoods, then there **may not be a green zone** in that nursing home (at least at that point of time), as everyone is going to be considered exposed.

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

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Staffing Strategies

Ideally, all zones (including dark and light red zones) should have dedicated staff. Consider the following:

- Dedicating staff to the red zone (preferably separate for dark and light red) is recommended, whenever possible.
- Nursing homes should consider avoiding assigning those staff who are working in the red or yellow zones to the green or gray zone to the extent possible.
- However, if the facility is making a tough choice that in order to staff a yellow zone, they either have to pull HCW from the green zone or red zone, it will be preferred to assign the red zone staff to cover the yellow zone too.
- If Staff must work in multiple zones, they should batch activities together per zone before a 'hard stop' and moving on to the next zone.

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

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Resident Isolation and Quarantine Guidance

Definitions

Quarantine

- Separates and restricts movement of exposed individuals to prevent the spread of a disease

Isolation

- Separates individuals with a confirmed infectious disease from those that are not sick

https://www.cdc.gov/quarantine/index.html

Isolation and Quarantine: Residents

Isolation (Red Zone)

- Residents with confirmed COVID-19 diagnosis (either tested or symptomatic)
- Isolate resident in a designated area (Red Zone)
- Residents should be isolated for at least 10 days and up to 20 days based on the severity of their illness
- Symptom based strategy: At least 10 days have passed from first symptoms and 24 hours fever free with no medication and symptoms have improved. If asymptomatic, at least 10 and up to 20 days after the date of their first positive test.
- Test Based Strategy: Negative results in 2 consecutive tests 24 hours apart and 24 hours fever free without medication and symptoms have improved
- Initiate contact tracing for the confirmed individual and isolate and test any that exhibit symptoms, quarantine any that were exposed but are currently asymptomatic and initiate outbreak testing

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

Isolation and Quarantine: Residents

Quarantine (Yellow Zone)

- Residents with confirmed exposure to someone that is COVID-19 positive
- Residents should be outbreak tested based on the frequency recommended by the CMS county positivity rate
- Residents should remain in quarantine for at least 14 days
- Residents can be removed from quarantine when there have been 14 days of no positive tests

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

Isolation and Quarantine: Staff

Isolation

- Staff with confirmed COVID-19 diagnosis (either tested or symptomatic)
- Isolate at home
- Staff should be isolated for at least 10 days and up to 20 days based on the severity of their illness
- Symptom based strategy for return to work: At least 10 days have passed from first symptoms and 24 hours fever free with no medication and symptoms have improved. If asymptomatic, at least 10 and up to 20 days after the date of their first positive test.
- Test Based Strategy for return to work (not recommended): Negative results in 2 consecutive tests 24 hours apart and 24 hours fever free without medication and symptoms have improved
- Initiate contact tracing for the confirmed individual and isolate and test any that exhibit symptoms, quarantine any that were exposed but are currently asymptomatic and initiate outbreak testing

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

Isolation and Quarantine: Staff

Quarantine

- Staff with confirmed exposure to someone that is COVID-19 positive
- Severity of exposure should be assessed for return to work after quarantine
- Staff should remain in quarantine for at least 14 days after the last exposure and self monitor for symptoms
- If symptoms develop during quarantine, isolation should be initiated and testing should occur
- Staff can return to work after their 14-day quarantine with the absence of symptoms

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

Crisis Staffing Measures

Strategies to Mitigate HCP Staffing Shortages

Crisis capacity (known staffing shortages)

- Consider plans for asymptomatic HCP with unprotected exposure but are not known to be infectious to continue to work (practicing universal source control and appropriate PPE use)
- Consider allowing HCP with suspected or confirmed COVID-19 who are well enough and willing to work but have not met all Return-to-Work Criteria to work.
    - Job duties where do not interact with others (e.g., telemedicine)
    - Direct care for only confirmed COVID-19 patients, preferably in cohort setting (e.g., COVID-unit/ Dark Red Zone)

ICAP is advising **against** assigning COVID-19 positive staff to work with COVID-19 negative or unknown status patients (i.e., yellow, green, or gray zones) due to the concerns of potential transmission.

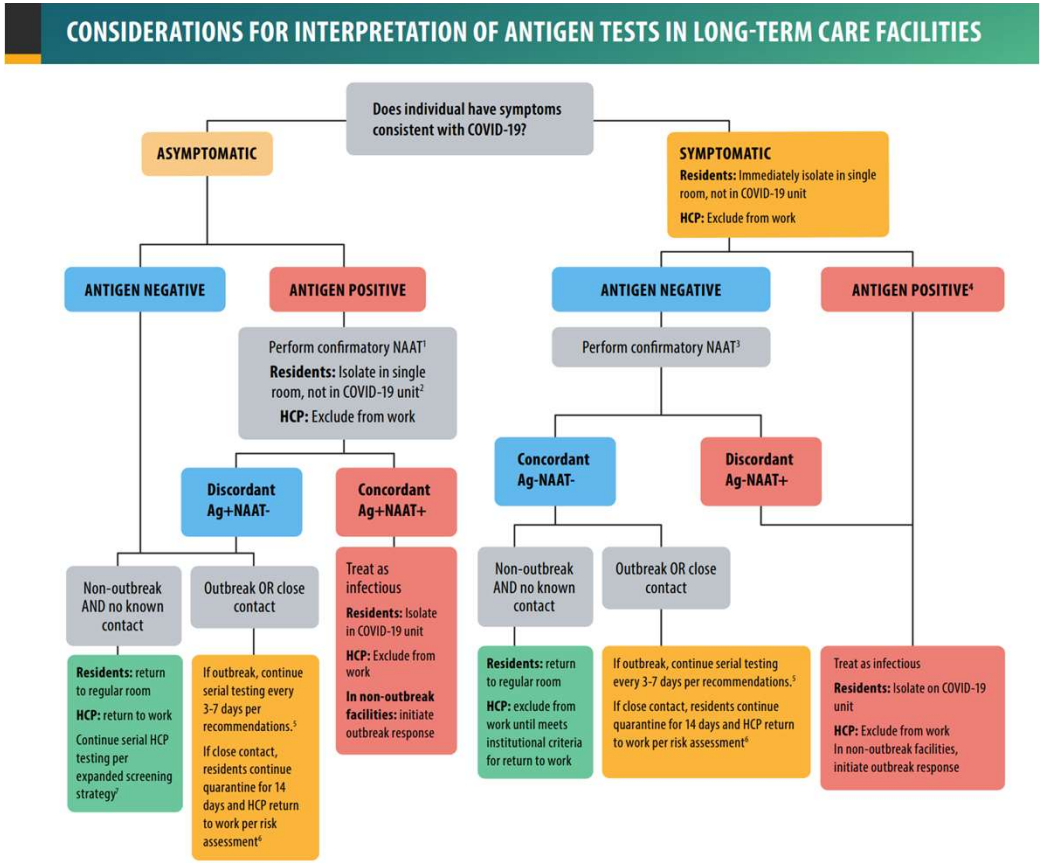
https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

Crisis Staffing Measures: Additional Precautions

- ONLY TO BE implemented in accordance/under the approval of the local health department. In addition, notify licensure.
- HCP with confirmed COVID-19 shall only care for Red Zone/ Confirmed COVID-19 residents
- Cleaning and Disinfection protocols for resident rooms and common areas must be strongly practiced, at least once daily in rooms and communal areas but may be more frequently in areas where people congregate or work.
- If allowing asymptomatic or mildly symptomatic COVID-19 positive staff to work in the red zone, facilities should ensure to protect the staff and residents who does not have COVID-19. Things to consider include:
    - Trying to staff the red zone with all positive staff (who meets the criteria to work) in all shift to avoid any exposures to the staff without COVID-illness
    - Identifying separate break and restroom areas and nursing stations for those who have COVID-19 versus those who do not
    - Focusing on cleaning and disinfection efforts between shifts in all common areas used by the staff

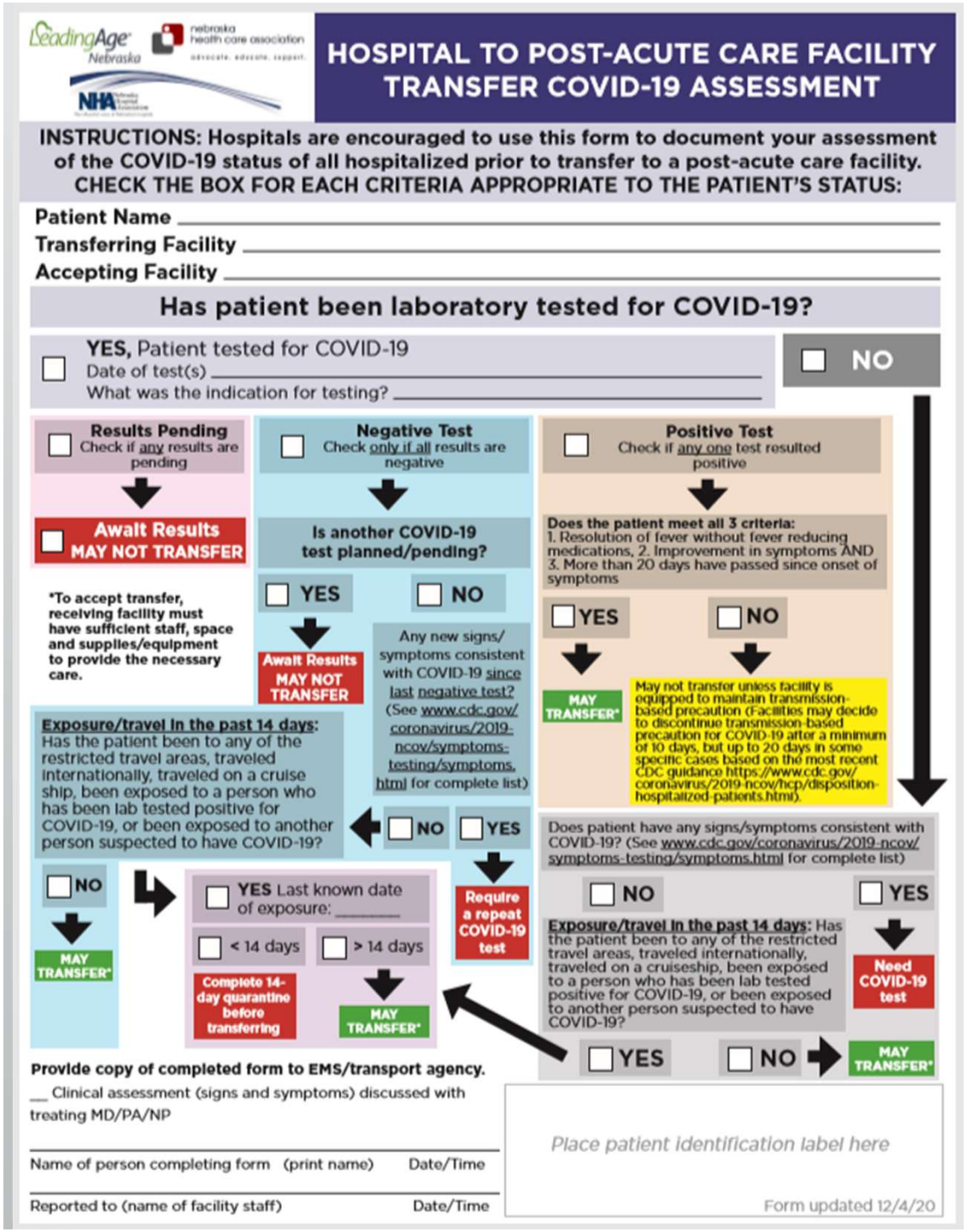
Antigen Testing Guidelines

- CDC updated their testing algorithm Jan. 8, 2021
- In general, validate all Positive Antigen POC results for an asymptomatic person
- Validate ALL Negative Antigen POC results for a symptomatic person



https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-testing-algorithm-508.pdf

Resident Transfer out of facility



HOSPITAL TO POST-ACUTE CARE FACILITY TRANSFER COVID-19 ASSESSMENT

INSTRUCTIONS: Hospitals are encouraged to use this form to document your assessment of the COVID-19 status of all hospitalized prior to transfer to a post-acute care facility. CHECK THE BOX FOR EACH CRITERIA APPROPRIATE TO THE PATIENT'S STATUS:

Patient Name _____

Transferring Facility _____

Accepting Facility _____

Has patient been laboratory tested for COVID-19?

☐ **YES,** Patient tested for COVID-19
Date of test(s) _____
What was the indication for testing? _____

☐ **NO**

Results Pending
Check if any results are pending
→ ☐ **Await Results MAY NOT TRANSFER**

*To accept transfer, receiving facility must have sufficient staff, space and supplies/equipment to provide the necessary care.

Negative Test
Check only if all results are negative
→ **Is another COVID-19 test planned/pending?**
☐ YES → ☐ **Await Results MAY NOT TRANSFER**
☐ NO → Any new signs/symptoms consistent with COVID-19 since last negative test? (See www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html for complete list)

Positive Test
Check if any one test resulted positive
→ **Does the patient meet all 3 criteria:**
1. Resolution of fever without fever reducing medications, 2. Improvement in symptoms AND 3. More than 20 days have passed since onset of symptoms
☐ YES → ☐ **MAY TRANSFER***
☐ NO → May not transfer unless facility is equipped to maintain transmission-based precaution (Facilities may decide to discontinue transmission-based precaution for COVID-19 after a minimum of 10 days, but up to 20 days in some specific cases based on the most recent CDC guidance https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html).

Exposure/travel in the past 14 days: Has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruise ship, been exposed to a person who has been lab tested positive for COVID-19, or been exposed to another person suspected to have COVID-19?
☐ NO → ☐ **MAY TRANSFER***
☐ YES → ☐ **Require a repeat COVID-19 test**

Does patient have any signs/symptoms consistent with COVID-19? (See www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html for complete list)
☐ NO → **Exposure/travel in the past 14 days:** Has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruiseship, been exposed to a person who has been lab tested positive for COVID-19, or been exposed to another person suspected to have COVID-19?
☐ YES → ☐ **Need COVID-19 test**
☐ NO → ☐ **MAY TRANSFER***

☐ YES Last known date of exposure: _____
☐ < 14 days → **Complete 14-day quarantine before transferring**
☐ > 14 days → ☐ **MAY TRANSFER***

Provide copy of completed form to EMS/transport agency.

__ Clinical assessment (signs and symptoms) discussed with treating MD/PA/NP

Name of person completing form (print name) Date/Time

Reported to (name of facility staff) Date/Time

Place patient identification label here

Form updated 12/4/20

Transfer Assessment Flow Chart

Available at the LeadingAge website:
https://leadingagene.org/

Objective Criteria for safe transfer: 3 S's

- Staff: staffing to designate/devote to a positive COVID-19 resident
- Stuff: PPE to care for the COVID-19 resident safely
- Space: Private room separated from COVID-19 free rooms

A case study:

Situation:

- A resident has tested positive (2/8) for COVID-19.
- Resident refused vaccination
- Has a history of COPD
- Has had visitation from family
- Is currently inpatient at local hospital
- Daughter reports that symptom onset was Friday 2/5, but resident did not report this to staff

Facility Information:

This is an assisted living facility. They had a serious outbreak of COVID-19 in early November, so any previously infected staff or residents are just now about 90 days post infection. They have used Abbott Binax Cards for rapid testing in the past and are prepared to resume this.

A case study:

Situation:

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Facility Information:

This is an assisted living facility. They had a serious outbreak of COVID-19 in early November, so any previously infected staff or residents are just now about 90 days post infection. They have used Abbott Binax Cards for rapid testing in the past and are prepared to resume this.

What would first steps be for this facility?

A case study:

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- Is currently inpatient at local hospital
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Facility Information:

This is an assisted living facility. They had a serious outbreak of COVID-19 in early November, so any previously infected staff or residents are just now about 90 days post infection. They have used Abbott Binax Cards for rapid testing in the past and are prepared to resume this.

What would be best practices for contact tracing within the facility based on the information available? Staff actions? Resident actions?

A case study:

Situation:

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- Has a history of COPD
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- Is currently inpatient at local hospital
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Facility Information:

This is an assisted living facility. They had a serious outbreak of COVID-19 in early November, so any previously infected staff or residents are just now about 90 days post infection. They have used Abbott Binax Cards for rapid testing in the past and are prepared to resume this.

How could zoning look within this facility? How might it look different in a SNF?

A case study:

Situation:

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- Resident refused vaccination
- Has a history of COPD
- Has had visitation from family
- Is currently inpatient at local hospital
- Daughter reports that symptom onset was Friday 2/5, but resident did not report this to staff

Facility Information:

This is an assisted living facility. They had a serious outbreak of COVID-19 in early November, so any previously infected staff or residents are just now about 90 days post infection. They have used Abbott Binax Cards for rapid testing in the past and are prepared to resume this.

Based on the information provided, when would this resident discontinue isolation? When can the yellow zone be discontinued?

A case study:

Situation:

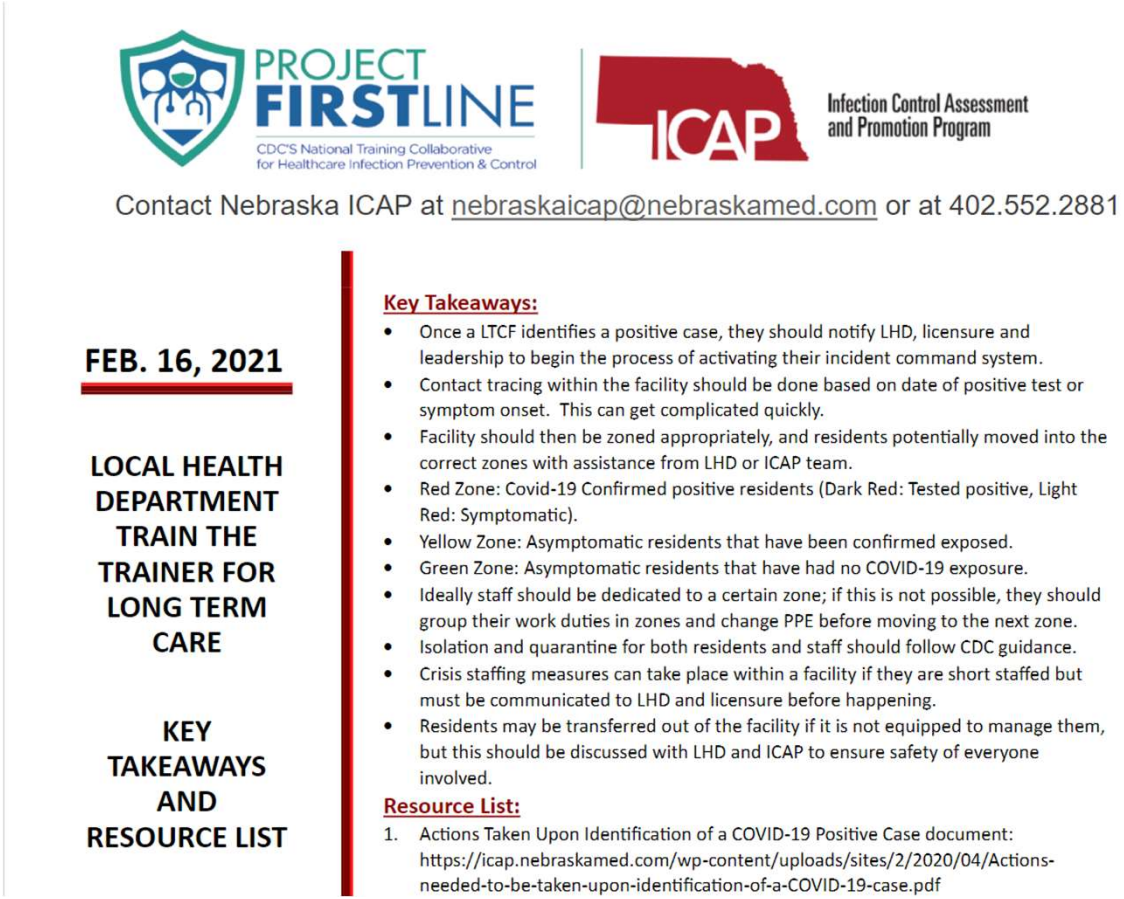
- A resident has tested positive (2/8) for COVID-19.
- Resident refused vaccination
- Has a history of COPD
- Has had visitation from family
- Is currently inpatient at local hospital
- Daughter reports that symptom onset was Friday 2/5, but resident did not report this to staff

Facility Information:

This is an assisted living facility. They had a serious outbreak of COVID-19 in early November, so any previously infected staff or residents are just now about 90 days post infection. They have used Abbott Binax Cards for rapid testing in the past and are prepared to resume this.

How would this have changed if the resident had been fully vaccinated with both doses? How would this have changed if the rest of the facility had both doses of the vaccination?

Key Takeaway Page



PROJECT FIRSTLINE
CDC'S National Training Collaborative for Healthcare Infection Prevention & Control

ICAP Infection Control Assessment and Promotion Program

Contact Nebraska ICAP at nebraskaicap@nebraskamed.com or at 402.552.2881

FEB. 16, 2021

LOCAL HEALTH DEPARTMENT TRAIN THE TRAINER FOR LONG TERM CARE

KEY TAKEAWAYS AND RESOURCE LIST

Key Takeaways:

- Once a LTCF identifies a positive case, they should notify LHD, licensure and leadership to begin the process of activating their incident command system.
- Contact tracing within the facility should be done based on date of positive test or symptom onset. This can get complicated quickly.
- Facility should then be zoned appropriately, and residents potentially moved into the correct zones with assistance from LHD or ICAP team.
- Red Zone: Covid-19 Confirmed positive residents (Dark Red: Tested positive, Light Red: Symptomatic).
- Yellow Zone: Asymptomatic residents that have been confirmed exposed.
- Green Zone: Asymptomatic residents that have had no COVID-19 exposure.
- Ideally staff should be dedicated to a certain zone; if this is not possible, they should group their work duties in zones and change PPE before moving to the next zone.
- Isolation and quarantine for both residents and staff should follow CDC guidance.
- Crisis staffing measures can take place within a facility if they are short staffed but must be communicated to LHD and licensure before happening.
- Residents may be transferred out of the facility if it is not equipped to manage them, but this should be discussed with LHD and ICAP to ensure safety of everyone involved.

Resource List:

1. Actions Taken Upon Identification of a COVID-19 Positive Case document: https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

https://icap.nebraskamed.com/project-firstline/

Infection Prevention and Control: Office and On-Call Hours

Call 402-552-2881

Office Hours are Monday – Friday

8:00 AM - 10:00 AM Central Time

2:00 PM - 4:00 PM Central Time

On-Call Hours are

Monday – Friday 4:00 PM – 8:00 PM and

8:00 AM – 8:00 PM Weekends and Holidays

The power to stop infections. Together.

Every frontline healthcare worker deserves to understand infection control principles and protocols and feel they can confidently apply them to protect themselves, their facility, their family, and their community. CDC's new infection control training collaborative, Project Firstline, is designed to help every frontline healthcare worker gain that knowledge and confidence.

Firstline Resources:

https://www.cdc.gov/infectioncontrol/projectfirstline/index.html

https://www.facebook.com/CDCProjectFirstline

https://www.facebook.com/NebraskaICAP

https://www.facebook.com/NebraskaICAP