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Updated Guidance for Assisted Living/Residential Care Facilities Mitigation Strategies
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Strategies to reduce the spread of infection in facilities with a resident with a confirmed or suspected case of COVID-19.

NOTE: Updates since March 20, 2020, are indicated in bold font throughout this document.

The following is guidance for assisted living/residential care facilities who house patients with a confirmed or suspected case of COVID-19. There are a few guiding principles:

1. Placement of resident in contact-droplet precautions with staff using available PPE-gown, glove, mask with face shield or eye protection
2. Proper donning and doffing of personal protection equipment when in contact with COVID-19 residents https://www.cdc.gov/HAI/pdfs/ppe/ppeposter148.pdf
3. Reduce the number of non-essential staff, those not providing direct medical care, who come into contact with the resident
4. Reduce the movement of staff between residents with and without COVID-19 –
    - cohort staff and confirmed or suspected COVID-19 residents in one area of the building if possible
    - cohort equipment for these residents to limit spread of infection
5. Perform hand hygiene frequently before and after patient/resident contact, before clean/ aseptic procedures, and after body fluid risk exposure, before and after coming on duty, and when hands are visibly soiled.

COVID-19 testing and prevention strategies

ISDH has a team available to come into facilities to rapidly test residents and staff who are suspected of having COVID-19. In addition, ISDH, through the local health departments, will supply PPE when available. It is critical that facilities practice conservation and re-use of current PPE supplies.

- **To request COVID-19 testing or to discuss prevention strategies, such as PPE donning and doffing, please send an email to striketeamrequest@isdh.in.gov.**

PPE guidance

Facilities should follow the CDC guidelines for health care workers and positive protective equipment - https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Secondary to limited PPE availability facilities should use N95 masks only if available and only in essential staff who do procedures that are likely to generate respiratory aerosols (e.g., nebulizer treatments, COVID-19 testing), which would pose the highest exposure risk to the staff.

- *Should N95 masks not be available the staff should wear a tight fitting surgical mask with no gaps around the face and eye-protection as in goggles (not just eye glasses) or face shield.*

Those who do not do procedures which generate respiratory aerosols (e.g., insulin injections, medication delivery, lab draw, x-rays, and wound care) do not need N95 respirators masks at this time. These staff should wear eye protection, gown, gloves and standard surgical facemasks, as available, to prevent droplet exposure.

- If there are shortages of isolation gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of essential staff

- Encourage staff to have a change of clothing on hand to change before leaving work and remember to perform hand hygiene after removal of uniforms and before leaving work for the day.

Facilities should require those involved in direct patient care to wear a mask during their entire shift. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

- **If national and local supplies are at conventional capacity then all staff in RCFs should wear a facemask per standard recommendations.**

- **If national and local supplies are at contingency levels, only direct care staff should wear a mask and they should use one mask per shift.**

- **If national and local supplies are scarce <1 week supply then only direct care staff should wear a mask and they should use the same mask for multiple days.**

- **If national and local supplies are at crisis capacity then direct patient care staff should wear a mask if available. If masks are not available, they should use**

alternative methods to cover their mouth and nose and decrease respiratory droplet spread.

Staffing recommendations

Non-essential staff are considered to be those staff who come into contact with residents, or resident rooms, but do not provide medical care. These staff may be needed in the facility for normal operations but should not come in contact with residents with COVID-19.

- Ancillary staff
- Administrative staff
- Housekeeping staff
- Maintenance staff (unless needing to repair vital equipment)
- Meal delivery
- Activity staff
- Volunteers
- Case managers (e.g., Area Agency on Aging, Community Mental Health)

To reduce the interaction between non-essential staff and residents with COVID-19, facilities should develop plans to shift duties from these staff to essential staff.

- ONLY ESSENTIAL staff should go into the room of a confirmed or presumed resident with COVID-19.

Essential staff are considered those staff who come into contact with resident and provide medical care:

- Certified Nurse Assistants (CNAs)
- Qualified Medical Assistants (QMAs)
- Nurses
- Home Health Aides
- Hospice care personnel
- Mental health counselors
- Paramedics – Paramedics, with appropriate PPE, are to be allowed into facilities to assess and transport residents to hospitals.
- X-ray staff – Those who come in to do emergency radiographs should have appropriate PPE and follow contact-droplet precautions
- Laboratory staff:

    - If the essential staff at the facility can draw blood, the facility should work with their local laboratory to develop a protocol by which the facility staff draw the blood.

    - If essential staff at the facility cannot draw blood the laboratory staff should follow contact-droplet precautions.

To reduce essential staff who care for confirmed or presumed residents with COVID-19 from interacting with residents, ISDH recommends the following:

- Consider single designated essential staff each shift for necessary resident contacts

- Appropriate infection control measures with hand hygiene and contact-droplet precautions
    - https://www.who.int/infection-prevention/campaigns/clean-hands/5moments/en/
    - https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html

- Use of appropriate PPE – video training of donning and doffing can be watched here
    - https://iuhealth.plateau.com/content/clarian/wbt/2020/Nursing/standard_iso_donning_and_doffing_update/index_lms_html5.htm

- Contract essential staff who recently cared for a COVID-19 confirmed, or presumed positive, resident should, if possible, provide care at only one facility

- Contract essential staff who care for confirmed or presumptive positive residents with COVID-19 should restrict their movements in facilities to those areas where the resident resides
    - Recommendation is to avoid working in other areas of the facility (e.g., going between assisted living and extended care facilities)

- To conserve PPE and N95 masks, limit the essential staff who perform testing or procedures that generate respiratory aerosols (e.g., suctioning, respiratory treatments). This can be done by identifying only one person who will do these procedures per shift.

Facility guidance

Included are considerations for designating entire units within the facility, with dedicated health care professionals, to care for residents with known or suspected COVID-19 and options for extended use of respirators, facemasks, and eye protection on such units.

Updated recommendations regarding need for an airborne infection isolation room (AIIR):

- Residents with known or suspected COVID-19 should be cared for in a single-person (private) room with the door closed.

- Residents with known or suspected COVID-19 should not share bathrooms with other patients/residents.

- All residents returning from the hospital with suspected or confirmed COVID-19 should be cared for in a private room.

- Residents should postpone or cancel routine outside of facility medical office visits and imaging.

- Residents having had close contact with a resident having confirmed COVID-19 (e.g., roommate or infected staff without wearing PPE) should be isolated and follow 14 day self-monitoring guidelines outline by CDC https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html. If they develop symptoms, and are confirmed or suspected to have COVID-19, they should remain in isolation until at least 14 days after illness onset or 72 hours after resolution of fever, without use of antipyretic medication, and improvement in symptoms (e.g., cough) whichever is longer.
    - Please note that older residents may not encounter a fever with COVID-19

- Personnel who develop symptoms confirmed or suspected to be COVID-19 should call their provider for testing authorization
    - The provider can have testing request entered into the Indiana State Department of Health (ISDH) request form: https://redcap.isdh.in.gov/surveys/?s=WMKD7PHEPF. **Please note that this form is intended to be used only by health care providers, infection preventionists or other health care personnel.**
    - For questions, please call ISDH line open 24/7 at 317-233-4672 to have testing approved.
    - Providers also have the option to work with Eli Lilly, LabCorp or Quest for commercial testing should they deem appropriate.

- Personnel should also note that their local health department will be making contact with them if their test comes back presumptive positive and will instruct them on home monitoring of all close contacts.

- Personnel should follow home quarantine recommendations from the CDC - https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html - and can return to work when the following conditions have been met:
    - Fever free for at least 72 hours (that is three full days of no fever without the use medicine that reduces fevers).
      AND

- Other symptoms have improved (for example, when your cough or shortness of breath have improved).
  AND
- At least 7 days have passed since your symptoms first appeared.

Guidance for medical providers

Thank you for caring for vulnerable populations during this pandemic. To prevent the number of staff who come in contact with a resident having confirmed or presumed COVID-19 at your facility please follow some simple guidance:

- Review all standing orders for appropriateness
- Do not order non-urgent labs or x-rays. Refrain from ordering labs and x-rays that are to follow the long-term course of a disease (e.g., hemoglobin A1C, routine chemistries, Chest X-rays for pulmonary lesion progression).
- Consider alternatives to treatments that generate respiratory aerosols (e.g., inhalers vs nebulizers)
- Postpone or cancel routine outside of facility and on-site medical visits and imaging

Emergency department and hospital transfers

Due to the coronavirus pandemic, the health care system is expected to experience increased patient volumes and limited availability of beds and personal protective equipment supplies. Thus, there is a heightened need for accurate and timely communication between residential care facilities and emergency departments prior to transfer of residents to the hospital. The RCF must communicate with EMS and the hospital on the transfer of a suspected or confirmed COVID-19 RCF resident to a hospital.

Residents should not be sent to the hospital for COVID-19 testing alone. Decisions to transfer a resident suspected or confirmed to have COVID-19 should be based on:

- **The resident's medical needs determined by the RCFs clinical staff, and medical provider when available;**
- **The RCFs ability to provide the resident's medical care at the RCF; and**
- **The resident's goals of care, including advance directives and decision for hospitalization.**