Management and Crisis Intervention

- **How should I get my facility prepared for a COVID-19 case/outbreak?**

    - Facilities should identify an area for cohorting COVID-19 patients. This should be an area that can be closed off from other parts of the facility.
    - There should be no sharing of equipment and supplies. Extra equipment like medication carts and wound care supplies should be planned for and available.
    - Staff movement should be minimized and assignments should be adjusted
    - Isolation carts and PPE supplies should be made available
    - Oxygen concentrators and contingency arrangements should be made.
    - Have medications meant to provide comfort, including at the end of live, available. These include morphine, lorazepam, and similar agents.
    - Work with environmental services (EVS) to adjust their schedule to be available on-call if possible
    - Plan for extra hospice support may be needed

- **We have two residents from different units with new onset respiratory symptoms. Should they be in the same room?**

    If two or more residents have acute respiratory symptoms suggestive of COVID-19, we suggest implementing facility-wide precautions. Until there is a confirmed diagnosis for the involved residents, they should not be cohorted. Once it is known that there are two individuals with the same infection, then those individuals may be cohorted if necessary.

    We recommend, if possible, dedicating one hallway or unit to the care of individuals with respiratory viral syndromes. There should be consistent staffing of this unit as well (i.e., the same staff members work in this area, including staff that works on evening and night shift). If other staff needs to come into this area to perform specialized care, such as hospice care, this should be the last group of residents to receive care before that person goes home. Prioritize the use of PPE in this area of the building. If possible several nursing functions (e.g. wound care) should be performed by the assigned staff to limit staff caring across the facility. If this is done consideration should be given to the increased intensity of work during staff assignments.

    Guidance from the CDC dating from 3/10/20 states that residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.

Source: AMDA

Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. Public health authorities can assist with decisions about resident placement.

- **We have several COVID-19 positive residents in varying stages of recovery. May we place them in the same wing? Can we cohort our COVID-19 positive residents?**

  Nursing facilities should identify units that can be effectively used to cohort COVID-19 patients who test positive while they are in the facility.
  - COVID-19 patients should be cohorted in a single unit.
  - There should be dedicated nursing staff to care for COVID-19 patients. They should not work on other units.
  - Equipment should not be shared between units.
  - Staff providing care to multiple patients should minimize contact with test positive or suspected COVID-19 patients and should provide care to these residents last.
  - Cohorting of residents with known COVID-19 is permissible as long as there is consideration of other reasons they may require different infection prevention and control procedures (e.g., recent history of C. difficile infection or known colonization with an extended-beta lactamase producing bacteria).

- **When can we discontinue transmission-based precautions for COVID-19 residents?**
  - The CDC currently recommends two approaches when considering whether to discontinue transmission-based precautions.
    - **Test-Based Strategy** – The resident is recovered from their illness with resolution of fever for at least 3 days (72 hours) without the use of fever reducing medications, improvement in symptoms such as cough and shortness of breath AND two consecutive nasopharyngeal swab specimens collected ≥24 hours apart are negative by molecular assay for SARS-CoV-2

    OR

    - **Symptom-Based Strategy** If testing is unavailable, discontinuing precautions by relying on symptom resolution in which there is at least 10 days' passage since the onset of symptoms and more than 3 days (72 hours) since resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath). It is prudent to keep residents with persistent cough on the COVID-19 positive unit or in a single room until their cough resolves.
      - We prefer the more conservative test-based strategy at the present time given the risks present in PALTC populations from

Source: AMDA

SARS-CoV2 and evidence for prolonged viral shedding, even at 14 days.

- For asymptomatic residents who were positive for SARS-CoV2 by molecular assay, in addition to a test-based approach, the CDC also provides a **time-based strategy** in which precautions are discontinued 10 days following the residents first positive test result, assuming no symptoms have occurred since testing Again, considering the severe outcomes associated with exposure to SARS-CoV-2 in the long-term setting, and prolonged viral shedding, we recommend the more conservative test-based approach.

- COVID-19 positive patient can be transferred to a COVID negative unit if they are asymptomatic and if at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart are negative. If testing is unavailable, discontinuing precautions can rely on symptoms resolution and should at least be 10 days of symptom onset and more than 3 days (72 hours) have passed since resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath). It is prudent to keep patient with persistent cough on the COVID-19 positive unit.

Source: AMDA