



Operational Guidance for Congregate-Living Facilities with Confirmed or Suspected COVID-19 Case(s) or Residents/Staff in Quarantine

Reminder: All nursing homes should already be following the Department of Health's (RIDOH) directive that visitors who are not providing medically essential services are not allowed. The approach is to consider the infection control and environmental cleaning measures that would be used for a resident who is confirmed positive for COVID-19 and apply the same aggressive infection control and environmental cleaning approaches to every resident in every nursing home and home health-related setting. To every extent possible, limit the number of different types of people who enter the resident's room or home to one staff person who conducts as many activities of different staff as possible upon entering the room. (i.e., Choose one staff person who can bring in the food, assist with daily functions, and clean the high touch surfaces, etc.) Keep the same staff assigned to the same residents in the same units.

If clinical staff determine that a patient is in end-of-life stage, asymptomatic screened family members who wear face masks may be permitted to be with loved ones. Decisions about visitation during an end-of-life situation should be made on a case-by-case basis. It should include careful screening of the visitor(s) for fever or respiratory symptoms. Anyone with symptoms should not be permitted to enter the facility. Visitors who are permitted must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. Visitors should also be reminded to frequently wash their hands.

Adapted from: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>

Immediate Action

- Report all suspected and confirmed COVID-19 cases in residents and staff to the Center of Acute Infectious Disease Epidemiology (CAIDE) at the Rhode Island Department of Health (RIDOH), Monday – Friday, 8:30 a.m. - 4:30 p.m., 401-222-2577; after hours, weekends, and holidays, 401-276-8046.

Infection Control

(For units with residents/staff who are confirmed or suspected COVID-19 cases OR have residents/staff who have had an exposure to a known COVID-19 case)

- Residents with suspected or confirmed COVID-19 should be moved to a private room with its own bathroom, if available.
- Residents with suspected or confirmed COVID-19 should be placed on contact and droplet precautions immediately (N95 respirator if available or a face mask if not, eye protection, gowns, and gloves).
- Two residents who are confirmed COVID-19 positive may be placed into a single room if needed.
- Roommates of suspected and confirmed case(s) should be tested and placed on contact and droplet precautions. Even with a negative test result, and certainly with a positive result, that roommate has already been exposed, and should be cared for as if they are a COVID-19 case, by maintaining isolation precautions. If this patient develops symptoms, they should be tested again.
- **Contacts** of a confirmed COVID-19 case, whether residents or staff, should be defined as all other residents on the unit and all staff members who have worked on that unit. If the staff on that unit also work in other units in that nursing home, in other healthcare facilities, or in home health agencies, the residents and staff in those additional settings are also considered exposed.
- All **contacts** of suspected and confirmed COVID-19 positive patient or staff should be tested, including asymptomatic individuals due to the increased risk of transmission in a nursing home setting. However, because the test is less accurate when obtained in an individual with no symptoms, a negative result cannot be interpreted as a true negative.
- Residents who are confirmed or suspected to be COVID-19 positive, or who are close contacts may **not** be transferred to other units in the facility or other facilities.
 - Residents may be discharged to home, with frequent telephone follow-up by their primary care physician after counseling on home-based infection control, self-management, and symptom monitoring.
 - Residents discharged to home on home health services should have their quarantine or isolation status communicated to the home care agency so that the necessary infection control measures are aggressively continued.
- If residents in quarantine need to leave the building for medical care, the residents' potential exposure to COVID-19 should be shared with the facility where the resident is going, and the resident must wear a mask.
- Facilities should have a **very low** threshold for re-testing residents if any symptoms develop, even symptoms not typical for COVID-19, such as diarrhea, fatigue, or headache with no fever. Coordinate with RIDOH to facilitate re-testing.
- New admissions to the facility where there are residents who are confirmed/suspected cases or quarantined should be discussed with RIDOH and handled on a case-by-case basis.
- For established residents who are being discharged back to the facility from the hospital should be accepted with the following conditions:

- The hospital has performed and received one negative COVID-19 test result.
- Full PPE (N95 respirator if available or a face mask if not, eye protection, gowns, and gloves) is used for 14 days for any interactions with the patient.
- Residents should remain in their rooms. Each additional person who enters the room should be considered an increased risk of further exposing the resident to COVID-19 and its negative outcomes, whether or not full infection control measures are in place. **To every extent possible, limit the number of different types of people who enter the resident's room to one staff person who conducts as many activities of different staff as possible upon entering the room. (i.e., Choose one staff person who can bring in the food, assist with daily functions, clean the high touch surfaces, etc.)** Keep the same staff assigned to the same residents in the same units.
- Group activities should not be conducted. Only critical services should be provided. Mobility chair use should be included in limiting resident movement throughout a nursing home.
- Staff must be cohorted to the unit. For staff who cannot be cohorted to a single unit (physical therapy, environmental services) these staff should be restricted from entering residents' rooms and taking the one person entering through the activities that need to be conducted for the resident.
- Ensure that advanced directives are in place and up to date for all residents (living wills and durable power of attorney).

Conservation of Personal Protective Equipment (PPE)

- PPE is extremely limited and supply chains are significantly disrupted. The State has been working diligently on procuring more. The State has been prioritizing, allocating and distributing the very limited supply that they had stockpiled and received from the Strategic National Stockpile (SNS). The State has been receiving numerous emails and phone calls from all types of healthcare providers asking for PPE. At this time, we are asking health care professionals to utilize www.health.ri.gov/ppe to request PPE assistance. Submissions will be categorized daily based on a variety of factors including, but not limited to, risk factors, size of practice, and amount of on-hand supply in both the practice and State caches. Expect requests to take a day or more to be handled. Expect that requests may not be able to be filled or only partially filled. If we are able to fill a request. Health care facilities and practices should continue to source their own PPE and use extreme conservation efforts regardless of placing a request and/or receiving an allocation from the State.
- RIDOH is working diligently on providing detailed guidance on ways to conserve PPE.
- Ensure that staff receive training in selection and conservation of transmission-based precautions and use of PPE, including safe donning and doffing of gowns, gloves, masks or respirators, and face shields or goggles.
 - Active monitoring of donning and doffing of PPE should occur and be documented.

Staff Work Practices

- It is strongly recommended to practice universal masking for the entire facility and for all patient interactions.
- Staff working on an affected unit should universally mask for the entire work shift. If staff from an affected unit must float to other units, they should also mask on those units. The mask should be

changed if it is wet or soiled or if the staff person has entered the room of a patient on isolation precautions. Avoid touching one's face, even with a mask.

- Surgical masks, as long as they are not wet or soiled, may be used for two working days.
- For staff who provide nebulizer medications/therapies to residents, consider the use of an N-95 respirator, if available, OR use metered-dose inhalers with a spacer device instead (the latter is the preferred recommendation). In general, nebulizer therapies should be avoided.

Staff Monitoring

- Self and active monitoring of all staff should be performed at the facility.
- Staff should be performing self-monitoring for symptoms while away from the facility. Consider providing inexpensive, multiple-use thermometers to staff so that they must be required to check their temperature at home before coming to work. Any staff who identify a fever or symptoms should call to report that they are unable to work rather than presenting for symptom monitoring.
- Actively monitor all staff entering the building. Before their shift, staff entering the facility should sanitize their hands, don a face mask, answer questions regarding any symptoms, and if there are no symptoms *then* they may proceed in *and* must have a temperature check. Maintain social distancing between the screener and the staff until symptom questions are answered.
 - The same recommendations apply to anyone coming into the facility to provide clinical care or services to residents (e.g., blood collection, wound care, physical therapy).
- Symptoms screening should include the following:
 - Symptom Screening Questions: Have you or anyone in your household had any of these symptoms in the past 72 hours (three days)?
 - Fever (temperature of 100° F or higher)
 - Cough
 - Shortness of breath or difficulty breathing
 - Body aches
 - Chills
 - Runny nose or stuffy nose
 - Sore throat
 - Diarrhea
- A staff member properly trained in the use of a surgical mask should observe another staff member donning their mask and ensure the mask covers the mouth and nose and will not slip easily. If deficiencies are observed, staff should be instructed as to the proper method of donning a mask.
- Fever and symptom checks of staff must include a thermometer and should occur throughout the work shift, every four hours.
- Swabbing for COVID-19 to test the entire cohort of staff serving an affected unit may be recommended on a case-by-case basis. Coordinate with RIDOH for that purpose.
- Staff who work in multiple facilities must immediately report all of the other facility names worked at to RIDOH. Transmission risk in one facility may spill over to other facilities. Collect this information as staff come in to work and complete the screening at the entrance.

Resident Monitoring

- Initiate active monitoring of all residents throughout the facility. Check every resident's vital signs (temperature, heart rate, respirations, and oxygen saturation) at the start of every shift. Evaluate all residents for any new symptoms. Residents able to respond should be asked about how they are feeling. For those residents unable to respond, early symptoms of COVID-19 in the elderly could include confusion, change in mental status, diarrhea, or other symptoms not typically associated with COVID-19.

Hand Hygiene

- Provide opportunities for hand hygiene (alcohol-based hand rub or soap and water) throughout the facility, particularly outside of patient rooms and in medication and food preparation areas.
- Ensure staff receive training on appropriate moments for the use of hand hygiene, including prior to entry into resident rooms, after exiting resident rooms, and if hands are visibly soiled or become soiled.
 - Active monitoring of hand hygiene practices should occur and be documented.

Environmental services

- Ensure that staff regularly (at least every four hours) clean and disinfect the physical environment, particularly high-touch surfaces (tables, counters, doorknobs, railings) with an EPA-registered disinfectant. Staff must be able to accurately describe and follow the instructions for use of any disinfectant used for environmental cleaning. Staff should also be aware of, and adhere, to the established cleaning schedule.
- Disinfectants for use against SARS-CoV-2 can be located here: <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>

Reusable Equipment

- Ensure that any reusable medical equipment or other items reused for multiple patients is cleaned and disinfected in between each patient use, and if possible, store all such items separately in a clean or dirty room to assist in separation of clean from dirty and to minimize reuse of dirty equipment.

Influenza Vaccine for Residents and Staff

- Continue to offer influenza vaccine to residents and staff at all times that influenza is circulating.

Guidance for All Residents Discharged Home

- Maintain a list of their name, date of birth, and contact information. This list will be provided to RIDOH should any additional cases be identified.