Preliminary Guidance:

Prevention and Management of COVID-19 in Long-Term Care Facilities

UPDATED March 19, 2020

The following preliminary guidance was developed by the San Francisco Department of Public Health for use by local facilities, and will be posted online at http://www.sfcdcp.org and updated as new information becomes available.

AUDIENCE: This guidance is targeted to long-term care facilities that provide 24-hour medical care on site.

BACKGROUND: COVID-19 is a new respiratory disease caused by the SARS-CoV-2 virus. Illness severity ranges from asymptomatic to life-threatening. Signs and symptoms of infection can include fever, cough, and difficulty breathing. Fatigue, myalgia, sore throat, headache, and, less frequently, gastrointestinal symptoms such as nausea, vomiting, or diarrhea also have been reported in some patients. Based on the limited available data, older adults and those with chronic medical conditions are at highest risk for severe illness.

For the purpose of this LTCF guidance:

- Fever is defined as temperature $\geq 100.0°F (37.8°C)$
- Respiratory symptoms are defined as new cough, sore throat or shortness of breath

At present there is no vaccine to prevent COVID-19 and no antiviral medication that can be used for post-exposure prophylaxis of exposed patients. Thus prevention and control efforts must rely on other measures.

Ill visitors and health care personnel are the most likely sources of introduction of COVID-19 into a facility. Spread can occur between and among residents, healthcare personnel, staff and visitors. Strict screening of all facility staff, including those not directly involved in patient care (e.g. food preparers, janitorial staff, and others) is important to prevent introduction of COVID-19 into a facility.

GENERAL MEASURES TO BE IMPLEMENTED NOW:

- To help protect vulnerable patients over age 60 and those with chronic medical conditions from being exposed to COVID-19, please:
  - Restrict all visitors from entering the facility
  - Cancel group activities and communal dining to minimize potential transmission between residents
  - Restrict all volunteers and non-essential health care personnel, as well as non-essential staff (e.g. barbers) and volunteers

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Restrict employees from working while ill.

- Screen all health care staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature with a thermometer and document cough, sore throat, shortness of breath, and temperature in a log.

- Health care workers, including consultants, may often provide care in multiple facilities and can be an important source of introduction of COVID-19 into a facility. These staff should be asked about exposure to other facilities with recognized COVID-19 cases.

- Once identified, staff with respiratory or influenza-like illness should not work until 72 hours after fever and other respiratory symptoms have resolved, and at least 7 days have passed since symptoms first appeared. Additionally, staff should wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after your symptoms began, whichever is longer. Staff should also be restricted from contact with severely immunocompromised patients until 14 days after illness onset. Staff should self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen. See CDC return to work criteria at https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

- Ensure sick leave policies are non-punitive, flexible, and allow employees to stay home if they have symptoms of infection.

- Staff developing symptoms while at work should immediately don a facemask, notify management, and leave work.

Encourage hand hygiene and respiratory etiquette by all residents, visitors, and employees:

- Employees should review and follow recommendations for hand hygiene before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE). https://www.cdc.gov/handhygiene/providers/index.html

- Encourage handwashing and/or use of alcohol-based hand sanitizer; place hand sanitizer inside and outside residents’ rooms; have sinks available with soap and paper towels for hand washing

- Post signs encouraging hand hygiene and respiratory etiquette. A hand hygiene sign with multiple translations is available for download at http://eziz.org/assets/docs/IMM-825.pdf

Provide infection control training in advance to dedicated employees who may care for COVID-19 patients.

- Guidance on implementing recommended infection prevention practices is available in CDC’s free online course at https://www.cdc.gov/longtermcare/training.html which includes resources and checklists for facilities and employees to use.

- Ensure health care staff demonstrate competency with putting on and removing PPE. See CDC graphic https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf.

Ensure easy and correct use of personal protective equipment (PPE).

- Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.
- Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately outside of the resident rooms.
- Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.

**Enhanced cleaning of patient rooms and common areas.**
- Make sure all surfaces are wiped with an EPA-approved disinfectant at least daily and as needed, especially “high-touch” surfaces such as doorknobs, handrails, etc.

**Influenza Vaccination**
- Because influenza can cause a similar, severe respiratory illness in the elderly, influenza vaccination should be provided routinely to all residents and healthcare personnel and staff of long-term care facilities. Vaccination can prevent influenza-related illness and death, especially among people at increased risk for severe influenza complications.

**Stay up to date** with local and state COVID-19 activity and developments (in addition to CDC):
- SFDPH [https://www.sfcdcp.org/covid19](https://www.sfcdcp.org/covid19)
- CDPH [https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx)

- **Assess residents’ symptoms of respiratory infection upon admission to the facility** and implement appropriate infection prevention practices for incoming symptomatic residents.

- **Perform daily active surveillance for potential new cases of COVID-19.**
  - Actively evaluate all residents at least once daily for symptoms (new cough, sore throat, shortness of breath), fever (using a thermometer), heart rate, and O2 saturation via pulse oximeter. A log should be kept.
  - Consider that patients who are medically fragile and those with neurological or neurocognitive conditions may manifest atypical signs and symptoms of viral infection (e.g., behavior change) and may not exhibit fever. Astute clinical judgement and flexibility in applying the clinical definition should be used.

**SYMPTOMATIC RESIDENTS:**
- **Isolate** the resident immediately in an airborne infection isolation room (AIIR, also known as “negative-pressure” room) if possible.
  - If an AIIR is not available, a single, private, well-ventilated room with its own bathroom and the door kept closed is a second option.
  - If a single, private room is not available, cohort ill residents in the same room with spatial separation of at least 6 feet and a privacy curtain or barrier.
  - The ill resident should remain in isolation and be excluded from participation in group activities, including group dining, use of common areas, and receiving visitors, while COVID-19 testing results are pending.

- **Implement standard, contact, and airborne precautions plus eye protection.**
o Wear gloves, gown, respiratory protection (fit-tested N95 respirator or PAPR), and eye protection (e.g., goggles or face shield)

o Change gloves and gowns after each resident encounter and perform hand hygiene

o If resident must leave their room for medically necessary procedures, have them wear a facemask

- **Contact SFDPH COVID-19 Clinical Consultation center** to discuss the case. Call 415-554-2830; after hours call 415-554-3613 to reach the on-call physician. All suspected cases are required to be reported to SFDPH.

- **Evaluate for COVID-19 and other respiratory infections.**
  
  o Collect a single nasopharyngeal swab for COVID-19 according to instructions published in the SFDPH Clinical Checklist at [http://www.sfcdcp.org/covid19hcp](http://www.sfcdcp.org/covid19hcp)

  o COVID-19 testing through the SFDPH Public Health Laboratory must first be approved by the SFDPH clinical consultant.

  o Testing concurrently for influenza and other respiratory pathogens is strongly recommended. If possible, test for a full respiratory viral panel. Note that coronavirus testing currently available with commercial respiratory panels does not detect COVID-19.

- **Closely monitor the ill resident.** Clinicians should maintain a low threshold for obtaining a chest radiograph to exclude pneumonia or ARDS and refer for further evaluation and hospitalization if the patient exhibits clinical worsening.

- **Follow guidance on removal from isolation in LTCF settings for patients with lab-confirmed COVID-19.**
  

  o In general, criteria for removal include: 72 hours after resolution of fever AND acute respiratory symptoms (e.g., cough, runny nose, sore throat). If the patient was diagnosed based on non-respiratory symptoms (e.g., lethargy or altered mental status), the provider should consult with SFDPH prior to removal from isolation.

**FURTHER STEPS SHOULD COVID-19 INFECTION BE CONFIRMED:**

- **Conduct further management in consultation with SFDPH COVID-19 Clinical Consultation center to limit the likelihood of transmission to others in the facility.** The following actions will be required in consultation with SFDPH:
  
  o Restriction of admissions to the facility and transfers to any unit with symptomatic residents

  o All meals to be served in resident rooms

  o Recording a log of all persons who care for or enter the room or care area of the ill resident

  o Monitoring and isolation of residents who were in contact with the case, including testing of symptomatic persons for COVID-19 and other respiratory pathogens.
- Symptom check, temperature, heart rate, and O2 saturation via pulse oximeter should be performed at least twice daily for all residents.
- Minimization of the number of staff providing care for COVID-19 patients, including restriction of staff from floating to more than one unit. Staff in contact with ill patients/units should not work with well patients/units (or in other health care facilities) until no new cases have been identified for 28 days.
- Notification of external facilities prior to transferring any ill resident for further care.
- Additional control measures and duration of implementation will be determined in consultation with SFDPH.

**ADDITIONAL RESOURCES:**

- Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)
  

- Steps Healthcare Facilities Can Take Now to Prepare for Coronavirus Disease 2019 (COVID-19)
  

  