NJ - Infection Control: COVID-19 Care and Containment – Outbreak Response rev. 2.10.22

Process Owner: Resident Care Director

Policy

Coronavirus Disease 2019 (COVID-19)

This guidance is based on the currently limited information available about coronavirus disease 2019 related to disease severity, transmission efficiency, and shedding duration. This cautious approach will be refined and updated as more information becomes available and as response needs change in the United States. This guidance is applicable to all Arbor Communities.

- Infection control procedures including administrative rules and environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery.
- Prompt detection and effective triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the community.
- All communities must ensure that their personnel are correctly trained and capable of implementing infection control procedures; individual healthcare personnel should ensure they understand and can adhere to infection control requirements.

Recommendations:

1. **Containment Minimize Chance for Exposures**

Definitions:

Isolation is used to separate **ill** residents who have a communicable disease from those who are healthy. Isolation restricts the movement of ill residents to help stop the spread of certain diseases.
Residents placed in **ISOLATION** include the following:

- Resident has symptoms of an illness including fever, cough, sore throat, shortness of breath, nausea with vomiting or diarrhea.
- Resident has been diagnosed with an infectious illness: COVID-19, pneumonia, strep throat, norovirus, influenza, or other communicable disease.
- Any resident who moves in and is not up to date with vaccines.
- Residents returning from another healthcare setting and meeting the criteria in 1 or 2 above.
- Newly admitted residents meeting criteria of 1 or 2 above.
- Residents who are a Person Under Investigation due to exposure to someone who has tested covid positive.

ISOLATION Practices using Transmission Based Precautions include the following:

- Place the STOP sign reminder on the door.
- Limit the number of staff interacting with the resident. One caregiver per shift. Keep these residents on the same group assignment when possible.
- If symptoms are respiratory, resident will wear a mask.
- Personal Protective Equipment (PPE) required:
    a. Mask
    b. Gloves
    c. Gown
    d. Eyewear
    e. Hair cover

Quarantine is used to separate and restrict the movement of **well** residents who may have been exposed to a communicable disease to see if they become ill. These residents may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.

Residents placed in **QUARANTINE** include the following:

- Resident is asymptomatic of illness residing in a community that is under a complete quarantine order.
- Resident moving into the community from hospital, rehab or nursing home.
- Resident returned from the hospital, rehab or nursing home.

QUARANTINE practices include the following:

- Personal Protective Equipment required:
    - Gloves when providing direct care or contact with the resident or cleaning surfaces or handling soiled items
    - Masks will be worn while in the community. Both staff and resident will wear a mask while staff are in the apartment.
    - Staff will wear either goggles or face shield while providing direct care
- Resident will remain in their apartment for meals and activity.
- They may be allowed minimal time in the hallway for exercise with a staff member present. During periods requiring universal source control, resident will wear a mask if they leave the apartment.
- They may have their apartment door open for brief periods of time while they are wearing a mask.

- If resident develops a fever or other symptoms; cough, shortness of breath, sore throat, etc., they will be placed in isolation.

Prospective Residents

- In addition to the existing Vitalsware assessment, prospective residents will be screened for symptoms of respiratory illness specifically **cough, fever, shortness of breath**.

Existing Residents

- All guidelines will be applied to residents returning to the community
- Each resident will have, heart rate, blood pressure, temperature, and pulse oximetry taken in frequency as directed by the NJDOH guidance, by caregiver or med tech and recorded in Quick MAR vital signs.
- Each resident will be observed for symptoms of respiratory illness including cough, shortness of breath, congestion, nasal secretions. When symptoms are present they will be documented in the resident's chart notes in QuickMar. **Refer to Documentation Guide COVID-19**.
- Any resident exhibiting one or more symptom will be isolated in their apartment and their primary physician will be notified of the symptoms.
    - Community staff will specifically ask for further medical evaluation and testing for COVID-19 for the resident.
- Implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the resident's nose and mouth if that has not already been done) and isolate the Patient Under Investigation for COVID-19.

2. **Adherence to Standard, Contact and Airborne Precautions Including the Use of Eye Protection**

- Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting.
- Elements of Standard Precautions that apply to patients with respiratory infections, including those caused by COVID- 19, are summarized below. Attention should be paid to training on correct use, proper donning (putting on) and doffing (taking off), and disposal of any PPE. Visitors or third-party providers who enter the apartment of a resident with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the following:

Resident Placement

- Personnel entering the apartment should use PPE, including respiratory protection, as described below.
- Only essential personnel should enter the apartment. Implement staffing policies to minimize the number of HCP who enter the apartment. Refer to **Suggested Staff Model Accommodations for Residents on Isolation**.

- Communities should consider caring for these residents with dedicated staff to minimize risk of transmission and exposure to other patients and other staff members.
- Communities should keep a log of all persons who care for or enter the apartment or care area of these residents.
- Use dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuff sleeves). If equipment will be used for more than one resident, clean and disinfect such equipment before use on another resident according to manufacturer's instructions.
- Staff entering the apartment soon after a resident vacates the apartment should use respiratory protection. (See personal protective equipment section below) Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including staff, from entering a vacated apartment until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). We do not yet know how long COVID-19 remains infectious in the air. In the interim, it is reasonable to apply a similar time period before entering the apartment without respiratory protection as used for pathogens spread by the airborne route (e.g., measles, tuberculosis). In addition, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

Hand Hygiene

- Staff should perform hand hygiene using alcohol-based hand sanitizer (ABHS) before and after all resident contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene in healthcare settings also can be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS.
- Communities should ensure that hand hygiene supplies are readily available in various locations in the building.

Personal Protective Equipment

- Staff must receive training on and demonstrate an understanding of when to use PPE; what PPE is necessary; how to properly don, use, and doff PPE in a manner to prevent self-contamination; how to properly dispose of or disinfect and maintain PPE; and the limitations of PPE.
- Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.

Gloves

- Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the resident apartment or care area. Change gloves if they become torn or heavily contaminated.
- Remove and discard gloves when leaving the resident apartment or care area, and immediately perform hand hygiene.

Face Masks

- If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces (often called source control).
- When caring for residents who have tested positive for COVID 19, N95 face masks should be worn.

Extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters.

- If adequate supplies are available of disposable masks, staff will wear mask and dispose of after use and between residents.
- If it becomes necessary to re-use a disposable mask the following steps will be taken:
    - Staff will obtain a clean mask at start of shift
    - Staff must take care not to touch the mask. If they touch or adjust the mask without gloves on, they should perform hand hygiene.
    - Mask will be worn until it becomes torn, visibly soiled, or hard to breathe through, then it will be discarded.
    - If it is necessary to remove the mask, staff will wear gloves and carefully fold so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag labeled with the staff members name.
- Prioritize facemasks for selected activities such as:
    - During care activities where splashes and sprays are anticipated
    - During activities where prolonged face-to-face or close contact with a potentially infectious resident is unavoidable
    - For performing aerosol generating procedures, such as nebulizer treatments.
    - During universal source control periods- all staff wear masks at all times while in the community
- Residents requiring masks will wear a disposable mask if available.
    - Resident will reuse the mask until it becomes torn, soiled, or difficult to breathe through.
    - Resident will wear the mask when staff are in the apartment with them.
    - Resident will wear the mask if they leave the apartment for an essential purpose or escorted exercise
    - Have residents with symptoms of respiratory infection use tissues or other barriers, such as a bandana, to cover their mouth and nose if no other type of facemask is available or in short supply.

Gowns

- If adequate supplies are available of disposable gowns, staff will wear gown and dispose of after use and between residents.
- Put on a clean isolation gown upon entry into the resident apartment. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or before leaving the resident apartment or care area. Disposable gowns should be discarded after use.
- After exhausting the supply of disposable gowns. Items that are cloth and reusable will be provided to protect clothing.
    - Use disposable gown one time and discard when supply is available.
    - Use reusable item such as a cloth lab coat is acceptable.
    - Staff will obtain a clean lab coat at beginning of shift to wear in resident's apartment while providing care that may transfer secretions to staff member clothing:
    - Dressing, bathing, changing linens, changing briefs, or assisting with toileting or wound care
    - Cloth coat will be donned prior to providing care in the resident's apartment and removed and placed on a hangar in the bathroom.
    - The cloth or plastic reusable gown will be placed in a receptacle for laundering at the end of the shift.
    - When possible, each resident apartment will have a coat for the assigned staff member during the shift.
    - Staff may wear gown for more than one resident with the same infectious disease.
    - Soiled gowns will be laundered in hot water and detergent in a separate load and dried in dryer before placing back in circulation.

Eye Protection

- Protective eyewear will be worn for residents in isolation *and* the following:
    - During showering of residents
    - Anytime the resident is unable or unwilling to wear a face covering and care is necessary
    - While working in memory care with residents during a period of quarantine
- Put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Remove eye protection before leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.
- Disinfectant wipes will be used while wearing gloves to wipe down goggles and face shields.
- Goggles will air dry prior to putting back on or in paper bag for remainder of shift, labeled with staff member's name.

- At the end of each shift goggles will be placed in a receptacle for disinfecting:
    - While wearing gloves, carefully wipe the *inside, followed by the outside* of the face shield or goggles using a clean EPA approved disinfectant wipe.
    - Carefully wipe the *outside* of the face shield or goggles using a wipe.
    - Wipe the outside of face shield or goggles with clean water or alcohol to remove residue.
    - Fully air dry on clean paper towel on clean surface.
    - Remove gloves and perform hand hygiene.

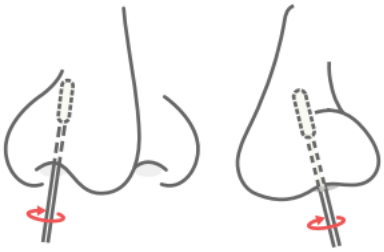
Storage of PPE supplies

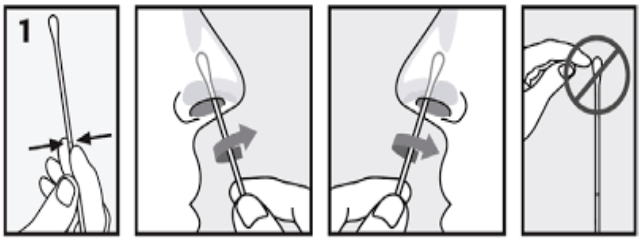
1. All clean, unused PPE will be maintained in a secure designated storage location.
2. The Nurse or Med Tech on duty will provide the necessary PPE to staff assigned to residents on Isolation.
3. Receptables for disposable and reusable PPE will be placed in the resident's apartment and labeled for scrubs/coats or goggles.
4. Soiled PPE should not be brought into a "clean" area such as the Wellness Center.
5. Identify how and when soiled PPE will be removed and brought to laundry or cleaning station.

Diagnostic Respiratory Specimen Collection: COLLECTION OF NASAL ANTERIOR SPECIMENS FOR SARS-CoV2

Each community will identify and train 2-3 staff members on the proper collection and handling of nasal anterior specimens for SARS-CoV2.

1. Staff identified will be trained on specimen collection following these guidelines.
2. The procedure for nasal (anterior) nasal sampling is as follows:
    - Staff will don proper PPE including gown, N95 mask, face shield and gloves after performing hand hygiene.
    - Assemble supplies including swab and Universal Viral Transport tube.
    - Identify resident or staff member by name and explain procedure for collecting the specimen.
    - Ask the resident or staff member to blow their nose and have them dispose of the tissue.
    - Ask resident or staff member who should be seated to lean back and their tilt head.
    - Remove one swab only from the package, taking care to hold it above the scored mark and not contaminate the swab.
    - Stand to the side of the resident or staff member.
    - Using a flocked or spun swab, gently insert the swab at least 2 cm (.75 inches) inside the nostril and firmly sample the nasal membrane by rotating the swab and leaving in place for 10 seconds.





- Using the same swab repeat for the other nostril.
- Remove the cap from the transport tube.
- Immediately insert and swirl the swab in the transport tube. Snap applicator at scored mark.
- Replace cap and tightly secure to prevent leakage.
- Place tube labeled with name and date of birth inside biohazard bag and seal.

3. After each specimen is collected, remove gloves, and perform hand hygiene with hand sanitizer. All other PPE (gown, N95 mask, face shield, head covering) will remain on unless visibly soiled.

Discontinuing of Isolation Precautions for Residents Under Investigation and confirmed COVID-19 Residents

- The decision to discontinue Transmission-Based Precautions for residents with confirmed COVID-19 should be made using the guidelines as described below.

The time period used depends on the resident's severity of illness and if they are severely immunocompromised.

A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in prolonged isolation of persons who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Symptom-Based Strategy for Discontinuing Transmission-Based Precautions

Residents with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**

- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- If fully vaccinated, symptom improvement, and atleast 24 hours have passed since last fever without use of fever-reducing medications, isolation may end after 5 days with day 0 being date of symptom onset or positive test.

Residents with severe to critical illness or who are severely immunocompromised

- At least 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Time Based Strategy for Discontinuing Transmission-Based Precautions

*Residents who are **not severely immunocompromised** and who were **asymptomatic** throughout their infection:*

- At least 10 days have passed since the date of their first positive viral diagnostic test.

*Residents who are **severely immunocompromised** who were **asymptomatic** throughout their infection:*

- At least 20 days have passed since the date of their first positive viral diagnostic test.

Test-Based Strategy for Discontinuing Transmission-Based Precautions

In some instances, a test-based strategy could be considered for discontinuing Transmission-based Precautions earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some patients (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the resident being infectious for more than 20 days.

The criteria for the test-based strategy are:

Residents who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved, **and**
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.).

Residents who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

    - Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

Illness Severity descriptions

Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the National Institute of Health are one option for defining severity of illness categories. The highest level of illness severity experienced by the resident at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions.
Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.
Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level.
Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Severely Immunocompromised examples

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.

4. **Manage Visitor Access and Movement Within the Community**

- All visitors will check in and sign in at the front desk upon arrival. Visitors will be screened for symptoms of illness including, but not limited to, cough, shortness of breath and fever. Communities will survey temperatures of visitors and not allow anyone with symptoms of cold or flu or temperature over 100 degrees to visit the community.

- All visitors must sign an informed consent that they are aware of the possible dangers of exposure to Covid-19 for both the resident and the visitor, and that they will follow the visitation rules set by the community.
- Restrict visitors from entering the apartments of known or suspected COVID-19 residents (i.e., PUI), unless an essential caregiver. Alternative mechanisms for residents and visitor interactions, such as video-call applications on cell phones or tablets should be explored. Communities can consider exceptions based on end-of-life situations or when a visitor is essential for the resident's emotional well-being and care.
- Communities should provide instruction, before visitors enter residents' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current community policy while in the resident's room if they are in isolation.
- Visitors should be instructed to limit their movement within the community. This includes private duty caregivers and third-party providers.
- All visitors should follow respiratory hygiene and cough etiquette precautions while in the common areas of the community.

5. **Monitor and Manage Ill and Exposed Healthcare Personnel**

- Movement and monitoring decisions for staff with exposure to COVID-19 should be made in consultation with public health authorities. Refer to the **Risk Assessment and Management of Persons with Potential Exposure to COVID-19** policy in the Resident Care Manual Policies and Procedures.
- Community staff will be reminded to not report to work if they have cold or flu symptoms including cough, nasal secretions, fever.

- Staff may be subjected to monitoring for these symptoms including temperature checks for fever upon reporting to work.
- Any staff member with a fever above 100 degrees will be sent home and asked to remain out until they are symptom free and deemed not contagious.
- Communities should implement sick leave policies for staff that are non-punitive, flexible, and consistent with public health guidance.
- Staff with confirmed case of COVID-19 will be removed from work and monitored using the Fever and Symptom Monitoring Log.

6. Return to Work Guidelines for Staff with Confirmed COVID-19

Symptom-based strategy for determining when HCP can return to work

HCP with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**

- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- In cases of extreme staffing crisis staff may be allowed to return sooner per State, Local, and CDC guidelines for Mitigation of Staffing Crisis. This **must be approved** by Regional VP of Resident Care.

HCP with severe to critical illness or who are severely immunocompromised:

- At least 20 days have passed *since symptoms first appeared*
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Time-Based strategy for determining when HCP can return to work when asymptomatic

- HCP who are **severely immunocompromised** but who were **asymptomatic** throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.
- HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.
- In cases of extreme staffing crisis staff may be allowed to return sooner per CDC guidelines for Mitigation of Staffing Crisis. This **must be approved** by Regional VP of Resident Care.

Upon returning to work staff should:

- Wear a facemask at all times while in the community
- Be restricted from contact with severely immunocompromised residents until 14 days after illness onset
- Adhere to hand hygiene, respiratory hygiene and cough etiquette
- Self-monitor for symptoms; obtain medical attention if symptoms recur or worsen

7. Train and Educate Healthcare Personnel

- Provide staff with job- or task-specific education and training on preventing transmission of infectious agents, including hand hygiene, cough etiquette, symptom management, isolation procedures and use of PPE.
- Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

8. **Implement Environmental Infection Control**

- Dedicated medical equipment should be used for resident care.
- All non-dedicated, non-disposable medical equipment used for resident care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA- registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings, including those resident-care areas in which aerosol-generating procedures are performed. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. These products can be identified by the following claim:

"[Product name] has demonstrated effectiveness against viruses similar to COVID-19 on hard non-porous surfaces. Therefore, this product can be used against COVID-19 when used in accordance with the directions for use against [name of supporting virus] on hard, non-porous surfaces."

This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to health care facilities, physicians, nurses and public health officials, "1-800" consumer information services, social media sites and company websites (non-label related). Specific claims for "COVID-19" will not appear on the product or master label.

- If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Ensure staff shared equipment or frequently touched surfaced are disinfected including: keys, phones, keyboards, medication cart scanners, pill crushers, radios, pagers.

9. **Establish Reporting within Communities and to Public Health Authorities**

- Notify Arbor support partners, including operations and resident care at the first observation of symptom and isolation of residents.
- Follow guidelines in **Infection Control Surveillance Line List policy** for reporting.
- Promptly notify state or local public health authorities of residents with known or suspected COVID-19 (i.e., PUI). Communities should designate specific persons within the community who are responsible for communication with public health officials and dissemination of information to HCP.
- Follow state regulations for notifying and reporting to licensure agencies.

- All mitigating actions implemented by the community to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered will be posted on the website and all visitors allowed according phase will be notified upon visiting the community.

10. **Mitigate staffing in the event of an outbreak**

- Understand staffing needs to provide a safe work environment and safe resident care.
- Collaborate with Arbor sister communities who are able to provide additional staff.
- Utilize internal HR and recruitment to hire additional HCP.
- Communicate with local healthcare coalitions to identify additional HCP, including those who are retired, students, and volunteers when needed.

12. **The Covid19 pandemic has brought a heightened awareness to the community, and along with it, new policy development in accordance with the lessons we have learned during this time.**

- Increased training to all staff on infection control measures and guidelines
- Vital sign and symptom monitoring policies
- Covid19 documentation guidelines
- Permanent staffing model to mitigate cross contamination and risk exposure
- Admission and Re-admission guidelines
- Infection Control Surveillance Line List policy
- Risk Assessment and Management of risk exposure
- Increased environmental infection control guidelines