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COVID Resource Info

General COVID recommendations: Infection Control Guidance: SARS-CoV-2 | COVID-19 | CDC

Managing Healthcare Personnel who are either infected or exposed to COVID:
https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html

Testing

Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**, should be tested as soon as possible.

- May use either contact tracing or broad-based testing.
- Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
  - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- If **no additional cases** are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively.
- If **additional cases are identified**, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered.

Masking and PPE During Outbreak

Staff should mask. Surgical masks are ok for in the building but N95's should be used when in the room of a COVID positive resident. Full PPE (gown, gloves, N95, and eye protection) is to be worn in the room of a suspected or confirmed COVID resident. Staff should wear masks until outbreak testing is complete.

From CDC re: Masking
Source control is recommended for individuals in healthcare settings who:

- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); **or**
- Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARSCoV-2 infection, for 10 days after their exposure

Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances:

By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission (See Appendix) Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high)

Cohorting

A COVID negative asymptomatic resident should be separated from a COVID positive resident. Either may be moved. If the COVID positive resident is moved, the room will need to be deep cleaned. Two COVID positive residents may room together if there are no other infectious diseases present.

Ideally, a COVID negative asymptomatic roommate would be moved to a private room to limit risks for contamination (see Exposure Management below).
Guideline for Isolation Precautions, pages 58-59

Exposure Management

Residents: In general, asymptomatic patients do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These residents should still wear source control **and** those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section. (i.e., Day 1, 3 and 5 post exposure)

Staff: Higher-risk exposures are classified as staff who had prolonged close contact with a patient, visitor, or other staff member with confirmed SARS-CoV-2 infection and:

- Was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)
- Was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- Was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

The exposed staff member should be testing as described in the testing section, wear a well-fitting mask, and self-monitor for symptoms of COVID. Work restriction is generally not necessary for asymptomatic staff following higher risk exposure.

Visitation

Visitors 'should' be masking but it is not mandated. Visitation may continue. Be sure that there are signs on the front door identifying that there is COVID in the building. Signs encouraging them not to visit while feeling ill and to complete hand hygiene should be posted as well. Put a trash can at each entrance for mask disposal.

CDC info on Visitation

- For the safety of the visitor, in general, patients should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation. Additional information about visitation from the Centers for Medicare & Medicaid Services (CMS) is available at Policy & Memos to States and Regions | CMS.
- Counsel patients and their visitor(s) about the risks of an in-person visit. Outdoor visits should be considered if weather conditions are favorable.
- Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
- Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- Visitors should be instructed to only visit the patient room. They should minimize their time spent in other locations in the facility.

Staff Return to Work

Mild to moderate illness who are not moderately to severely immunocompromised**:**

- At least 7 days since symptoms first appeared with a negative test 48 hours prior to retuning to work (or 10 days if testing is not performed or if test is positive on day 5 – 7) 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.

Either NAAT or antigen test should be used. If an antigen test is used, the HCP should have a negative test on day 5 and 48 hours later

Severe to critical illness and not moderately to severely immunocompromised

- At least 10 days and up to 20 days 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.
- A test-based strategy can be used to determine return to work.

Moderately to severely immunocompromised

- Test based strategy as described below

Test-Based strategy

Asymptomatic Staff: Two consecutive negative tests 48 hours apart (Day 5 and 7)using either antigen or NAAT testing.

Symptomatic Staff:

Resolution of fever without use of fever-reducing meds AND
Improvement of symptoms AND
Two consecutive negative tests 48 hours apart (Day 5 and 7) using either antigen or NAAT testing

Ending Resident Isolation

Generally, 10 days since first positive AND 24 hours since last fever AND symptoms improved. If no symptoms, 10 days. Another option is test based strategy – 2 negative tests 48 hours apart.

CDC info: In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for patients.
Patients with mild to moderate illness who are not moderately to 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

Patients who were asymptomatic throughout their infection and are not moderately to severely immunocompromised:

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

The criteria for the test-based strategy are:
Patients 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 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT Patients who are not symptomatic:
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

General IPC Recommendations during COVID outbreak

- Improve ventilation in building and isolation rooms.
  - Ensure that ventilation systems are functioning effectively ○
    Other resources:
    Air guidelines from the Guidelines for Environmental Infection Control in Health-Care Facilities:
    https://www.cdc.gov/infection-control/hcp/environmental-control/air.html
    American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities, which also provides COVID-19 technical resources for healthcare facilities
    Ventilation in Buildings, which includes options for non-clinical spaces in healthcare facilities

- Be attentive to hand hygiene and cough etiquette by all staff, residents, and visitors.
- Ensure that high touch surfaces are wiped down at least daily
- Observe residents at least twice/day for changes in condition
- Promote hydration
- Encourage physical distancing when possible. Avoid large group activities.