NOTE: These are only recommendations and guidelines. Every facility has different characteristics. Please use your discretion, and feel free to adapt to your specific situation.
Symptomatic ALF Resident

Assessment by designated Nurse or Infection Preventionist

Screening Criteria for COVID-19 met* (determined by PCP)

YES

Unstable (hypoxia, resp distress)

MD attempt to notify family with staff assistance

Complete PUI form (RN to complete w MD input)

Order COVID-19 Test AND Influenza RT-PCR

Designated Nurse/ Infection Preventionist does COVID-19 swab (FULL PPE= airborne and contact precautions, N95, shield, gloves, gown)

Facility calls DOH 586-4586 for Priority approval

Facility to notify DOH, who will strategize with Infection Preventionist for cohorting, contact tracing, and further testing

COVID +

Lab calls facility nurse to report COVID Test result

Contact & Droplet Precautions with close monitoring of VS And symptoms daily x 2 weeks by designated Nurse, and reassessed for need of retesting.

COVID -

Facility to notify DOH, who will strategize with Infection Preventionist for cohorting, contact tracing, and further testing

Continue Isolation Contact & Droplet Precautions Manage Symptoms

Manage in ALF ** Immediate isolation with contact and droplet precautions

Residents may discontinue isolation when ALL of the following criteria met:

- 72 h after resolution of fever (*without use of fever-reducing medications), AND
- 10 days after onset of first symptom, AND
- Respiratory symptoms are improved

Residents may discontinue isolation when ALL of the following criteria met:

- 72 h after resolution of fever (*without use of fever-reducing medications), AND
- 10 days after onset of first symptom, AND
- Respiratory symptoms are improved

Contact Hospice immediately for Palliative/ Hospice care

Unstable (hypoxia, resp distress)

MD attempt to notify family with staff assistance

Complete PUI form (RN to complete w MD input)

Designated Nurse/ Infection Preventionist does COVID-19 swab (FULL PPE= airborne and contact precautions, N95, shield, gloves, gown)

Facility calls DOH 586-4586 for Priority approval

IF courier not available, call 586-4586 to coordinate transport of specimens.

Updated 4/30/2020

* Screening Criteria for COVID-19


Facility Screening Criteria for COVID-19

- Fever OR symptoms/signs of LOWER respiratory infection (e.g. new dry cough, dyspnea, or new/worsening hypoxia) OR change in clinical status with no immediate explanation for infection/sepsis (e.g. UTI, bacteremia, skin/soft tissue infection) should be investigated.

- Anyone with close contact within 14 days of a suspect or confirmed COVID-19 patient.

- CAVEATS:
  - Older adults may NOT have fever, cough, chest discomfort or sputum. They MAY present with Delirium, elevated RR, HR, or low BP.
  - The definition of fever in Older Adults*: temperature of > 100.0 F, or temperature > 99.0 F on two consecutive measurements, or temperature > 2.0 F above patient’s baseline temperature

*Fever definition taken from IDSA Clinical Practice Guideline for the Evaluation of Fever and Infection in Older Adult Residents of Long-term Care Facilities (High et al, Clinical Infectious Diseases 2009) and Society for Healthcare Epidemiology of America surveillance definitions (Stone et al, Infection Control and Hospital Epidemiology 2012).

Table 1: Epidemiologic Risk Classification for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease 2019 (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations


<table>
<thead>
<tr>
<th>Epidemiologic risk factors</th>
<th>Exposure category</th>
<th>Recommended Monitoring for COVID-19 (until 14 days after last potential exposure)</th>
<th>Work Restrictions for Asymptomatic HCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) who was wearing a cloth face covering or facemask (i.e., source control)</td>
<td>Medium</td>
<td>Active</td>
<td>Exclude from work for 14 days after last exposure</td>
</tr>
<tr>
<td>HCP PPE: None</td>
<td>Medium</td>
<td>Active</td>
<td>Exclude from work for 14 days after last exposure</td>
</tr>
<tr>
<td>HCP PPE: Not wearing a facemask or respirator</td>
<td>Medium</td>
<td>Active</td>
<td>Exclude from work for 14 days after last exposure</td>
</tr>
<tr>
<td>HCP PPE: Not wearing eye protection</td>
<td>Low</td>
<td>Self with delegated supervision</td>
<td>None</td>
</tr>
<tr>
<td>HCP PPE: Not wearing gown or gloves</td>
<td>Low</td>
<td>Self with delegated supervision</td>
<td>None</td>
</tr>
<tr>
<td>HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)</td>
<td>Low</td>
<td>Self with delegated supervision</td>
<td>None</td>
</tr>
</tbody>
</table>
Table 1: Epidemiologic Risk Classification\(^1\) for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease 2019 (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations

**COMMENTS:**

The highest risk exposure category that applies to each person should be used to guide monitoring and work restrictions.

Note: While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into our assessment of risk.

HCP=healthcare personnel; PPE=personal protective equipment

\(^a\)The risk category for these rows would be elevated by one level if HCP had extensive body contact with the patients (e.g., rolling the patient).

\(^b\)The risk category for these rows would be elevated by one level if HCP performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction). For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol generating procedure would be considered to have a medium-risk exposure.

The Need to Include ALF in Response to the COVID-19 Pandemic

KEY RECOMMENDATIONS

• Ensure all AL residents are involved in discussion related to COVID-19
• Be especially vigilant to medical signs of possible COVID-19 (especially for residents with dementia)
• Be proactive in instilling infection control practices in AL
• Consider capacity of AL to promote social engagement and provide infection control— they may need outside assistance
• Keep MDs informed— make telehealth available if possible
• Ensure the direct care workforce has knowledge and skills for COVID-19
• Communicate with family- practices in place to prevent/combat COVID-19 and helping them remain meaningfully involved in resident oversight and well-being

Zimmerman, et al. The Need to Include Assisted Living in Responding to the COVID-19 Pandemic. JAMDA 21 (2020); 572-575. https://doi.org/10.1016/j.jamda.2020.03.024
For Assistance setting up Telehealth: Visit website, contact Christine Higa and join their weekly webinar every Thursday from 1-2 pm

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Suggestions

- **Infection Preventionist**
  - To keep track of supply of PPE for employees and cloth masks for residents
  - To educate, and monitor IC practices for:
    - Direct care workers
    - Activities
    - Dining
    - EVS
  - To be a resource for assessment/communication for onset of suspected COVID-19 symptoms
    - Communicate w PCP
    - Communicate w DOH
    - Trained to perform NP swab?
  - To assist DOH regarding isolation or quarantining of residents
    - Assist w contact tracing
    - Setting up support services to allow for quarantine
    - Ensure compliance with quarantine
Suggestions

• Charge Nurse/DON
  • Work with Director of Activities to provide Telehealth
  • Assist residents in scheduling for Telehealth
  • In consultation with the Infection Preventionist,
    • Provide education regarding disinfection, face masks to residents and families
    • Arrange for education/ opportunities to address Advance Care Planning
    • Be available to direct care workers or staff to monitor for COVID-19 suspected cases
    • Daily VS and symptoms checks for COVID -19/ suspected or symptomatic residents.
Suggestions

- Director of Activities- additional duties during pandemic
  - Ensure that social distancing does not result in social isolation or disengagement
  - Special attention to residents with dementia
  - Expand the use of technologies to schedule phone/video social contact with families and friends
  - Increase frequency of communication to families on resident’s health, well-being, finances.
Considerations for Memory Care

Key Considerations
• Routines are important
• Dedicate staff to memory care
• Structured and safe activities
• Social distancing
• Active cleaning
• Ensure access to necessary medical care and services

Confirmed/Suspected COVID-19 Residents
• Testing
• Appropriate PPE
• Assess risks and benefits of moving residents to designated COVID-19 care unit
• When moving residents:
  • Provide information
  • Prepare personnel
  • Move familiar objects with resident