Q&A from April 9th, 2020 with Dr. Ouslander and Dr. Russell.

Isolation & Social Distancing Related Questions

1. We have established an isolation wing as advised in preparation & have some questions. This wing has a separate air exchange from the rest of the facility. The goal is to obtain a Covid-19 test prior to admission.

Any concerns about false negatives? Dr. Russell: Of course. The false negative rate is still a matter of investigation, depending on the type of test and the test provider. Human error, especially sampling error, can occur. Its also important to look at the pretest probability of COVID19. Health care workers are often required to have two negative tests before returning to work. Your medical director should review every admission for possible signs of COVID19. A clinical suspicion of COVID followed by a negative test should be followed by a second test.
However, some can be asymptomatic. If people are tested who have a lower pretest probability for COVID19 (for example, a scenario where a hospital is doing universal screening of potential NH transfers) and that test is negative, it is still important to treat anyone (healthcare worker or resident or patient) with universal precautions, whether on the COVID unit or not.

Dr. JO: Agree

If a new admission has a negative Covid-19 prior to admission and our non-isolation wing is full. How should we proceed? Dr Russell: I would proceed as if I did not have an available bed. You need universal precautions everywhere. Do not assume your non COVID residents are COVID free even if you have never had COVID19 in your building. You must use universal precautions.

Dr. JO: The decision to admit new patients from the hospital who have a negative COVID test should be based on local needs. As Dr. Russell mentioned one test is not adequate because there are false negatives. But getting more than one may be impractical. Whether a patient has one negative test or not, they should meet the CDC criteria of 3 days without symptoms of fever in the absence of Tylenol, and preferably 7 days from onset of any symptoms. I recommend ISOLATING ALL NEW ADMISSIONS WHO DO NOT HAVE TWO NEGATIVE COVID TESTS AND USING PPE IF AVAILABLE (MINIMUM MASK AND GLOVES) FOR A MINIMUM OF 7 DAYS WHILE OBSERVING FOR SYMPTOMS. I recognize the potential negative effects of isolation and the shortage of PPE, but if you want to contain the potential spread of the virus, this is a conservative approach.

2. How would you recommend designing this hallway to accommodate all the possible situations that may occur in a long-term care facility?
    a. If current resident becomes ill on our non-isolation hall, immediately move this resident to this wing with precautions, then "back to clean hall" after negative Covid-19 & 7 days symptom free? Dr. Russell: Residents with known infection should remain on the COVID19 unit until two tests are negative, preferred 48 hours apart. Talk to your Medical Director if testing is not available. I don't believe 7 days of symptom free is enough to reintroduce the patient to your COVID naïve residents. Again, the building program and footprint will be considered before moving these folks. Your Medical Director needs to look at each case. IgG and IgM testing is not yet validated to allow you to make these decisions but once it is available you will get a better sense of the infectiousness of cases. All that said, UNIVERSAL PRECAUTIONS.

Building footprint and program are critical to isolation strategies. All private rooms make a big difference. Medication administration and dining programs continue and are a potential source of spread. Workforce is a potential or likely vector. The isolation strategy needs to be individualized to a building and done in close conjunction with your Medical Director and the CDC checklist; https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf

Dr. JO: While I agree that 7 days symptom free may not be enough but it is probably OK when there is one negative COVID test. For those without a test, I agree that the medical director should be involved in these individual decisions.

b. If clean hall is full & a resident in our isolation hall has been cleared, where do we put them? Dr Russell: As above. What does cleared mean? Naïve or recovered? It is very difficult to "clear" residents" with the certainty needed to return them to a unit with COVID19 naïve resident.
Dr. JO: Based on Dr. Russell's recommendations above, I would say that the safest definition of "cleared" is no symptoms for 14 days and two negative tests. This may not be practical in all facilities. Again, the medical director should be involved in these individual decisions.

3. Are small group (5-6) activities OK if 6 feet apart, proper hand washing, no contact activities & no symptoms? Staff is wearing proper PPE. Dr Russell: As much as it pains me to say, understanding the importance of social programming in the facility, this outbreak needs to be seen as a nursing home and healthcare worker disease, targeting your residents and spread by your staff. I would not increase the movement or interactions between residents and staff unless absolutely necessary.

   Dr. JO: I agree

4. If positive Covid-19 in facility- What are your recommendations re: staff scrubs, shoes, cloth masks. What about change& shower in facility after shift? Dr. Russell: In China, the staff of health care facilities stayed in the facility for 3 months to avoid cross contamination with the community. It is that contagious and prevalent. I don't think you can take too many precautions here; what is possible in the facility is going to vary by facility. Your Medical Director needs to provide guidance, but you must comply with all CDC and OSHA guidance. A shortage of supplies or testing will not absolve you if an outbreak occurs.
   a. Laundry scrubs & cloth masks in house? Any shoe recommendations? We have shoe covers in preparation for isolation wing. Dr Russell: As above.

   Dr. JO: I agree. You must do the best you can with what you have and document what you are doing and any barriers including PPE shortages in minutes of quality or infection control meetings, which should occur at least weekly during this pandemic. I have not seen information that shoe coverings are helpful, but I would follow CDC guidance.

5. Curious on regulations and thoughts on creating a COVID unit in a large open room, if actual private patient rooms are not available. Dr Russell: the guiding principle of creating space around the infected person is a good one. There are risks, though, especially comingling naïve

and infected residents. There are limited options. Universal precautions must be in place. In essence, your entire building needs to be a COVID19 unit. A decanting facility for sick residents should be investigated. Talk with your community hospital, they may have such plans in place.

Dr. JO: Many are developing concepts and units across the country. As we indicated in the presentation, it is complicated and requires a lot of cooperation between LTCFs, hospitals, county and state authorities, and provider groups. Regulatory, liability, financial, staffing, and PPE issues need to be addressed.

The California Association of Long Term Care Medicine (state chapter of AMDA) has developed a proposal in collaboration with the QIO and sent it to the state health department. Dr. Michael Wasserman, president of CALTCM sent it to me with permission to disseminate. It has been shared with Telligen.

6. IHCA & Leading age are recommending isolating for 14 days all admits Asymptomatic. You say 7days. Do you think residents that have had 2 negative tests and came from the hospital need to go into the isolation unit for 7 days too? Dr. Russell; CDC Guidance and the abundance of caution can be different. As above, if at all possible, make it exceptionally difficult for COVID to get into your building Don't kick yourself afterwards. Every admission needs to be reviewed by your medical director as a PUI.

   Dr. JO: I agree. However, if the patient has not had symptoms for 7 days, no fever for 3 days in the absence of Tylenol, and two negative COVID tests I would be comfortable admitting them. To be ultra conservative you could isolate them for 7 additional days if feasible.

Miscellaneous:

1. How are others tracking their infections? Line listings still work. Your health department should have a template you can use. See the CDC guidance for CORONAVIRUS PREPARATION link above.

   Dr. JO: In the intermediate term enrollment in your state or regional Health Information Exchange would be helpful. Facilities should be encouraged to look into this.

2. What is the name of the self admin COVID-19 test that is a good resource to test our workforce? Where can I purchase the tests? Dr Russell: I am not sure of all the manufacturers, but I believe Everlywell is one.

   Dr. JO: I am not aware of these tests. I Googled Everlywell and their website says the tests are not yet available for individual purpose. They may be for group purchases. You would have to check.

Personal Protective Equipment (PPE)

1. If we are treating new admissions as they are positive and putting them on droplet precautions for 7 days are we OK to use surgical masks instead of n95 masks? Dr Russell; This is important. Surgical masks are fine for SOURCE control. Everyone in the building should have a face covering, prefer a mask. That is part of universal precautions. Residents who can tolerate a mask should have one too. This is to prevent them from spreading the virus through droplets. Precautions when handling masks must be used. Staff working with COVID19 cases need to be in full PPE including eye protection. Staff in close contact with residents should be in N95 at a minimum.

   Dr. JO – I agree. A minimum should be some kind of mask and gloves for everyone. When interacting with those on isolation or quarantine, as much PPE as available should be used. N95 mask, gloves, gowns, eye shields. Proper techniques for donning and removing the PPE should be used as recommended on the CDC website.

   https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf

2. It seems hard to get fit testing in long term care - any ideas? is it ok to use teaching on a seal test? Dr Russell: There are self-administered FIT testing kits. They do about 150 staff. The standard sized mask, properly worn, works for about 85 percent of faces, smaller people usually need a smaller mask and facial hair can be a problem. Please get your staff FIT tested.

   Dr. JO – I agree if fitting is available, however if not immediately available make sure staff understand the importance of making the mask fit tightly.

3. I am curious about the fit test, I have heard this was waived, but then I have heard that the initial fit is not waived, do we need to use this. Dr Russell: As above. Get it done. It's not that difficult.

   Dr. JO – I agree if fitting is available, however if not immediately available make sure staff understand the importance of making the mask fit tightly.