SPICE TOWN HALL: COVID-19 FAQ SESSION

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NC Statewide Program for Infection Control and Epidemiology (SPICE)
February 3rd, 2021
SPICE EDUCATIONAL ACTIVITIES
(CONGREGATE CARE SETTINGS)

- **Quarterly Webinar(s):**
  - Vaccine Hesitancy in HCP: Is There a Solution? **February 18th: 12 noon-1pm**
  - 2021: May, August, November
  - 2022: February, May and August

- **Infection Control in Long Term Care Facilities:**
  - March 29-31st, 2021
  - June 7-9th, 2021

- **Provide 2-DVD set that includes 6 modules:**
  - Antibiotic resistant bacteria, isolation precautions, environmental cleaning, preventing UTIs, preventing *C. difficile*, and safe injection

- **Infection Control Course:**
  - Adult Care Homes and Assisted Living Facilities (12/31)

- **Development of tool kits related to infection prevention**
OBJECTIVES

- Review CDC guidance for infection prevention COVID-19 recommendations
  - Most frequently discussed issues
- Q&A Session
GUIDANCE NURSING HOMES

- CDC:
  - Responding to COVID-19 in NHs
  - Preparing for COVID-19 in NHs
  - Testing Guidelines for NHs

- CMS:
  - QSO-20-38-NH (Nursing Home Testing)
  - QSO-20-39-NH (Nursing Home Visitation)
  - QSO-20-31-ALL (January 4th)

- NCDHHS:
  - Toolkit for LTCFs
  - Reporting of Antigen Results

- [https://www.cdc.gov/media/subtopic/images.htm](https://www.cdc.gov/media/subtopic/images.htm)
# NEW ADMISSIONS/RE-ADMISSIONS

<table>
<thead>
<tr>
<th>Resident Status</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly admitted/readmitted resident with confirmed COVID-19 <strong>who have met criteria</strong> for discontinuation of TBP</td>
<td>Place in a regular room</td>
</tr>
<tr>
<td>Newly admitted/readmitted resident with confirmed COVID-19 <strong>who have not met criteria</strong> for discontinuation of TBP</td>
<td>Place on the COVID-19 designated unit until criteria for discontinuing precautions is met</td>
</tr>
<tr>
<td>Newly admitted/readmitted resident <strong>whose COVID-19 is unknown</strong></td>
<td>Private room&lt;br&gt;Staff wear all recommended COVID-19 PPE-N95 (facemask if respirator not available), eye protection, gown and gloves&lt;br&gt;Observe and monitor for 14 days&lt;br&gt;Testing at admission could identify those infected&lt;br&gt;Testing at end of observation could increase certainty</td>
</tr>
</tbody>
</table>

Families and Visitors

* DO NOT ENTER THE ROOM
* REPORT TO THE NURSES STATION WITH QUESTIONS
* SI TIENE PREGUNTAS, VAYA A LA ESTACIÓN DE ENFERMERAS

**ENHANCED DROPLET ISOLATION**

**PRECAUCIONES DE AISLAMIENTO REFORZADAS PARA TRANSMISIÓN POR GOTAS**

Before entering this room, follow the instructions below:

Antes de entrar a esta habitación, siga las instrucciones a continuación:

**Universal masking:** N95 (if available) if not, surgical mask acceptable and MUST fully cover the nose, mouth, and chin.

_Uso generalizado de mascarilla:_ N95 (si está disponible) si no, la mascarilla quirúrgica es aceptable y DEBE cubrir completamente la nariz, la boca y la barbilla.

**N95 or higher level respirator (must be fit tested) needed when performing aerosolized procedures.**

_Se necesita un respirador N95 o de nivel superior (debe haber pasado la prueba de ajuste) cuando se practican procedimientos que producen aerosoles._

- **Perform Hand Hygiene**
  - Llevar a cabo la higiene de las manos

- **Eye protection when entering the room**
  - Utilizar protección para los ojos al entrar a la habitación

- **Gown and gloves when entering room**
  - Utilizar bata y guantes al entrar a la habitación
CONFIRMED COVID-19:
DISCONTINUING TBP (RESIDENTS/HCP)

For most persons:
- Symptomatic:
  - 10 days after symptom onset
  - Resolution of fever (24 hours off medications)
  - Improvement of symptoms
- Asymptomatic:
  - 10 after first positive test

Severe illness:
- Increase 10 days to 10-20

Persons previously diagnosed with COVID-19:
- Recovered and remain asymptomatic retesting not recommended within 3 months
- Do not need to undergo repeat quarantine in the case of another COVID-19 exposure within 3 months

STRATEGIES TO MITIGATE HCP SHORTAGE

Contingency (shortages are anticipated):

- Hire additional staff, postpone elective time off
- Plans to allow asymptomatic HCP who have high risk unprotected exposure but are not known to be infected to continue to work onsite during the 14-day post-exposure

Crisis: (no longer enough staff to provide safe patient care):

- **As a last resort** implement criteria to allow HCP confirmed to have COVID-19 who are well enough to work but have not met all return-to-work criteria to work:
  - Restrict from severely immunocompromised patients
  - Perform job duties where they do not interact with other
  - Provide direct care to persons with confirmed COVID-19 preferably cohort setting
- **As a last resort** allow HCP to provide direct care for persons without suspected or confirmed COVID-19

DISCONTINUING QUARANTINE

**HCP**

- Prolonged close contact with a person with confirmed COVID-19
  - Exclude from work for 14 days after last exposure
  - Advise to self-monitor for fever or symptoms consistent with COVID-19
  - If symptoms occur immediately contact occupational health program
  - Test initially and if negative again at 5–7-day interval (should still be excluded if negative)

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OPTIONS TO REDUCE QUARANTINE

- Quarantine can end after Day 10:
  - Without testing and if no symptoms have been reported during daily monitoring

- Quarantine can end after Day 7:
  - When diagnostic testing resources are sufficient and available
  - Diagnostic specimen tests negative
  - Specimen collected and tested within 48 hours before time of planned quarantine
  - No symptoms reported during daily monitoring

- Quarantine cannot be discontinued earlier than after Day 7
<table>
<thead>
<tr>
<th>Planned day after which quarantine is completed and can be discontinued</th>
<th>Residual post-quarantine transmission risk (%) with and without diagnostic testing of a specimen within 48 hours before time of planned discontinuation of quarantine</th>
</tr>
</thead>
<tbody>
<tr>
<td>No testing</td>
<td>RT-PCR testing</td>
</tr>
<tr>
<td>Median</td>
<td>Range</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>7</td>
<td>10.7</td>
</tr>
<tr>
<td>10</td>
<td>1.4</td>
</tr>
<tr>
<td>14</td>
<td>0.1</td>
</tr>
</tbody>
</table>
Are the alternatives to the 14-day quarantine recommended for healthcare facilities?

Given the need for often extensive and close contact between patients and healthcare personnel, a 14-day quarantine period continues to be recommended for patients receiving healthcare and healthcare personnel with exposures to SARS-CoV-2 warranting quarantine or work restrictions, respectively.

This option maximally reduces post-quarantine transmission risk and is the strategy with the greatest collective experience at present.

HCF could consider alternatives as a measure to mitigate staffing shortages, space limitations or PPE supply shortage but due to the special nature of healthcare settings, **NOT AS A PREFERRED OPTION**
<table>
<thead>
<tr>
<th></th>
<th>Conventional: Normal Supply (incorporate the anticipated number of persons for whom PPE should be worn by HCP)</th>
<th>Contingency: Temporarily instituted during periods of expected shortage</th>
<th>Crisis: Not commensurate with standard US standards; periods of known shortages</th>
</tr>
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<tbody>
<tr>
<td>Face mask</td>
<td><strong>Source control:</strong></td>
<td>Extended use of facemasks as PPE:</td>
<td>Limited re-use with extended use:</td>
</tr>
<tr>
<td></td>
<td>• Used until soiled or damaged or hard to breathe through</td>
<td>• Discard whenever removed and always at the end of the workday</td>
<td>• No maximum number of uses</td>
</tr>
<tr>
<td></td>
<td>• Discard after removal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>PPE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Removed and discarded after each person encounter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N95s (respirators)</td>
<td>Resume conventional practices</td>
<td>Extended use; ideally discarded after extended use (shift)</td>
<td>Limited re-use with extended use:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider use of face shield or facemask during AGPs - splashes and sprays</td>
<td>• No more than 5 dunning’s</td>
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N95 RESPIRATOR

- During times of increased demand for N95 filtering facepiece respirators (FFRs), hospitals or other medical facilities may want to protect these devices from surface contamination in order to prolong their use.
- When protection against surface contamination is needed, **CDC recommends wearing a cleanable face shield over an N95 FFR.**
- **Wearing a surgical mask or cloth covering over an FFR, such as an N95, is not approved or recommended by NIOSH because it is not consistent with the conditions of the approval, therefore voiding the certification, however this is a strategy that can be used in a crisis situation, as described in the CDC strategies for Optimizing the Supply of N95 Respirators**

[https://blogs.cdc.gov/niosh-science-blog/2020/06/16/covering-n95s/](https://blogs.cdc.gov/niosh-science-blog/2020/06/16/covering-n95s/)
Healthcare providers who are in close contact with an LTCF resident with suspected or confirmed SARS-CoV-2 infection must use a NIOSH-approved N95 FFR or equivalent or higher-level respirator (29 CFR 1910.134)

Whenever respirators are required, employers must implement a written, worksite-specific respiratory protection program (RPP), including medical evaluation, fit testing, training, and other elements, as specified in OSHA’s Respiratory Protection standard (29 CFR 1910.134).


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<td><strong>Eye Protection</strong></td>
<td>Resume conventional practices: • Shift from disposable to reusable</td>
<td>Extended use • Removed, cleaned if visible soiled or hard to see through</td>
<td>Prioritize eye protection: • Activities where splash/splatter anticipated • Prolonged face to face close contact</td>
</tr>
<tr>
<td><strong>Gowns</strong></td>
<td>Resume conventional practices: • Reusable (cloth) gowns</td>
<td>Prioritize gowns for higher risk activities: • AGP • Close/prolonged contact</td>
<td>Extended use: • COVID-19 unit only</td>
</tr>
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Questions?

- Why were they tested?
- Are they symptomatic?
- Are they asymptomatic?
- Were they a close contact?
- Is the facility in an outbreak?
- Serial testing for HCPs?
FREQUENTLY ASKED QUESTIONS

- **Question:** Can staff care for both COVID-19+ and COVID - residents during the same shift?

- **Response:** Ideally, CDC recommends dedicated staff be assigned to provide care on the designated COVID unit while the unit is open. This may not be feasible if the facility only has one resident. If HCP do have to (due to staffing shortages) care for a negative resident during the same shift, ALL PPE must be removed at time of exit from the isolation room (including mask) and new PPE as appropriate (mask and possible eye protection) be donned when caring for other residents.
Question:

Should vaccines be offered if resident or HCP have had COVID-19 and recovered

Answer:

Yes. Due to the severe health risks associated with COVID-19 and the fact that reinfection with COVID-19 is possible, you should be vaccinated regardless of whether you already had COVID-19 infection.

If you were treated for COVID-19 symptoms with monoclonal antibodies or convalescent plasma, you should wait 90 days before getting a COVID-19 vaccine.

Vaccination of persons with known current SARS-CoV-2 infection should be deferred until the person has recovered from the acute illness (if the person had symptoms) and criteria have been met for them to discontinue isolation. Persons with documented acute SARS-CoV-2 infection in the preceding 90 days may delay vaccination until near the end of this period, if desired.

This recommendation applies to persons who develop SARS-CoV-2 infection before receiving any vaccine doses as well as those who develop SARS-CoV-2 infection after the first dose but before receipt of the second dose.

https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
SUBMITTED QUESTIONS

1. As most (if not all) our residents are being vaccinated, and family members as well, will changes be recommended in the visitation policies we have in place? For example, will family members be allowed to hug and make human contact with their family members? If so, when do you advise that to happen after shots?

2. For staff who complete the vaccine protocol, will we still need to check temps, ask questions etc. at the beginning of each shift? If so, when after shots do you anticipate that happening?

3. After vaccination protocols have been completed and all residents participate, will strict compliance change- related to residents being able to socialize more normally? If so, when after shots, do you anticipate that happening?
Every storm runs out of rain

Maya Angelou
RESOURCES

- NCDHHS COVID-19 Guidance
- CDC Responding to COVID-19 in NHs
- CDC Preparing for COVID in NHs
- Options to Reduce Quarantine
- Considerations for Interpretation of Antigen Test in LTCF
OPTIMIZING PPE RESOURCES

- CDC Strategies to Optimize Face Mask
- CDC Strategies to Optimize N95s
- CDC Strategies to Optimize Eye Protection
- CDC Strategies to Optimize Gowns