COLORADO
Department of Public Health & Environment

COVID-19 Preparation and Rapid Response:

Checklist for Long-Term Care Facilities (LTCFs)

Since COVID-19 is now circulating in communities across Colorado, all LTCFs should implement additional measures to prevent COVID-19 from entering the facility. **Prevention** measures should be implemented immediately to protect residents from possible COVID-19 infection. **Rapid Response** measures should be implemented immediately when even a single case of respiratory illness is identified in a resident.

I. Prevention

Every LTCF should immediately implement the following:

Restrictions for Visitors and Non-Essential Healthcare Personnel

- ☐ Post signage at the front entrance restricting visitors and non-essential staff.
- ☐ Restrict all volunteers and non-essential healthcare personnel from entering the facility.
- ☐ Restrict all visitation except for certain compassionate care situations, such as end of life situations. (See Public Health Order 20-20.)
  - All essential visitors must be screened when entering the building, to include fever, any respiratory symptoms or other symptoms of infection, and potential exposure to COVID-19.
  - All visitors should sign-in, including: name of visitor, resident that was visited, date of visit and time.
  - Visitors should perform hand hygiene and wear a facemask when entering the building.
  - Visitors should be limited to 2 persons for a resident.

Monitor Staff and Residents for Fever and Symptoms of Respiratory Infection

- ☐ All staff should be screened at the beginning of their shift for fever (take temperature) or respiratory symptoms (shortness of breath, cough, sputum production, sore throat, rhinorrhea); consider also subjective fever, chills, myalgias, fatigue, anorexia, headache, diarrhea, nausea or vomiting. All staff should also be asked about close contact with ill persons.
- ☐ Any staff member with identified illness (as defined above) should immediately put on a facemask or use a tissue for source control and leave the facility. They should be excluded from work based on return-to-work criteria. [1]
- ☐ Any staff with an identified exposure to COVID-19 should undergo risk assessment and follow the CDC recommendations for monitoring and work restrictions. [2]
- ☐ Active monitoring of all residents should occur once daily to include temperature, heart rate, blood pressure, respiratory rate, pulse oximetry, changes in mental status, and any respiratory symptoms (shortness of breath, cough, sputum production, sore throat, rhinorrhea); consider also subjective fever, chills, myalgias, fatigue, anorexia, headache, diarrhea, nausea or vomiting.
- ☐ Reinforce sick leave policies. Remind staff not to report to work when ill with even mild symptoms.

Social Distancing

- ☐ Restrict all residents to their rooms as much as possible, making sure residents remain safe and considering resident well-being and mental health. Try to keep residents within a unit, wing or floor when possible.
- ☐ If residents must leave their room, they should perform hand hygiene, limit their movement within the facility, and perform social distancing (stay at least 6 feet from others).
- ☐ All group activities should be cancelled.
- ☐ Communal dining should be cancelled unless assistance is required as part of the resident care plan. Residents requiring assistance with feeding should maintain a 6-foot distance from other residents during supervised meals and staff should perform hand hygiene when moving from one resident to another.

Isolation Precautions

- ☐ Implement universal use of facemasks for all facility staff. Strongly consider extended use of facemasks when PPE supply in the community is limited.[3]

- ☐ Limit staff movement; cohort staff to a unit when possible, including across multiple shifts.
- ☐ Discourage staff from working in multiple facilities, when possible.
- ☐ Standard precautions should always be followed.
- ☐ Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of PPE. Have healthcare staff demonstrate competency with putting on and removing PPE.
- ☐ Residents who must regularly leave the facility for care (e.g., hemodialysis) should wear facemasks when outside of their rooms including when outside of the facility.
- ☐ When possible, all long-term care facility residents, whether they have COVID-19 symptoms or not, should cover their noses and mouths when staff are in their room. Residents can use tissues for this. They could also use cloth, non-medical masks when those are available. Residents should not use medical facemasks unless they are COVID-19-positive or assumed to be COVID-19-positive.

Communicate with Staff, Residents and Families

- ☐ Educate residents and families, including
  - Information about COVID-19
  - Actions the facility is taking to protect them and their loved ones, including visitor restrictions and how they can protect themselves.

Supplies

- ☐ Ensure adequate hand hygiene supplies: Put alcohol-based hand sanitizer with 60–95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., in dining room at front entrance). Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- ☐ Make necessary PPE available in areas where resident care is provided.
- ☐ Put a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room, or before providing care for another resident in the same room.
- ☐ Ensure adequate supplies for respiratory hygiene and cough etiquette.
  - Make tissues and facemasks available for coughing people.
  - Consider designating staff to steward those supplies and encourage appropriate use by residents, visitors and staff.
- ☐ Assess current facility inventory of PPE. Facilities should have supplies of:
  - facemasks
  - respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested providers)
  - gowns
  - gloves
  - eye protection (i.e., face shield or goggles)
- ☐ Ensure adequate supplies and procedures for environmental cleaning and disinfection.

Environmental Cleaning and Disinfection

- ☐ Ensure that all non-dedicated, non-disposable resident care equipment is cleaned and disinfected according to manufacturer's instructions after each use (e.g., thermometers, pulse ox, blood pressure cuffs, resident lifts) prior to use on additional residents.
- ☐ Use an EPA-registered, hospital-grade disinfectant to frequently clean high-touch surfaces and shared resident care equipment in addition to routine environmental cleaning. Refer to the EPA website for a complete list of approved disinfectants with an emerging viral pathogen claim: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2.
- ☐ Validate environmental services staff members processes: (1) Follow label instructions on the hospital grade disinfectant; (2) Validate disinfection policies and procedures (e.g., cleaning from clean to dirty, changing gloves and performing hand hygiene between rooms and between resident surfaces within the same room).

II. Rapid Response

Additional measures to be implemented when suspected illness (fever or respiratory symptoms) is identified in even a single resident:

Restrict New Admissions

- ☐ If you have one or more residents with fever or respiratory symptoms, do not admit new residents to the facility until an outbreak of COVID-19 has been ruled out and/or the outbreak is contained (14 days after the date of symptom onset of the last known case). (Under certain circumstances, admissions might be considered in consultation with public health.)

Monitor Staff and Residents for Fever and Symptoms of Respiratory Infection

- ☐ Increase active monitoring of all residents to **twice** daily to include temperature, heart rate, blood pressure, respiratory rate, pulse oximetry, changes in mental status, and any respiratory symptoms (shortness of breath, cough, sputum production, sore throat, rhinorrhea); consider also including subjective fever, chills, myalgias, fatigue, anorexia, headache, diarrhea, nausea or vomiting.

Social Distancing

- ☐ Restrict all residents to their rooms with the door shut to the extent possible, ensuring resident safety, well-being and mental health.
- ☐ If residents with fever or respiratory symptoms must leave their room, they should perform hand hygiene, limit their movement within the facility, perform social distancing (stay at least 6 feet from others), and should also wear a facemask or use tissues for source control.

Isolation Precautions

- ☐ Restrict staff movement between areas of the facility with and without ill residents (which might be accomplished by cohorting staff to a unit across multiple shifts). Staff as much as possible should not work across units or floors. Facilities should also use separate staffing teams for COVID-19-positive residents to the best of their ability. The goal is to decrease the number of different staff interacting with each resident as well as the number of times those staff interact with the resident.
- ☐ Staff should follow standard, contact and droplet precautions (with eye protection) for any resident with fever, respiratory symptoms, or when COVID-19 is suspected.[3,4,5]
- ☐ Avoid transferring residents between different units. When designating separate units or facilities to care for COVID-19-positive residents and COVID-19-negative residents, it is recommended to consult with public health prior to moving residents.
- ☐ When EMS is activated, notify them that the facility is currently experiencing a suspected or confirmed outbreak of COVID-19 prior to their arrival so they may don appropriate PPE prior to resident contact.
- ☐ If transfer is medically indicated, inform the receiving facility that the facility is currently experiencing a suspected or confirmed outbreak of COVID-19 verbally in addition to written documentation prior to the arrival of the resident at the receiving facility.
- ☐ All visitors that must enter the facility (e.g., compassionate care) must wear appropriate PPE if visiting a resident with suspected or confirmed COVID-19 (e.g., gloves, gown, facemask and eye protection). In times of PPE shortages, prioritize a facemask.

Testing

- ☐ When one or more residents are identified with fever or respiratory symptoms, collect nasopharyngeal specimens on symptomatic residents as early as possible in the course of illness. They should be tested for COVID-19 and influenza at a minimum; consider RSV and other respiratory viruses according to clinical suspicion. COVID-19 testing should not wait for results of other viral testing.

- ☐ Consider post-mortem testing on residents who die of respiratory illness or die unexpectedly when a suspected or confirmed COVID-19 outbreak is ongoing.
- ☐ Once COVID-19 has been detected in two or more residents on a unit, the facility can consider cessation of further testing on that specific unit. If residents on other units develop symptoms as described above, perform testing as listed above.

Environmental Cleaning and Disinfection

- ☐ Limit shared medical equipment: dedicate equipment for residents with respiratory illness or elevated temperature when possible.

Communication

- ☐ Communicate with staff, residents, and families about the suspected or confirmed COVID-19 outbreak, and steps the facility is taking to halt the outbreak. Confirmed outbreaks will be publicly reported by facility name by the state emergency operations center.

Notify Public Health Immediately

- ☐ If you have a single suspected or confirmed case of COVID-19, or a suspected (>=2 ill residents) or confirmed (>=2 ill residents including >=1 positive test) outbreak of COVID-19, report to public health immediately.

[1] Return-to-work criteria for healthcare personnel with identified illness:

Test-based criteria:

- Resolution of fever without the use of fever-reducing medications AND
- Improvement in respiratory symptoms (e.g., cough, shortness of breath) AND
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens)

Non-test-based criteria:

- At least 3 days (72 hours) after recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath) AND
- At least 10 days have passed since symptoms first appeared.

[2] Risk-assessment for healthcare personnel with an identified exposure to COVID-19:

- CDC guidance for risk-assessment for healthcare personnel can be found here https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.
- Facilities could consider allowing asymptomatic healthcare personnel who have had an exposure to a COVID-19 resident to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These healthcare personnel should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed healthcare personnel wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If healthcare personnel develop even mild symptoms consistent with COVID-19, they must cease resident care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.
- Healthcare personnel with known exposures to COVID-19 should also follow community-based restrictions, found here https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html.

[3] PPE-sparing strategies:

- See CDC PPE-sparing strategies for more information (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html).
- CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency strategies can help stretch PPE supplies when shortages are anticipated, for example if facilities have sufficient supplies now but are likely to run out soon. Crisis strategies can be considered during severe PPE shortages and should be used with the contingency options to help stretch available supplies for the

most critical needs. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices.

- Sequence for proper donning and doffing of PPE: https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf.

[4] CDC and CMS recommend that if COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE (gowns, gloves, facemask and eye protection) for the care of all residents irrespective of COVID-19 diagnosis or symptoms. When PPE shortages are present, this recommendation may be impractical for implementation by healthcare facilities, and PPE use should be prioritized for use with any resident with fever, respiratory symptoms, or when COVID-19 is suspected.

[5] Discontinuation of Isolation for Residents:

Test-based criteria:

- CDC recommends a test-based strategy for discontinuation of transmission-based precautions: Interim Guidance for Discontinuation of transmission-based Precautions and Disposition of Hospitalized Residents with COVID-19 (CDC).
  - Resolution of fever without the use of fever-reducing medications and
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens)

Non-test-based criteria:

- When testing is not available, CDPHE recommends a non-test-based strategy. Standard, Droplet, and Contact Precautions, including eye protection, should be maintained on residents with respiratory symptoms, regardless of testing results, until the following criteria are met:
  - At least 3 days (72 hours) after recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); AND
  - At least 10 days have passed since symptoms first appeared.
  - Facilities may consult public health on a case by case basis as necessary for guidance regarding special populations (e.g., severely immunocompromised persons).