Alameda County Health Care Services Agency
Public Health Department
www.acphd.org

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COVID-19 Information: (510) 268-2101

Contact Name:
Phone:
Fax/Email:

Date:
Name of Facility:
Complete Address:

These recommendations supplement the California Department of Public Health (CDPH) All-Facilities Letters (including but not limited to 20-25.2, 20-32.1, 20-33.2, 20-38.3, 20-43.3, 20-46.1, 20-52, 20-53, and 20-60) and include additional precautions and actions to control a suspected or confirmed outbreak.
https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL20.aspx

Case Definitions for Skilled Nursing or Residential Care Facilities

Confirmed COVID-19 Outbreak: 1 case of laboratory-confirmed COVID-19 in either a resident or staff member

Suspected COVID-19 Outbreak: Two or more cases of suspected COVID-19 within 72 hours of each other

Suspected COVID-19: at least one of the following symptoms: new or worsening cough, shortness of breath or difficulty breathing; OR at least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new or worsening congestion & runny nose, new olfactory and taste disorder(s), nausea, vomiting or diarrhea.

Reporting Requirements

- ☐ INITIAL suspected or confirmed COVID-19 outbreaks must be **immediately** reported to the Alameda County Public Health Department (ACPHD) at (510) 267-3250, Mon-Fri 8:30 am to 5 pm. After hours and on weekends, call Alameda County Fire Dispatch at (925) 422-7595 and ask to speak to the Public Health Duty Officer on call.
- ☐ For repeat outbreaks, please report to (510) 267-3250 or email LTCFOutbreak@acgov.org. Reports made on weekends will be responded to on Monday. Begin implementing these Outbreak Control Recommendations immediately.
- ☐ Skilled Nursing Facilities (SNFs) should report outbreak to Licensing and Certification East Bay District Office: (510) 620-3900.
- ☐ Residential Care Facilities (RCFE and ARF) should report to Community Care Licensing and Certification Regional Office: (510) 286-4201 and CCLASCPOaklandRO@dss.ca.gov
- ☐ Complete a Confidential Morbidity Report-LTCF-SNF-RCFE (CMR) form for all residents that test positive: https://covid-19.acgov.org/covid19-assets/docs/clinical-guidance/cmr-resident-report-form-for-ltcf-rcfe-2020.04.22.pdf. Completed forms should be sent to LTCFOutbreak@acgov.org.
- ☐ If an LTCF medical provider serves as the ordering provider for testing staff, complete a standard CMR form for all staff that test positive: https://covid-19.acgov.org/covid19-assets/docs/healthcare-guidance/cmr-d-reporting.pdf. Completed forms should be sent to AcuteCD@acgov.org.

- ☐ Complete line list daily for all **new** cases and submit to ACPHD by secure email to LTCFOutbreak@acgov.org or by fax to 510-273-3744 until instructed otherwise by ACPHD. ACPHD's Line List Template can be downloaded at http://www.acphd.org/2019-ncov/providers/skilled-nursing-residential-care-facilities.aspx
- ☐ Submit a map/floor plan of your facility to ACPHD within 24 hours of reporting the outbreak

Outbreak Control Recommendations

Communication

	In addition to notifying ACPHD and Licensing & Certification, notify: • Infection Preventionist and Director of Nursing • Facility Administrator and Health Services Director • Medical Director • All staff and contracted employees who work at the facility • Residents, family, and visitors
	Distribute an outbreak communication letter to all residents and their families. See: https://www.ahcancal.org/facility_operations/disaster_planning/Documents/Template-Letter-Families-Confirmed-Case.docx
	Post signs at facility entrance. Post visual alerts instructing residents and staff to report symptoms of COVID-19 to a designated person.

Surveillance of General Population

	Measure temperature and oxygen saturation and assess for symptoms of suspected COVID-19 every shift among all residents. A change in baseline temperature (up or down) and/or a drop in oxygen saturation should trigger a more thorough assessment. Residents over 60 may present with atypical signs and symptoms such as loss of appetite, confusion, weakness & falls.
	Maintain universal precautions while performing all surveillance activities: • If oral thermometer used, wear new gloves for each person. • Perform hand hygiene before and after donning and doffing gloves. Wear a face mask (procedure or surgical mask). May wear the same mask for multiple encounters **if not touched by healthcare personnel (HCP) and if no encounters with coughing person.** If person is coughing or HCP touches mask, remove gloves, discard mask, perform hand hygiene, and don a new mask.
	Institute symptom and temperature monitoring of all staff at the facility entrance or within main reception area. See Screening Guidance for Employers & Self-Assessment Guidance for Workers. • Exclude from entrance any staff presenting with the following symptoms: fever, chills, rigors, headache, new or worsening cough, sore throat, myalgias,

	shortness of breath or difficulty breathing, or alterations in sense of smell or taste. • See "Managing Ill Staff & Exposure" section for details on handling ill staff.
	Monitor and report staff absenteeism due to any suspected COVID-19 symptoms.
Diagnostic Testing	
	Preferred method: Collect NP swab specimens for COVID-19 PCR testing. Use only synthetic fiber swabs with plastic or aluminum shafts. Calcium alginate swabs or swabs with wooden shafts are not acceptable. Place swabs immediately into sterile tubes containing 2-3 ml of viral transport media (VTM), Amies transport media, Universal transport media (UTM) or sterile saline. Please check with your testing laboratory to confirm the most appropriate transport medium for collection. **Alternate methods for COVID-19 specimens** if NP swab, VTM, or UTM not available: • A nasal mid-turbinate (NMT) swab using a flocked tapered swab or • An anterior nares specimen (NS) using a round foam swab or • An oropharyngeal (OP) specimen (but may be less sensitive test if used alone) • For NS, use a single polyester swab with a plastic shaft to sample both nares. • Place NS or NMT swabs in a transport tube containing either viral transport medium, Amies transport medium, or sterile saline. • If both NP and OP swabs are collected, combine in a single tube.
	Follow infection control precautions when collecting NP swabs: • Patient should be in a single room with door closed • Minimum number of staff should be in room • Wear N-95 respirator, eye protection (face shield or goggles), disposable gown and gloves. If N-95 respirator is not available, wear a surgical face mask. • Perform hand hygiene immediately before donning and immediately after doffing • Don and doff in the correct sequence to avoid self-contamination. • For further guidance on proper specimen collection, see CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-facility-wide-testing.html
	Consider testing for additional respiratory viruses, i.e. influenza. Send these NP swabs for testing through the facility's usual laboratory.
	Rapid antigen tests are NOT recommended for surveillance testing of asymptomatic individuals. A positive rapid antigen test may be useful in confirming infection in a symptomatic individual, but negative results must be confirmed using COVID-19 RT-PCR test.
	As soon as possible after a COVID-19 positive case is identified in a facility, serial retesting of all residents & HCP who tested negative upon initial baseline testing or during routine surveillance testing should be performed every 7 days until no new cases are identified in two sequential rounds of testing; the facility may then resume their regular surveillance testing schedule. Once a resident or HCP tests positive, no additional testing is needed for 90 days. Results should be used to immediately implement cohorting of residents and HCP who provide direct patient care. Refer to your

	mitigation plan strategies for testing and cohorting. See Skilled Nursing Testing FAQ for additional guidance. • Specimen collection from residents should be performed by facility care staff and testing should be performed by the facility's usual laboratory provider with a preferred turnaround time of 48 hours or less for results. • Staff should be tested by their health care provider or at community testing sites. • All testing must be ordered by a clinician who will be responsible for informing the patient and arranging for appropriate clinical follow-up.
	RCFEs should consult with ACPHD to consider a more targeted testing strategy. This might include focusing testing within an affected unit or building.
	ACPHD offers assistance to coordinate testing but has limited ability to support testing in facilities; contact the Public Health Nurse assigned to your facility outbreak and/or email LTCFOutbreak@acgov.org with requests for assistance.
	Do not send specimens directly to the Alameda County Public Health Laboratory without approval.
Resident Placement, Movement Restrictions & Transferring Residents	
	Create three distinct, cohort areas. These could be a separate wing, unit, or rooms at the end of the hallway: 1. **RED zone:** COVID-19 (+) 2. **GREEN zone**: COVID-19 (-) 3. **YELLOW zone:** COVID-19 unknown. Includes an observation unit of residents recently admitted or returned to facility
	DO NOT MOVE PUIs from their rooms within the GREEN or YELLOW zones unless they receive a laboratory confirmed COVID-19 (+) test. Call your assigned ACPHD outbreak nurse for instructions on moving patients between zones.
	Staff must be instructed on the importance of separate equipment, full changes in PPE whenever going from one resident to the next to provide care.
	Suspend group activities and close communal dining areas. Suspend salon, podiatry, and other non-essential personal care services.
	Residents should stay and be served meals in their rooms.
	Residents who must leave their room should perform hand hygiene, wear a face mask before leaving the room and maintain social distancing.
	Before transferring ANY resident outside of the facility, such as to outpatient appointments, dialysis centers, acute care hospitals, and other facilities, you **must** use the Infection Control Infection Control Transfer form (http://www.acphd.org/media/500766/acphd-infection-control-transfer-form.pdf) to communicate to transport personnel and other HCP accepting the resident that your facility is experiencing a suspected or confirmed COVID-19 outbreak. If the resident is a suspected or confirmed COVID-19 case, you must also include symptoms, signs, date of illness onset, laboratory test results, and infection control precautions.

Transmission-Based Precautions and Other Infection Control Measures	
	All staff, residents who must leave their rooms, and essential visitors at facilities should always cover their nose and mouth with a surgical mask while in the facility. If surgical masks are not available, a clean and dry cloth mask or other cloth covering shall suffice. If cloth coverings are used, they should be laundered after each shift before reuse. Staff who are caring for suspected or confirmed COVID-19 case patients should wear a fit-tested N-95 respirator, when available, and additional personal protective equipment recommended by the Alameda County Public Health Department.
	Use Standard + Droplet + Contact + Eye Protection precautions when caring for residents with suspected or confirmed COVID-19.
	HCP should perform hand hygiene before and after donning and doffing personal protective equipment (PPE). Ideally, PPE should be discarded after every contact with every resident if supplies allow. However, with critical shortages of PPE, consider extended use and re-use practices. See https://www.dir.ca.gov/dosh/Use-of-Respirator-Supplies.html and https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
	Identify dedicated HCP to care for residents with COVID-19 and ensure they are N-95 respirator fit-tested. Fit-testing of N-95 respirators must be performed at least annually or when there is a change in type of mask used. Ask the nurse assigned to your facility about fit testing options.
	Minimize the number of HCP assigned to patient care activities for residents with COVID-19.
	Cohort HCP caring for residents with COVID-19. Do not allow these staff to interact with other residents or the staff who care for residents without COVID-19. Cohort HCP staff should not take breaks with other staff. Provide separate locker rooms or break areas if possible; otherwise, consider staggering the use of break areas and clean and disinfect thoroughly after each use.
	Ensure all HCP practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break).
	Whenever possible, bundle care & treatment activities to minimize entries into resident room (e.g. having clinical staff clean and disinfect high-touch surfaces when in the room)
	Educate HCP on hand hygiene, respiratory hygiene, cough etiquette. Document training.
	Ensure all HCP are familiar with standard, droplet, contact and eye protection precautions. Document training.
	Verify all HCP can demonstrate competency in proper PPE donning and doffing procedures. Document competency.
	Conduct ongoing monitoring of compliance with hand hygiene and PPE procedures. Provide on-the-spot correction.
	Ensure an adequate supply of facemasks, N-95 respirators (in size and model for fit-tested staff), face shields /goggles, gowns and gloves. Place supplies in all areas where patient care is provided.

	Ensure an adequate supply of alcohol-based hand rub (at least 60% ethanol or 70% isopropanol) and that it is easily accessible both inside and outside every patient room. Also ensure that hand-washing stations are easily accessible and equipped with soap and paper towels.
	Use single-use equipment for residents with COVID-19 infection whenever possible; otherwise, dedicate reusable medical equipment to residents with COVID-19 infection (e.g., thermometers, stethoscopes, hoyer lifts, medication carts, wheelchairs) and clean and disinfect between each use.
Discontinuation of Transmission-Based Precautions for COVID-19 Recovered Residents	
	Discontinuation of transmission-based precautions should be determined by using a time and symptom-based strategy for patients with lab-confirmed or suspected COVID-19 as follows: 1. Residents who have never been symptomatic Droplet+contact+eye protection precautions may be discontinued 10 days from date of COVID-19 (+) test. 2. Residents who are **NOT** severely immunocompromised Droplet+contact+eye protection precautions may be discontinued after at least 24 hours have passed since last fever (without fever-reducing medications), and improvement in symptoms (e.g. cough, shortness of breath); and at least 10 days have passed since symptoms first appeared. 3. Residents with severe or critical illness or who are severely immunocompromised Droplet+contact+eye protection precautions may be discontinued after at least 24 hours have passed since last fever (without fever-reducing medications) AND at least 20 days have passed since since symptoms first appeared AND symptoms (e.g. cough, shortness of breath) have improved. This category includes patients under cancer treatment, bone marrow or organ transplant recipients, immune deficiencies, poorly controlled HIV or AIDS, on immunosuppressant medications such as prolonged use of corticosteroids and other immune weakening medications, and patients who were critically ill with COVID-19 (intubated and/or in ICU).
	DO NOT require a negative test result for new or re-admissions or when moving a COVID recovered resident back into the general population (“green zone”). Except for rare situations, a test-based strategy is NOT recommended to determine when to discontinue Transmission-Based Precautions.
Environmental and Equipment Cleaning	
	Clean and disinfect high-touch surfaces and shared resident care equipment with EPA-registered, healthcare-grade disinfectants. See the EPA Pesticide Registration List: N: Disinfectants for Use Against SARS-CoV-2 for products with label claims against COVID-19. https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
	Increase frequency of environmental cleaning to at least twice per shift and whenever

	surfaces or equipment are soiled or contaminated with body fluids or respiratory secretions. Greater frequency of cleaning will also be needed for any areas where someone must take off their mask to eat or drink.
	Educate Environmental Services staff on proper PPE donning & doffing procedures & appropriate contact times for cleaning solutions. Document training.
	Consider placing EPA-registered disinfectant wipes on or next to frequently used equipment so they are easily accessible for all staff to use.
Clinical Monitoring of COVID-19 cases	
	Check vital signs, including pulse oximetry, on all COVID-19 positive cases every 4 hours. Close monitoring in order to detect early signs of clinical deterioration is imperative in this patient population. Check for subtle changes in mental status, somnolence, hydration status, and respiratory rate.
	Elicit and document treatment preferences and ensure advance planning forms (POLST, Advance Directive) are easily accessible to HCP.
Managing Staff Illness & Exposure	
	Instruct HCP to not report to work if they have any symptoms suspicious for COVID-19. HCP must report symptoms to their supervisor.
	Instruct HCP who develop any symptoms suspicious for COVID-19 while at work to immediately stop work, alert their supervisor, leave the facility, and self-isolate at home.
	Exclude HCP with confirmed COVID-19 infection, with or without symptoms. You MUST issue work exclusion letters to all staff who test COVID-19 (+). Use the letter sent to you with these outbreak control recommendations provided by your assigned LTCF Outbreak Nurse.
	For return to work criteria, follow current guidance under “Criteria for Returning to Work after Isolation or Quarantine” on our website: https://covid-19.acgov.org/covid19-assets/docs/isolation-quarantine/criteria-release-from-iso-or-quar-and-return-to-work-eng-2020.07.28.pdf. Do NOT require a negative test or doctor’s note for return to work.
	Exclude HCP with symptoms consistent with COVID-19. Exclude until at least 24 hours have passed since recovery (defined as resolution of fever without the use of fever-reducing medications), *and* improvement in symptoms (e.g., cough, shortness of breath) *and* at least 10 days have passed since symptoms first appeared.
	When a COVID-19 positive HCP returns to work they should restrict contact with severely immunocompromised patients until 14 days after illness onset. This includes patients under cancer treatment, bone marrow or organ transplant recipients, immune deficiencies, poorly controlled HIV or AIDS, on immunosuppressant medications such as prolonged use of corticosteroids and other immune weakening medications, and patients who were critically ill with COVID-19 (intubated and/or in ICU).
	If staffing shortages arise, consult with ACPHD about mitigation strategies. In limited situations facilities may be authorized to have asymptomatic (never symptomatic) HCP with confirmed COVID-19 return to work before full Return to Work Criteria are met.

	These HCP should provide direct care only for residents with confirmed COVID-19, preferably in a cohort setting. These HCP are restricted from contact with severely immunocompromised patients. A separate break room & bathroom should be provided as well.
	Plan for worker absences. Do not require a healthcare provider's note for employees who are sick to validate their illness.
	Facilities must avoid as much as possible using employees who have worked at another Licensed Facility or Other Agency in the past 14 days, while maintaining adequate staffing needs of the facility. If this is unavoidable then consider the following: • Ask HCP who arrive directly from another facility to change scrubs or uniform prior to entering your facility • Maintain consistency of assignments as much as possible (same registry staff caring for the same residents in the same cohort unit) • Instruct HCP who work at multiple facilities to notify all other employers that they are working at a facility that is currently experiencing an outbreak.
	Facilities shall keep a daily log of employees present, identifying any other facilities they have worked at in the previous 14 days. That log shall be made available to local health department if requested.
Closure, Admissions and Re-admissions	
	Consult with medical director and ACPHD to determine if the facility should close to new admissions during a suspected or confirmed COVID-19 outbreak. If required, the duration of closure to new admissions will be determined for each situation individually. The effectiveness of the control measures implemented and the availability of a separate, unaffected building or unit to receive new admissions may be considered. ACPHD will provide clear reopening criteria to ensure that the facility can reopen as soon as possible once the outbreak is controlled.
	Facilities must develop plans for managing new admissions and providing care for residents with COVID-19 who require standard + droplet + contact + eye protection precautions, while still maintaining the capacity to provide care safely for other residents. A negative test result is not required for admission.
	Hospitalized patients with COVID-19 should be discharged when they no longer require the level of care provided in an acute care setting. Hospital discharge and admission or re-admission to a facility should not be delayed or prevented due to the COVID-19 status of the patient. Facilities should be prepared to accept and care for COVID-19 (+) patients. Determined by the period of potential virus shedding or recommended duration of transmission-based precautions.
	Assess residents being newly admitted for symptoms compatible with COVID-19. Follow recommendations above for resident placement and movement restrictions and infection control precautions.
	All new or readmissions should be quarantined for a period of 14 days. If the resident was not tested for COVID-19 prior to admission then test upon admission, quarantine x

	14 days and test again on day 14. If negative, release from quarantine.
	For new or returning residents who were hospitalized for COVID-19 and are clinically ready for discharge from the hospital, implement Standard + Droplet + Contact + Eye Protection precautions and place resident in a single room until they qualify for discontinuation of precautions. If a single room is not available, residents with laboratory-confirmed COVID-19 may be cohort in the same room.
Managing Family, Visitors, and Volunteers in a COVID-19 Outbreak	
	Limit visitation to end-of-life situations or when a visitor is essential to the resident's well-being and care. Exclude visitors who have: • Signs and symptoms consistent with COVID-19: new or worsening cough, shortness of breath, difficulty breathing, fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new or worsening congestion & runny nose, new olfactory and taste disorder(s), nausea, vomiting or diarrhea. • In the last 14 days, had close contact with someone with confirmed COVID-19
	Visitors must wear a facemask while in the facility.
	Visitors must perform hand hygiene when entering the facility and when leaving the resident's room.
	Visitor may only go the resident's room and not to other areas of the facility.
	Restrict / exclude volunteers.
Assess Outbreak Control Measures	
If new cases continue to be identified, facility leadership and ACPHD should review practices, obstacles to fully implementing control measures, and additional actions. ACPHD LTCF Outbreak surveillance for new cases will continue until two consecutive weeks of response driven testing reveal no positive test results AND 14 days have elapsed since last report of new confirmed or suspected cases. Certain exceptions may apply.	

Additional resources:

- CDPH COVID-19 webpage: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx
- CDC guidance for long-term care facilities preparing for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
- CDC infection control training modules: https://www.cdc.gov/longtermcare/
- CDC PPE Burn rate calculator: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html
- Alameda County Public Health, COVID-19, SNF & RCFE webpage: http://www.acphd.org/2019-ncov/providers/skilled-nursing-residential-care-facilities.aspx
- Duration of Isolation and Precautions for Adults with COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html
- Discontinuation of Transmission-Based Precautions and Disposition of Patients of COVID-19 in Healthcare Settings (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

- Alameda County COVID-19 Laboratory Testing Guidance for Clinicians – July 2020 http://www.acphd.org/media/594258/alameda-county-testing-guidance-for-clinicians.pdf