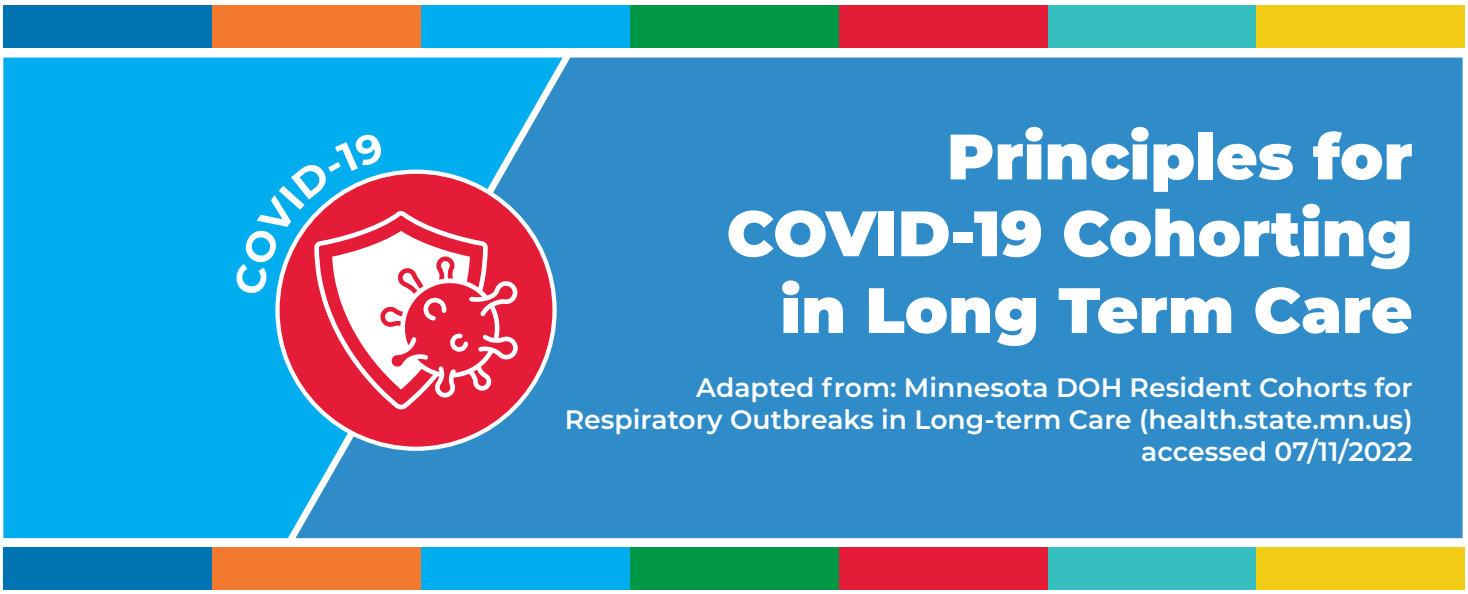

Principles for COVID-19 Cohorting in Long Term Care

Adapted from: Minnesota DOH Resident Cohorts for Respiratory Outbreaks in Long-term Care (health.state.mn.us) accessed 07/11/2022

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INTRODUCTION

Using sound infection prevention and control measures, including cohorting, is critical to prevent entry and spread of COVID-19 in long-term care facilities. This information sheet outlines best practices and essential considerations for long-term care providers as they work to prevent COVID-19 in their facilities, respond to one or more cases, or react to results from facility-wide testing. In certain situations, moving an exposed resident or a resident with suspected or confirmed COVID-19 may cause other safety concerns and/or risks. It is up to the facility to determine the risk of moving a resident to another location, and if necessary, to put into practice appropriate infection prevention and control measures.

Key infection prevention and control terms

Isolation separates infectious people with a contagious disease, like COVID-19, from people who are not sick.

Quarantine separates and restricts the movement of people who were exposed to, or may have been exposed to, a contagious disease, like COVID-19, in case they become infectious.

Cohorting is an infection prevention and control strategy of grouping residents together who are infected with the same organism, like COVID-19, to confine their care to one area and prevent contact and spread to other residents.

KEY PRINCIPLES FOR COVID-19 UNITS

Why should LTC facilities cohort positive residents?

Cohorting positive residents who test positive together in a single area allows dedicated staff to work with only COVID-19-positive residents to prevent spreading the virus from infected to uninfected residents. Staff can adjust the use of personal protective equipment (PPE) if supplies are limited. This includes extended use of respirators, facemasks, eye protection, and gowns. Staff should change gloves between residents and perform hand hygiene at each glove change. Staff should change gowns if soiled or after caring for a resident with a different infection (e.g., influenza) or infection or colonization with a multi- drug-resistant organism. Why should LTC facilities cohort positive residents?

Make a COVID-19 unit floor plan

- Use a floor plan document (e.g., exit route plan) to plan the physical COVID-19 unit layout.
- Pick a separate floor, wing, or other designated area of the facility (e.g., cluster of rooms).
- Dedicate staff to this unit as much as able. Ensure that they do not work in other parts of the facility.
- Do not allow unnecessary staff on the COVID-19 unit (e.g., dietary). Add signage to eliminate unnecessary traffic in the isolation area. Place signage at eye level, ensure the font is visible and the language understood by the staff, visitors, and residents.
- Close doors to resident rooms, as long as safety allows.
- Admit only residents with confirmed COVID-19 to the unit. See COVID19 Testing Recommendations for Long-term Care Facilities (https://www.cdc.gov/ coronavirus/2019-ncov/hcp/nursing-homes-testing.html)
- Post signs prominently at the point of entry to the COVID-19 unit.
- Identify clear locations for PPE donning and doffing.
- Designate clean and dirty (contaminated) areas. Consider marking these areas with tape on the floor to serve as visual reminders to staff.

- Establish a traffic flow, with people moving from clean to dirty areas, so clean areas stay clean.
- Donning station: supplied with gowns, gloves, alcohol-based hand rubs, extra respirators, and/or facemasks and eye protection.
- Doffing station: large wastebaskets (or laundry bins) for gowns disposal, alcohol-based hand rubs, disinfecting wipes, and space to put eye protection and other personal protective equipment that needs cleaning/disinfection
- Place easy-to-see posters with instructions for donning and doffing in both areas.

Establish a dedicated staff break area and restroom for COVID-19 unit

Create a location with alcohol-based hand rubs for safe donning and doffing of personal protective equipment when on break. Define a place and process in each of the areas for doffing, hand hygiene, disinfecting personal protective equipment (e.g., eye protection), storing personal protective equipment, and donning personal protective equipment after the break. Ensure that the break area has enough space for social distancing and limit the number of staff present at any time. If possible, the break area should have a dedicated restroom for staff working on the COVID-19 unit.

- Clean and disinfect surfaces in the break area and staff restroom frequently (e.g., daily).
- Ideally, the COVID-19 unit should also have a work area specifically used by COVID-19 unit staff only.

Manage personal protective equipment

Count personal protective equipment supplies every day during times of high usage. Use the CDC: PPE Burn Rate Calculator (www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator. html). Contact your Health Care Coalition for personal protective equipment if you are down to a supply for five to seven days.

Key principles for quarantine

Facilities should follow CDC guidance for the admission and readmission of residents for quarantine and testing. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html Options include placement in a single room or in a separate observation area so the resident can be monitored for signs and symptoms of COVID-19. CDC recommends placement of these residents in a single room where possible. In situations where single rooms are not available, residents should remain in their current location pending return of test results. Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-COV-2 infection.

Create a plan to manage new admissions and readmissions

Residents with confirmed SARS CoV2 infection who have not met criteria to discontinue Transmission-Based Precautions should be placed in the designated COVID-19 care unit, regardless of vaccination status.

In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmission should be placed in quarantine, even if they have a negative test upon admission and should be tested as specified by the CDC. COVID19 vaccination should also be offered.

- For residents who are not up to date with all recommended COVID-19 vaccine doses, facilities located in counties with low community transmission might elect to use a risk-based approach for determining which of these residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside of the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the

community prior to admission (**Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC**)

- Staff should wear an N95 or higher-level respirator (or medical-grade facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. They should change gloves and gown when moving between residents and perform hand hygiene after glove removal.
- Guidance for removal of residents from Transmission Based Precautions can be found on **this CDC page** under the section: "Manage Residents who had close contact with Someone with SARS-CoV-2 Infection".
- As part of universal source control measures, all residents should wear a face covering or facemask (if tolerated) whenever they leave their room or when staff are within 6 feet. See CDC: **Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC**
- Consider increasing the frequency of sign and symptom screening (e.g., pulse oximetry, temperature) for residents in observation to detect potential early development of COVID-19 symptoms.
  - Active screening of residents should be conducted when they are admitted and, thereafter, at least once daily for fever (≥100.0°Fahrenheit) and symptoms of COVID-19 (shortness of breath, new or change in cough, chills, sore throat, muscle aches). Older adults with COVID-19 may not show common symptoms, such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, new confusion, or altered mental status. More than two temperatures >99.0° Fahrenheit may also be a sign of fever in this population. In addition, routine use of pulse oximetry to screen for new or worsening hypoxia may identify infected residents.

Create a plan to manage residents exposed to COVID-19

- Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).
- Guidance for removal of residents from Transmission Based Precautions can be found on **this CDC page** under the section: "Manage Residents who had close contact with Someone with SARS-CoV-2 Infection".
- Residents who are up to date with all recommended COVID-19 vaccine doses and residents who have recovered from SARS-CoV-2 infection in the prior 90 days who have had close contact with someone with SARS-CoV-2 infection should wear source control and be tested as described in the testing section. In general, these residents do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS- CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority.
- Staff should wear an N95 or higher-level respirator (or medical-grade facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and a gown when caring for these residents if symptoms develop. Change gloves and gown when moving between residents and perform hand hygiene after each glove removal.

Placement of residents when single-person rooms are not available during quarantine

Under certain circumstances, such as during periods of limited hospital bed capacity, single-person rooms may not be an option for some facilities. The decision to place residents in a shared room during their quarantine period increases the resident risk of exposure to SARS-CoV-2 and should be considered only on a

limited, case-by-case basis. In these circumstances, providers should weigh risks and benefits during decision making. Residents and family members should be consulted and provided information about the potential risk of exposure.

Symptomatic residents or those suspected to have SARS-CoV-2 infection should be prioritized for placement in a single-person room with a bathroom. Door should be kept closed, if safe to do so.

This section outlines considerations for deciding when and how to place newly admitted, re-admitted, or exposed residents together in a shared room. This list is not exhaustive, and the facility Infection Preventionist, or the person at the facility who is responsible to ensure infection control measures are put into practice, must be consulted on resident management decisions.

Resident status

- Assess the health status of two potential roommates; if possible, avoid pairing residents who are at higher risk of severe illness due to medical fragility or CDC: **People with Certain Medical Conditions (People with Certain Medical Conditions | CDC**

Community status

- Consider the rate of COVID-19 spread in the surrounding community. This may increase the likelihood that new admissions or readmissions were exposed to SARS-CoV-2.
- Consider the risk level of the setting from which the resident is being admitted (hospital versus another congregate setting versus community). The setting and/or the exposure source may influence your decision about potential roommates.
- Partnering with another facility in the local area may provide options for placing residents into a single room.

Facility layout and capacity

- Dedicate a separate observation or quarantine area if single rooms are not available. This may mean a dedicated wing or unit, or a designated block of rooms set aside for this purpose. Having dedicated space in the facility for an observation unit facilitates both the physical and procedural separation of residents during their quarantine period.
- Provide as much space as possible between room- mates, ensuring that they can be at least six feet apart.
- Assess new or additional engineering controls that may be put in place. For engineering control considerations, see American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) **Guidance for Building Operations During the COVID-19 Pandemic pdf** [78 KB, 3 pages] and CDC Ventilation in Buildings (**https://www.cdc.gov/ coronavirus/2019-ncov/community/ventilation. html**)

Infection protection and control practices and procedures

- Establish visual reminders when transitioning from one resident to another, like tape on the floor or signs to prompt staff to change personal protective equipment and perform hand hygiene.
- Plan for space to safely don and doff gowns and gloves and perform hand hygiene between residents. Refer to the guidance on stations for donning and doffing personal protective equipment outlined for COVID-19 units.
- Educate residents to remain at least 6 feet apart when in the room together.

- Educate staff on appropriate donning and doffing of personal protective equipment when moving between residents.
- Ensure frequent cleaning and disinfection of high- touch surfaces and equipment between resident uses.
- If a bathroom is shared, ensure cleaning of high- touch surfaces (e.g., doorknob, toilet handle, water faucet, grab bars, hand railings etc.) between each resident use.
- Residents should wear a cloth face covering or face- mask (if tolerated) when within 6 feet of staff and when within 6 feet of their roommate, if possible.
- Make a plan for how compassionate care visits can be conducted safely for these residents.
- Follow your state and CDC guidance for aerosol-generating procedures. Roommates should not be present during these procedures. Residents that routinely require these procedures may need to be prioritized for a private room. Consult the person at the facility who is responsible to ensure infection control measures are practiced.
  - Scientific Brief: SARS-CoV-2 Transmission (https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html)
- If meals are served in the room, residents should remain at least 6 feet apart during meals.

Testing

- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible.
- Newly-admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV2 infection; immediately and, if negative, again 5-7 days after their admission.
- Asymptomatic residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure.
- In general, testing is not necessary for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 90 days; however, if testing is performed on these people, an antigen test instead of nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not infectious during this period.
- Facilities may consider routinely testing residents admitted from a hospital or other facility (whether or not the referring facility has known COVID-19 cases). This testing strategy may allow for the early detection of COVID-19 in newly admitted residents. Testing frequency may depend on the current testing schedule and capacity of the facility. For example, a facility could consider testing new residents upon admission and on days five, seven, 10, and 12. Testing Guidelines for Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing. html

RESOURCES

Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes | CDC accessed 7/1/22
Resident Cohorts for Respiratory Outbreaks in Long-term Care accessed 7/11/22
Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC accessed 7/11/22

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