Infection Control Recommendations for Long Term Care Facilities During Large-Scale Evacuations

The unprecedented wildfire emergency in Oregon has necessitated the evacuation of long-term care facilities in affected areas, resulting in the need for facilities to use many different options for providing residents and staff with safe accommodations. During an evacuation, the primary goal is to safely remove residents from the facility if there is an immediate threat to safety in the area. When an evacuation occurs during a pandemic, it is also important to take steps whenever possible to minimize the risk of infectious disease transmission. The recommendations below are intended to reduce the risk of infection for both residents and staff when a facility evacuation has occurred, based on possible evacuation destinations. Specifically, these recommendations are for:

A. Residents evacuated to a family member's home
B. Residents and staff evacuated to hotels
C. Residents and staff evacuated to temporary congregate shelter such as a Red Cross shelter, community center, or meeting space
D. Residents evacuated to another long-term care facility
E. Transport of evacuated persons
F. Monitoring of evacuated persons for new symptoms
G. Management of evacuated residents and staff who develop COVID-compatible symptoms
H. Management of evacuated residents and staff with confirmed COVID-19 infection

In addition, this document also contains recommendations for post-evacuation returns to a facility. These recommendations were also contained in a previous Provider Alert.

Infection Control Recommendations for Evacuations

A. For residents evacuated to a family member's home
    1. Minimize contact with family members (e.g., keep resident in private room, provide access to private bathroom, designate one family member to provide care).
    2. A face covering or mask should be worn by the family member when providing care. All family members, including resident, should wear a face covering or mask when within 6 feet of the resident and ideally all the time when in the same room indoors.
    3. Educate family members about the importance of:
        i. Prevention steps, including hand hygiene before and after caring for the resident. Placing alcohol-based hand sanitizer bottles outside and inside the resident's room (and bathroom if not ensuite) will facilitate this.
        ii. Monitoring for symptoms to enable prompt diagnosis and appropriate disease management, including infection control measures.
        iii. Notifying and obtaining guidance from the resident's medical provider when symptoms develop, including the need to admit the resident to a long-term care facility. This need assessment should include the level of care required and infection control considerations.

This education should be provided by the facility.[1] Facilities are also encouraged to contact their Local Public Health Authority (LPHA) to see if they have educational materials or other resources available. Facilities should also contact their LPHA if they believe that additional public health follow-up is needed for a resident.

B. For residents and staff evacuated to hotels
    1. Facilities should provide private rooms for each individual (i.e., residents and staff). If room sharing is necessary, pair up residents who shared rooms at the facility. Room sharing is permissible between asymptomatic staff not known to have COVID-19 if they are members of the same family or household or would reasonably be expected to have contact outside of the workplace (e.g., partners, roommates, etc.).
    2. If possible, reserve a block of rooms in a part of the hotel, such as a separate wing, floor or building that facilitates separation of the residents and staff from other hotel guests.
    3. If possible, cohort residents and staff by evacuated facility using block of rooms, such as a separate wing, floor or building.
    4. Restrict residents to their rooms. If it is necessary for residents to leave their rooms, a face covering or mask should be worn and appropriate physical distancing (at least 6 feet) maintained.

    5. Staff should stay in their rooms as much as possible and avoid common areas. A face covering or mask* should be worn and appropriate physical distancing maintained (at least 6 feet) when leaving their rooms.
       *A mask (medical grade) is required when providing care to residents
    6. Staff staying at the facility should continue to adhere to hand hygiene, personal protective equipment (PPE), and disinfection best practices when interacting with the residents.
    7. If a room reserved for staff is shared on a rotating basis (i.e., one room to be used by different staff covering different shifts), terminal cleaning and disinfection should occur between each rotation.

C. For resident and staff evacuated to temporary congregate shelter such as a Red Cross shelter, community center, or meeting space.
    1. Cohort residents and staff by evacuated facility, ideally with temporary physical barriers and separate bathrooms for different cohorts. If possible, designate separate bathrooms for residents and staff.
    2. To minimize droplet transmission, ensure appropriate spacing (at least 6 feet) of resident beds and dining tables and chairs. Use signage and floor markers as reminders.
    3. Implement a system that facilitates frequent hand hygiene for both staff and residents, while keeping memory care residents safe if applicable (e.g., distribute pocket-sized hand sanitizers to staff).
    4. Implement protocol to frequently disinfect high-touch surfaces, including shared bathrooms. The protocol should include a system to routinely audit practice.

D. For residents evacuated to another long-term care facility

[1] Printable educational materials that facilities could print out and send home with residents and their relatives include OHA's "How to Protect Yourself and Others from COVID-19" (available in multiple languages here: https://govstatus.egov.com/OR-OHA-COVID-19 - click on the "Protect yourself and others—learn more" button)

1. If possible, cohort residents and staff from the evacuated facility and minimize their interaction with the host facility's residents and staff. This can be achieved by dedicating a separate building, floor, wing, or a block of adjacent rooms for the evacuated residents and staff.
2. If the above is not feasible, prioritize placement of evacuated residents in private rooms or in an observation area that allows appropriate physical distancing (at least 6 feet), using signage and floor markers as reminders.
3. Restrict evacuated residents to their rooms or observation area as applicable.
4. Track all placements and each resident's ability to comply with restriction to room or observation area. For facilities hosting wandering residents, assign additional staffing (e.g., staff-to-resident ratio of 1:1 for these residents) to facilitate their redirection, and increase frequency of environmental disinfection.
5. If staff from the evacuated facility are working at the new facility to support evacuated residents, they should also minimize interaction with host facility staff and residents. When feasible, designate separate breakrooms and bathrooms for the evacuated facility staff.

In addition to the above, the following recommendations apply to all evacuation destinations except for evacuation to a family member's home.

E. Transport of evacuated persons
    1. To the extent possible, maintain appropriate physical distancing (at least 6 feet) between all evacuees during transport.
    2. All staff should wear a medical-grade face mask, and all residents should wear a face covering or mask, if tolerated, even when 6 feet of physical distancing is possible.
    3. Ensure that a sufficient supply of PPE is available for the duration of the transport.

F. Monitoring of evacuated persons for new symptoms
    1. All evacuated residents and staff should be screened upon entry to evacuation destination and at least daily thereafter (or per facility protocol if more frequent monitoring is already underway) so that suspected cases can be quickly identified and tested.

G. Management of evacuated residents and staff who develop COVID-compatible symptoms
    1. Immediately notify the Oregon Department of Human Services (DHS) and LPHA and test the symptomatic individual(s).
    2. If not already in a private room, separate the symptomatic individual from roommates. Notify DHS and LPHA when this is not feasible.
    3. Implement transmission-based precautions:
        i. Restrict staff to room; note that restriction of residents to rooms should have already been implemented.
        ii. All recommended PPE should be worn by health care personnel when caring for symptomatic individuals:
            - Eye protection (face shield or goggles) and mask (medical-grade mask or N95 respirator) as part of ongoing universal PPE in long-term care facilities
            - Gloves
            - Gowns

H. Management of evacuated residents and staff with confirmed COVID-19 infection
    1. Immediately notify DHS and LPHA of confirmed infection status.
    2. Confirmed COVID-19 cases may share the same room or be placed in a dedicated COVID-19 observation area as applicable.
    3. Implement transmission-based precautions as outlined in G.3. above.
    4. Follow CDC's symptom-based approach to discontinuing transmission-based precautions.

Post-Evacuation Recommendations

For facilities that have evacuated and are ready to return to their facilities, we recommend that facilities they consider all evacuated residents potentially exposed and use conservative infection control strategies that facilities have been implementing during this pandemic to limit the spread of COVID-19. Below are specific measures recommended for evacuated residents returning to their home facilities.

1. To the extent possible: place residents in private rooms, prioritizing those who were in private rooms pre-evacuation.; Once all private rooms are utilized, place residents in their original rooms with their pre-evacuation roommates.
2. Restrict residents to their rooms for 14 days (herein referred to as observation period) upon their return to the facility.
    - For facilities with wandering residents, assign additional staff for redirection and increase frequency of environmental disinfection.
    - Minimize the use of shared spaces: avoid group activities, including communal dining; limit the use of shared bathrooms; increase frequency of disinfection of shared spaces.
3. During the 14-day observation period, all recommended PPE should be worn by health care personnel providing direct care to residents:
    - Eye protection (face shield or goggles) and mask (medical-grade mask or N95 respirator) as part of ongoing universal PPE in long-term care facilities
    - Gloves
    - Gowns if available
4. During the 14-day observation period, closely monitor (at least 3 times per day) all residents for signs and symptoms of COVID-19, including vital signs. For any resident with suspected COVID-compatible signs or symptoms, immediately notify DHS and the LPHA and arrange for testing.
5. If the facility chooses to implement testing before lifting restrictions, testing should be completed at the end of the 14-day observation period. If a confirmed case in either a resident or staff is identified during this period, follow standard protocol for full facility testing.

The Healthcare-Associated Infections Program is available for consultation regarding re-integration of evacuated residents. A consultation can be requested by completing this form.