LTCF COVID-19 RESPONSE TOOLKIT

Oregon Health Authority

March 22, 2020

COVID-19 in Long-Term Care Facilities

The current coronavirus disease (COVID-19) pandemic is rapidly evolving. Older individuals and those with chronic medical conditions are at higher risk for severe illness from COVID-19. Long-term care facilities (LTCFs) have experience managing respiratory infections and outbreaks among residents and staff, and can apply similar outbreak management principles to COVID-19.

LTCFs are at high risk for severe COVID-19 outbreaks because they provide both housing and care for a vulnerable population (e.g., older adults with multiple co-morbidities). It is through ill healthcare personnel (HCP) and visitors that COVID-19 is most likely to be brought into LTCFs. To protect this fragile population, the Oregon Health Authority (OHA) is urging ALL LTCFs to take aggressive actions immediately to reduce the risk of COVID-19 infections in their residents and staff.

This toolkit provides resources for LTCFs to utilize in their COVID-19 response planning. We encourage you to use all components of this toolkit, as you continue to revise your facility's current COVID-19-related policies, procedures, and forms.

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About COVID-19

Clinical Presentation & Management

- COVID-19 illness presentation ranges from mild respiratory illness to severe pneumonia with respiratory failure and septic shock.
- Symptoms of COVID-19 include fever, cough, myalgia or fatigue, and shortness of breath. Less common symptoms include sore throat, headache, and diarrhea.
- A fever will likely present during the clinical course, but not all residents with COVID-19 will present with a fever. Residents and staff should be screened regularly for both the presence of fever and respiratory symptoms (cough, shortness of breath, sore throat).
- Severity of illness may worsen in the second week of infection.
- Older individuals and those with chronic medical conditions are at higher risk for severe disease.
- Not all residents with COVID-19 infection will require hospital admission. The decision to provide care in the residential setting should be made on a case-by-case basis.
- No specific treatment for COVID-19 is currently available. Clinical management should include close monitoring and supportive medical care. COVID-19 testing can be used to confirm the presence of the virus in long-term care settings, to determine the degree of spread, or to guide infection control measures. Once multiple COVID-19 cases have been confirmed, no further testing is required, and COVID-19-specific infection control measures should be implemented for all ill residents or staff.

Modes of spread

- The virus that causes COVID-19 (SARS-CoV-2) spreads mainly between people in close contact or through respiratory droplets produced by coughs and sneezes. Staying home when ill, respiratory etiquette practiced by ill residents, and appropriate personal protective equipment use by healthcare personnel can reduce risk of spread.
- The virus can survive on surfaces and may also be spread through touching contaminated surfaces (e.g. nursing station areas, handrails, telephones, or doorknobs). Frequent and effective cleaning and disinfection of high-touch surfaces, avoiding touching one's face, and frequent hand hygiene can reduce the risk of transmission.

References

Desai AN, Patel P. Stopping the Spread of COVID-19. *JAMA.* Published online March 20, 2020. doi:10.1001/jama.2020.4269

Coronavirus disease (COVID-19) advice for the public. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19). https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html

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LTCF Infection Prevention Readiness Assessment Tool for COVID-19

The following infection prevention and control readiness assessment tool has been adapted from CDC's Infection Prevention Assessment Tool and is used to assist LTCFs, such as nursing homes, with preparations to care for residents with COVID-19. Elements should be assessed through front-line staff interviews and direct observation. Your facility can use this tool more than once, throughout the pandemic.

The assessment reviews the following domains:

- Visitor restrictions
- Education, monitoring, and screening of all employees
- Education, monitoring, and screening of residents
- Availability of personal protective equipment (PPE) and other supplies
- Infection prevention and control practices (e.g., hand hygiene, use of PPE, and cleaning and disinfection of environmental surfaces and resident care equipment)
- Communication

DATE OF ASSESSMENT:

Which of the following situations currently apply to the facility?

□ No cases of COVID-19 currently reported in this facility

□ No cases of COVID-19 in this facility, but acute respiratory illness identified

□ Cases of COVID-19 identified in your facility (either among HCP or residents)

How many days' supply of the following does this facility currently have ON HAND?

Facemasks:

N95 respirator (masks):

Powered air-purifying respirators (PAPRs):

Isolation gowns:

Eye protection (e.g., goggles or face shield):

Gloves:

Alcohol-based hand rub (ABHR):

Visitor restrictions		
Elements to be assessed	**Assessment**	**Notes/areas for Improvement**
Facility has sent a communication (e.g., letter, email) to families notifying them of the visitor restriction policy, and advising them to use alternative methods for visitation (e.g., video conferencing) until further notice. Consider scheduling routine communications to families (e.g., weekly, or more frequently if needed).		
Facility has posted signs at entrances to the facility, restricting all visitors.		
For the few visitors who are exceptions to visitor restriction (e.g., in end-of-life situations), facility carefully asks about the following and restricts anyone (even in end-of-life situations) with fever, cough or shortness of breath. Healthy visitors should wear a facemask and confine their visit to the resident's room or other location designated by the facility.		
When permitted, facility instructs visitors to perform hand hygiene frequently; to limit their interactions with others in the facility; and to confine their visit to the resident's room or other location designated by the facility. Visiting areas are cleaned and disinfected immediately after use.		
When permitted, visits are scheduled in advance, during a specific, predetermined number of hours (e.g., a one-hour visit schedule from 4:00 P.M. to 5:00 P.M.).		
Facility has protocol that advises visitors to monitor themselves for fever, cough, or shortness of breath for at least 14 days after exiting the facility. • If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the residents with reported contact, and take all necessary actions (e.g., isolation, testing) based on findings.		
Facility has provided alternative methods for visitation (e.g., video conferencing).		

Education, monitoring, and screening of all employees		
Elements to be assessed	**Assessment**	**Notes/areas for improvement**
Facility conducts routine (e.g., daily or per shift) employee huddles to review: • Outbreak situation in state, county, and facility • Sick leave policies and importance of not reporting or remaining at work when ill • Reminder that if employee becomes feverish or ill while at work, they should immediately put on a mask, notify their supervisor, and return home • Importance of meticulous and frequent hand hygiene • Any changes to usual policies or procedures in response to PPE or staffing shortages		
Facility keeps a list of staff who work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screens and restricts them if ill, to ensure that they do not place individuals in the facility at risk for COVID-19.		
Education, monitoring, and screening of all healthcare personnel (HCP)		
Elements to be assessed	**Assessment**	**Notes/areas for improvement**

Facility has provided initial and recurring training to HCP (including consultant personnel) about the following:
• COVID-19 symptoms and modes of transmission
• Adherence to additional recommended infection prevention and control practices, including:
  o Hand hygiene during interactions with residents and their environment
  o Selection of appropriate PPE
  o Competency in correct donning and doffing PPE
  o Cleaning and disinfecting environmental surfaces
  o Cleaning and disinfecting resident care equipment
• Any changes to usual policies or procedures in response to PPE or staffing shortages		

Facility keeps a list of symptomatic HCP that includes: • Date of first symptoms • Date(s) HCP worked while symptomatic		
Screen all HCP (including consultant personnel) at the beginning of their shift for fever and respiratory symptoms (take their temperature and document presence or absence of shortness of breath, new or change in cough, and sore throat). • If they are ill, have them put on a facemask immediately and return home		

Restrict all non-essential people including volunteers and non-essential consultant people (e.g., barbers) from entering the building.		
Education, monitoring, and screening of residents		
Elements to be assessed	**Assessment**	**Notes/areas for improvement**

Facility has provided education to residents about:
• COVID-19 symptoms and mode of transmission
• Importance of immediately informing HCP if they feel feverish or ill
• Actions they can take to protect themselves:
  o Hand hygiene
  o Respiratory etiquette (covering their cough, using and disposing of tissues)
  o Maintaining social distancing
• Actions the facility is taking to keep them safe (e.g., visitor restrictions, changes in PPE, canceling group activities and communal dining)		

Facility has a policy and plan in place to assess residents for fever, cough, shortness of breath, and sore throat upon admission and throughout their stay in the facility, including a plan to monitor residents unable to communicate subjective symptoms.		
Facility has a policy and plan in place to ensure that residents with suspected respiratory infections are isolated appropriately and that appropriate personal protective equipment (see infection control practices below) is accessible to staff.		
Facility keeps a list of symptomatic residents that includes: • Date of first symptom onset • List of current symptoms • Date resident placed into isolation precautions		
Facility has canceled all group activities until further notice.		
Facility has canceled communal dining until further notice.		
Facility has established protocols and criteria for closing units or the entire facility to new admissions.		
Facility has established protocols and criteria for cohorting ill residents with dedicated HCP.		
Additional actions to be taken when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier): • Restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room, they should wear a facemask, perform hand hygiene, limit movement in the facility and perform social distancing. • Implement protocols for cohorting residents with COVID-19 and using dedicated HCP.		

See "LTCF COVID-19 Outbreak Response Tool" for more information		
Availability of PPE and other supplies		
Elements to be assessed	**Assessment**	**Notes/areas for improvement**
Facility has assessed current supply of PPE and other critical materials (e.g., alcohol-based hand rub [ABHR], EPA-registered hospital-grade disinfectants, tissues).		
Facility has assessed current supply of items needed to collect respiratory specimens for respiratory virus testing (including COVID-19 and influenza): • Synthetic fiber (not cotton!) swabs with plastic shafts • Transport media (viral transport media or universal transport media, 3-mL vials) • Biohazard bags and absorbent material for transport		
If shortages of PPE or testing supplies are identified or anticipated, facility has attempted to obtain resources from healthcare partnerships and, if local resources have been exhausted, have notified their local public health authority (LPHA).		
Hand-hygiene supplies are available in all resident care areas: • ABHR* with 60%–95% alcohol is available in every resident room and other resident-care and common areas • Sinks are stocked with soap and paper towels, have a supply of warm water, and are accessible to residents *If there are shortages of ABHR, hand hygiene using soap and water for at least 20 seconds is expected		
PPE is available in all resident-care areas (e.g., outside resident rooms). PPE includes gloves, gowns, facemasks, N-95 or higher-level respirators (if facility has a respiratory protection program and HCP are fit-tested) and eye protection (face shield or goggles). Facemasks are an acceptable alternative when N95 masks are not available.		
EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 (the virus that causes COVID-19 infection) are available to allow for frequent cleaning of high-touch surfaces and shared resident-care equipment. *See EPA List N: www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2		
Tissues are available in common areas and resident rooms for respiratory hygiene, cough etiquette and source control. Residents should be instructed to use tissues once and discard appropriately.		

Infection prevention and control practices		
Elements to be assessed	**Assessment**	**Notes/areas for improvement**
HCP perform hand hygiene in the following situations: • Before contact with the resident, even when PPE is worn • After contact with the resident • After contact with blood, body fluids or contaminated surfaces or equipment • Before performing sterile procedures • After removing PPE, including gloves		
Facility has a plan to minimize, when possible, patient-care procedures that may generate infectious aerosols (e.g., consider switch to metered dose inhaler vs. continuous nebulizer where possible)		
HCP wear the following PPE when caring for residents with undiagnosed respiratory illness unless the suspected diagnosis requires airborne precautions (e.g., tuberculosis): • Gloves • Isolation gown • Facemask • Eye protection (e.g., goggles or face shield) If available and the facility has a respiratory protection program with fit-tested HCP, use a N-95 or higher-level respirator. Facemasks are an acceptable alternative.		
PPE are removed ("doffed") in a manner to prevent self-contamination, hand hygiene is performed, and new PPE are put on after each resident-care encounter, except as noted below. • Display posters and signage to guide HCPs how to remove (doff) PPE correctly • Develop just-in-time training program to reinforce appropriate PPE use if undiagnosed respiratory illness is noted in the facility. Consider room monitor or "buddy system" to have trained staff provide doffing assistance to those conducting patient care.		
Develop plan to implement PPE optimization strategies. See "Strategies for Conservation of PPE' section.		
Additional actions when COVID-19 is identified in the community (some facilities may choose to implement these earlier) • Consider implementing universal use of facemasks for HCP while in the facility. Facemasks should be safely doffed after contact with a symptomatic individual or when visibly soiled.		

Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) • Implement universal use of facemasks by HCP if not already done • Consider having HCP wear all recommended PPE (gown, gloves, eye protection, and facemask [or N95 respirator if available]) for the care of all residents, regardless of presence of symptoms		
Non-dedicated, non-disposable resident-care equipment is cleaned and disinfected after each use.		
EPA-registered disinfectants are prepared, labeled, stored and used in accordance with instructions.		
Communication		
Elements to be assessed	**Assessment**	**Notes/areas for improvement**
Facility communicates information about residents with known or suspected COVID-19 to appropriate personnel (e.g., transport personnel, receiving facility) before transferring them to healthcare facilities.		
Facility notifies the LPHA about any of the following: • COVID-19 is suspected or confirmed in a resident, employee, or recent visitor • A resident has a severe, acute respiratory infection *leading to death or requiring hospitalization* • Two (2) or more individuals with positive laboratory results for COVID-19 (any combination of residents and staff) with new onset of respiratory symptoms over a 72-hour period		

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LTCF COVID-19 Outbreak Response Tool

Frequent and thorough symptom monitoring for long-term care residents and staff is the best strategy to identify new cases and outbreaks as soon as they occur. Once this has happened, it is very important to act quickly to contain the spread of illness. It is also important to treat all respiratory disease as COVID-19 unless testing or other information suggests otherwise.

A SINGLE CASE OF ACUTE RESPIRATORY ILLNESS SHOULD PROMPT ACTION.

The following situations in the facility should be considered a suspect outbreak of COVID-19:

- ☐ New onset of severe respiratory illness identified in a resident. Severe illness is defined as respiratory symptoms that lead to death or require urgent transfer to a hospital, ***or***
- ☐ Two (2) or more individuals (any combination of residents and staff) with new onset of respiratory symptoms over a 72-hour period.

If one of the above two situation occurs in the facility, implement the following steps immediately:

- ☐ Notify your local public health authority (LPHA) immediately.
- ☐ Notify staff, volunteers, residents, and families of the outbreak.
- ☐ Post signage at facility entrances and outside affected units and resident rooms.
- ☐ If the cause of respiratory illness in the facility is unknown, testing for influenza and other respiratory viruses can be carried out. However, appropriate personal protective equipment (PPE) should be used for specimen collection.
- ☐ Actively perform surveillance to identify any new cases rapidly so they can be managed appropriately. Screen for fever, cough, sore throat, and shortness of breath. Report these cases daily to your LPHA.
- ☐ Implement system to screen employees for illness before each shift; screening should include a check for fever, and respiratory symptoms (cough, shortness of breath, or sore throat). Any ill employee should be immediately excluded from work. See OHA Provisional Guidance: Clinical Care and Healthcare Infection Prevention and Control for COVID-19 for return-from-work guidance.
- ☐ Ensure availability of PPE throughout the facility, including masks, gowns, gloves, and eye protection (face shields or goggles).
- ☐ Monitor stocks of these supplies and re-order as needed. If PPE shortages arise and supplies cannot be obtained from local healthcare partners nor any additional vendors, contact your local health department.
- ☐ Ensure that staff know how to don, doff, and dispose of PPE properly, to avoid contamination and wastage of limited supplies. Post donning and doffing instruction posters.

- ☐ When interacting with any resident with an undiagnosed respiratory illness, HCP should adhere to standard, contact, and droplet precautions, including eye protection such as goggles or a face shield. If the suspect diagnosis requires (e.g., tuberculosis), implement airborne precautions.

- ☐ When interacting with any resident with COVID-19, HCP should adhere to standard, contact, and droplet precautions, including eye protection such as goggles or a face shield.

- ☐ If available, N95 masks should be used for patient care that may generate aerosols (e.g., mechanical ventilation, continuous nebulizer). As N95 masks may not be available in all facility types, aerosol-generating procedures should be avoided when possible.

- ☐ Ensure that respiratory etiquette is followed by all residents. Ill staff must not come to work. Those with signs and symptoms of a respiratory infection should:
    - Wear a facemask if the need to leave the room
    - Cough or sneeze into their elbow
    - Cover their nose and mouth with tissue when coughing or sneezing, dispose of the tissue in the nearest waste receptacle, and perform hand hygiene

- ☐ Ensure that materials for respiratory etiquette are available throughout the facility, including tissues and no-touch waste receptacles.

- ☐ Ensure that materials for frequent hand hygiene are available throughout the facility, including alcohol-based hand rub, and supplies for soap-and-water hand hygiene, such as disposable paper towels and accessible sinks supplied with warm water.

- ☐ To limit HCP exposure risks and to maintain PPE supply, bundle care as much as possible. Limit room entry to healthcare personnel needed for resident medical care (e.g., have healthcare personnel caring for the resident bring in meals; and disinfect high-touch surfaces in the room).

- ☐ During an outbreak caused by confirmed COVID-19, dedicate specific HCP to treat residents with the same infection, and do not share staff between affected and unaffected units to decrease the potential for transmission.

- ☐ Limit the degree to which staff members (e.g. wound care nurses, delivery-service personnel) have contact with all or many residents. If an individual provides essential services and must see a large number of residents, supply carts should remain outside of resident rooms. These staff members should be checked daily for symptoms and should use appropriate PPE and frequent hand hygiene.

- ☐ Enhance routine cleaning and disinfecting procedures, focusing on high-touch surfaces such as railings, door handles, nursing station areas, mobile computer stations, phones, and light switches at least twice daily. Ensure that your facility is using an appropriate EPA-registered disinfectant.

- ☐ If COVID-19 has been confirmed in two or more individuals (any combination of residents and staff), close the facility to new admissions, and stop non-essential transfers. This should remain in effect until the LPHA and DHS have approved lifting these restrictions.

- ☐ If a resident's medical condition requires transfer, place facemask on resident, and ensure that interfacility communication takes place and that the receiving facility and emergency transport is notified in advance so they can take appropriate steps to transport and receive the resident safely.

- ☐ Discontinue group activities, including communal dining (if not already restricted).

- ☐ Ill residents should be separated from others:

    - Ill residents should be cohorted, meaning they should be assigned to single-patient rooms with private bathrooms. If more than one resident has been tested and they are both confirmed to have the same illness, they may be cohorted together.
    - Do not transfer ill residents or residents with known exposures (e.g., a roommate of a confirmed case) to unaffected units.
    - Limit the activities and movements of ill residents by restricting them to their rooms. If they must leave their room, residents should wear a facemask (if tolerated) or use tissues to cover their mouth and nose.
    - During an outbreak caused by confirmed COVID-19, limit the activities and movements of all residents by restricting them to their rooms and practicing social distancing (remaining at least 6 feet away from others).

- ☐ If your LPHA has advised testing for COVID-19, train and prepare appropriate clinical staff to collect specimens safely, using all recommended personal protective equipment (gloves, gowns, mask, and eye protection). Your facility should ensure that it has an adequate supply of materials that will be needed for testing, including:

    - Swabs for specimen collection
        - Only synthetic fiber swabs with plastic shafts are acceptable. Do not use calcium alginate or cotton swabs or swabs with wooden shafts, as they may contain substances that interfere with PCR testing.
    - Transport media (viral transport media or universal transport media, 3-mL vials)
        - Place swabs immediately into sterile tubes containing 2–3 mL viral transport media
    - Biohazard bags and absorbent material for transport

- ☐ In consultation with DHS and the LPHA, develop an infection control plan to prepare for readmission of clinically stable residents with COVID-19 after discharge from the hospital setting. LTCFs can accept a resident diagnosed with COVID-19 and still under transmission-based precautions as long as the facility can follow CDC guidance for transmission-based precautions.

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Strategies for Personal Protective Equipment (PPE) Conservation During COVID-19 Pandemic

The following provisional guidance has been adopted by the Oregon Health Authority (OHA) to maximize existing supplies of PPE while ensuring that HCP remain as protected as possible.

Wearing appropriate personal protective equipment (PPE) prevents the spread of infection between residents and healthcare personnel (HCP). Major U.S. distributors are currently reporting shortages of PPE, specifically N95 respirators, surgical masks, and gowns. This may impair your facility's ability to purchase adequate supplies and to adhere to PPE recommendations.

HCP are at risk for exposure to COVID-19 due to prolonged, close contact with residents. Because PPE can easily become contaminated and may come into contact or be worn near mucous membranes, unsafe re-use of PPE by HCP due to limited supplies poses a risk of exposure and infection. It is very important for HCP to stay safe and healthy, because they play an essential role in limiting the impact of COVID-19. This document provides guidance to maximize existing supplies of PPE while protecting HCP safety. There are four major strategies:

Limiting use: PPE in short supply should be dedicated to the highest-priority needs for these materials. Consider delaying non-essential care and procedures that will require the use of PPE until supplies are more abundant. Limiting patient room entry to those individuals who must enter to provide resident care is one method of limiting the use of PPE. If needed, consider limiting the number of HCP caring for an individual resident or performing a particular duty to reduce needed PPE changes.

Reprocessing: Using PPE that can be cleaned, disinfected, or sanitized can be a more sustainable approach. Only some PPE can be reprocessed; this depends on the materials it is made of and what it has been or will be used for. Information on reprocessing is available in the manufacturer's guidelines. Examples include washable gowns; and goggles or face shields that can be disinfected after use. There are currently no widely accepted procedures for reprocessing of face masks with disinfectants.

Extended use: Wearing the same PPE (especially facemask [N95 or surgical/procedural] and face shields) by one HCP for repeated close-contact encounters with several different residents, without removing or touching it between patient encounters. It can be used with multiple residents who are cohorted together with the same infectious disease diagnosis (e.g. confirmed COVID-19). Note that extended use of a face shield and facemask together can prolong the use of the underlying mask, as the shield protects it to some degree from surface contamination.

Limited Reuse: Wearing the same facemask (N95 or surgical/procedural) by one HCP for multiple encounters with different residents but removing it after each encounter. This strategy should be considered only in a *crisis-level* of PPE shortage. Contact-based transmission of COVID-19 (spread that occurs from touching contaminated surfaces, objects, or clothing) may play an important role in transmission. Because limited re-use involves touching potentially contaminated PPE between residents, it may pose a risk to HCP. The use of a face shield may reduce contamination of facemasks. See more information in CDC's Crisis Alternate Strategies.

Current PPE recommendations for the treatment of residents with known or suspected COVID-19 include facemasks (N95 respirators or surgical masks), gowns, gloves, and eye protection (e.g., goggles or face shields).

Education for HCP is essential. Training HCP about how and when PPE should be used can conserve supplies.

Respiratory protection: N95 respirators

What they are: Devices worn over the mouth and nose and designed to fit the face very closely and to filter out at least 95% of 0.3-micron airborne particles. For N95 masks to work properly, HCP must be medically cleared to wear them, be fit-tested to ensure that a proper seal has been achieved, and trained in their proper use, safe removal and disposal, and in medical contraindications to their use. Respirator use should be in the context of a complete respiratory-protection program in accordance with OSHA Respiratory Protection standards (29 CFR 1910.134).
When they are used and how to maximize supply: Limit the use of N95 respirators for situations where respiratory protection is most important, such as performance of aerosol-generating procedures on residents with suspected or confirmed COVID-19 or provision of care to residents with other infections for which respiratory protection is strongly indicated (e.g., tuberculosis, measles, varicella). HCP can employ extended use of N95 respirators to care for groups of residents with confirmed COVID-19. For specific guidance on extended use of N95 respirators, refer to Strategies to Optimize the Current Supply of N95 Respirators. The respirator must be discarded when: o Damp, damaged or hard to breathe through o Used during an aerosol-generating procedure o Contaminated with blood or other body fluids

Respiratory protection: Surgical masks

What they are: Devices worn over the mouth and nose that fit loosely and create a physical barrier from potential contaminants in the environment.
When they are used and how to maximize supply: Surgical masks should be used when providing care for any patient known or suspected to be infected with a respiratory pathogen, including COVID-19. HCP can employ extended use of surgical masks when caring for groups of residents with the same diagnosis (e.g., confirmed COVID-19). The respirator must be discarded when: o Damp, damaged or hard to breathe through o If contaminated with blood or other body fluids

Gowns

What they are: Coverings worn over clothing to minimize contact between skin and clothing and potentially infectious materials.

When they are used and how to maximize supply: Gowns should be used when providing care for any patient known or suspected to be infected with a respiratory pathogen, including COVID-19.

Limiting the use of gowns for high-priority activities such as:

- Aerosol-generating procedures
- Care activities where splashes and sprays are anticipated
- High-contact patient-care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
    - Dressing
    - Bathing or showering
    - Transferring
    - Hygiene-related activities (e.g., shaving)
    - Changing linens
    - Changing briefs or assisting with toileting
    - Device (e.g., central line, indwelling urinary catheter) care or use
    - Wound care

Depending on the type of gown and availability of appropriate laundry services, it is possible to reprocess and re-use gowns. It is crucial that gowns be reprocessed appropriately between uses.

Eye protection: Goggles

What they are: Equipment that covers the eyes and surrounding area to prevent droplets or splashes of potentially infectious materials from contacting the eyes.

When they are used and how to maximize supply: Some form of eye protection should be used when providing care for any patient known or suspected to be infected a respiratory pathogen, including COVID-19, or when splashes or sprays of secretions or body fluids are anticipated.

Depending on the type of goggles and availability of materials and facilities for reprocessing, it is possible to reprocess and re-use a pair of goggles for more than one patient. It is crucial that goggles be cleaned and disinfected appropriately between uses.

Eye protection: Face shields

What they are: Waterproof equipment that covers the face to prevent droplets or splashes of potentially infectious materials from contacting the eyes and surrounding face.

When they are used and how to maximize supply: Some form of eye protection should be used when providing care for any patient known or suspected to be infected with a respiratory pathogen, including COVID-19, or when splashes or sprays of secretions or body fluids are anticipated.

HCP can employ extended use of masks and eye protection when caring for groups of residents with the same diagnosis (e.g., confirmed COVID-19). HCP would remove only gowns and gloves (if used) and perform hand hygiene between treating residents while continuing to wear the same eye protection and respirator or surgical mask. The risk of transmission due to extended use of eye protection and facemasks expected to be very low. HCP must take care not to touch their eye protection, respirator or facemask. If these items become damaged or soiled at any time, eye protection and respirator or facemask should be removed, and hand hygiene performed.

Depending on the type of face mask and availability of materials and facilities for reprocessing, it is possible to reprocess and re-use a face shield for more than one patient, regardless of their diagnosis. It is crucial that face shields be reprocessed appropriately between uses.

It must be replaced when:

- Damaged or hard to see through
- If used during an aerosol-generating procedure

LOCAL PUBLIC HEALTH AUTHORITY NUMBERS IN OREGON

(updated Feb 2020)

County	General	CD Nurse	CD Fax	Env Health	Animal Bites	After Hours CD
Baker	541-523-8211	General	541-523-8242	General	General	541-523-6415
Benton	541-766-6835	General	541-766-6197	541-766-6841	EH	541-766-6835
Clackamas	503-655-8411	503-655-8411	503-742-5389	503-655-8411	CD	503-655-8411
Clatsop	503-325-8500	General	503-325-8678	General	General	503-791-6646
Columbia	503-397-7247	971-757-4003	503-893-3121	503-397-7247 Env Health & Animal Bite Fax 888-204-8568	EH	503-397-7247
Coos	541-266-6700	541-266-6700	541-888-8726	541-266-6720	541-266-6720	541-266-6700
Crook	541-447-5165	General	541-447-3093	541-447-8155	General	541-447-5165
Curry	541-425-7545	541-373-8118	541-425-5557	541-251-7074	EH	541-425-7545
Deschutes	541-322-7400	541-322-7418	541-322-7618	541-388-6566	EH	541-322-7400
Douglas	541-440-3571	541-440-3684	541-464-3914	541-317-3114	EH	541-440-3571
Gilliam*	541-506-2600	General	541-506-2601	541-506-2603	General	541-506-2600
Grant	541-575-0429	General	541-575-3604	General	General	541-575-0429
Harney	541-573-2271	541-573-2271	541-573-8388	541-575-0429	EH	541-573-2271
Hood River	541-386-1115	541-387-7110	541-386-9181	541-387-6885	541-387-7110	541-386-1115
Jackson	541-774-8209	General	541-774-7954	541-774-8206	General	541-774-8209
Jefferson	541-475-4456	General	541-475-0132	General	General	541-475-4456
Josephine	541-474-5325	General	541-474-5353	General	General	541-474-5325
Klamath	541-882-8846	541-882-8846	541-850-5392	541-882-8846	General	541-891-2015
Lake	541-947-6045	General	541-947-4563	General	General	541-947-6045
Lane	541-682-4041	General	541-682-2455	541-682-4480	EH	541-682-4041
Lincoln	541-265-4112	General	541-265-4191	541-265-4127	EH	541-265-4112
Linn	541-967-3888	541-967-3888 x2488	541-924-6911	541-967-3821	EH	541-967-3888
Malheur	541-889-7279	541-889-7279	541-889-8468	541-473-5186	EH	541-889-7279
Marion	503-588-5342	503-588-5621	503-566-2920	503-588-5346	EH	503-588-5342
Morrow	541-676-5421	General	541-676-5652	541-278-6394	General	541-676-5421
Multnomah	503-988-3674	503-988-3406	503-988-3407	503-988-3400	CD	503-988-3406
Polk	503-623-8175	General	503-831-3499	503-623-9237 x1442	EH	503-932-4686
Sherman*	541-506-2600	General	541-506-2601	541-506-2603	General	541-506-2600
Tillamook	503-842-3900	503-842-3912	503-842-3983	503-842-3902	EH	503-842-3900
Umatilla	541-278-5432	General	541-278-5433	General	General	541-314-1634
Union	541-962-8800	541-910-7209	541-963-0520	General	541-910-7209	541-962-8800
Wallowa	971-673-1111	971-673-1111	971-673-1100	971-673-0440	541-426-3131	971-673-1111
Wasco*	541-506-2600	General	541-506-2601	971-673-0440	General	541-506-2600
Washington	503-846-3594	503-846-3594	503-846-3644	503-846-8722	503-846-3594	503-412-2442
Wheeler	541-763-2725	General	541-763-2850	General	General	541-763-2725
Yamhill	503-434-7525	503-434-4715	503-434-7549	General	CD	503-434-7525

**operated jointly as North Central Public Health District*

www.healthoregon.org/lhddirectory

COVID-19/Coronavirus Announcement

NO VISITORS UNTIL FURTHER NOTICE

Our facility is currently closed to all visitors.

The world is experiencing a pandemic of respiratory illness (COVID-19) caused by a new coronavirus. The virus can spread from person to person. Older adults and those with underlying medical conditions are especially at risk.

We take our role in protecting the health of our residents very seriously.

Please talk to a staff member if you have any questions or concerns.

Thank you for your understanding during this challenging time.

FACILITY ENTRY LOG

version 3/19/2020

County: _____

Facility: _____

Daily Log of All Individuals Who Enter Facility	Date of facility entry	Time of facility entry	Time of facility departure	Approved as "ESSENTIAL?"	Facility or Resident Support	Room number(s) to visit (enter NA, if none)	Job duty code	Fever >100.0 or Feverish?	Cough?	Runny nose?	Nasal or chest congestion?	Hand hygiene, PPE education?	Mask?	Comments
NAME	TODAY'S DATE	ARRIVAL TIME	DEPARTURE TIME	Y/N	F/R	Room	Codes Below	WRITE YES OR NO FOR EACH						

Instructions:

The form is used to track all persons who enter the facility. Complete all columns for each person UPON ENTRY. Add rows as necessary. Do not throw away form once full. Save and store for future review, if needed.

Use these job codes for staff

A	administrative	M	maintenance
F	food service	P	patient care
H	housekeeping	O	other (add to Comments)

Respiratory Illness Log

version 3/19/20

County: _____

Facility: _____

Residents and staff with fever and/or any respiratory symptoms	Date of birth	Sex	Resident or staff	Room number	Job duty code (staff only)	Date of illness onset	Fever >100 F (Tmax)	Cough	Shortness of breath	Pneumonia	Emergency Dept Visit	Hospitalized	Died	Seen by provider	Lab confirmed COVID-19?	Other lab results (e.g., flu test, legionella)	Comments
NAME	DOB	F or M	Codes Below	Room	Codes Below	Date (m/d)	Check all that apply							YES/NO	YES/NO		
					Totals												

Instructions:

The form is used to track all staff or residents who become ill with fever or respiratory illness. Complete all columns for each person listed. Add rows as necessary. Do not throw away form once full. Save and store for future review, if needed.

R resident
S staff

Use these job codes for staff duties

A	administrative	M	maintenance
F	food service	O	other (write in Comments)
H	housekeeping	P	patient care

Additional COVID-19 Resources for LTCF

Resources from OHA

1. **Novel Coronavirus Updates (COVID-19):** https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/Pages/emerging-respiratory-infections.aspx
2. **Provisional Clinical and Infection Control Guidance For Healthcare Providers** https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/Pages/COVID-19.aspx

CMS Announcements

1. March 4: Actions to Address Spread of Coronavirus
2. March 4: Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge
3. March 4: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes
4. March 13: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes (Revised) (PDF)

Resources from CDC

1. **Personal Protective Equipment Resources for Donning and Doffing** https://www.cdc.gov/hai/prevent/ppe.html
2. **Long-Term Care (LTC) Respiratory Surveillance Line List**: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf
3. **Poster reviewing proper PPE Donning/Doffing**: https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf
4. **Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Setting**: https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf
5. **Preparing for COVID-19**: Long-term Care Facilities, Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
6. **Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings**: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
7. **Sample long-term care facility letter to residents, families, friends, and volunteers.** https://www.cdc.gov/coronavirus/2019-ncov/downloads/healthcare-facilities/Long-Term-Care-letter.pdf
8. **What Healthcare Personnel Should Know about Caring for Patients with Confirmed or Possible COVID-19 Infection** https://www.cdc.gov/coronavirus/2019-ncov/hcp/caring-for-patients.html
9. **Healthcare Professionals: Frequently Asked Questions** https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html