City of Berkeley Public Health Officer Unit

Communicable Disease Prevention & Control Program
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Suspected or Confirmed COVID-19 Outbreak Control Recommendations for Long-Term or Residential Care Facilities

Contact Name:
Phone:
Fax/Email:

Date:
Name of Facility:
Complete Address:

These recommendations are supplemental to the California Department of Public Health (CDPH) All-Facilities Letter 20-25.1 (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-25-1.aspx#**) and include additional precautions and actions to control a suspected or confirmed outbreak.**

Case Definitions for Long-Term Care 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 ILI within 72 hours of each other, and both have negative tests for influenza

Influenza-like illness (ILI): Fever (temperature ≥ 100° F or 37.8° C) AND cough and/or sore throat in the absence of a known cause

Reporting Requirements

- ☐ All suspected or confirmed COVID-19 outbreaks must be **immediately** reported to the City of Berkeley Communicable Disease Prevention and Control Program (COB-CDPCP) at 510-981-5292, Mon-Fri 8 am to 5 pm. After hours and on weekends, call Police Dispatch at 510-981-5911 and ask to speak to the Health Officer on duty.
- ☐ Report outbreak/cluster to Licensing and Certification East Bay District Office: 510-620-3900.
- ☐ Complete attached line list daily for all **new** cases and submit to COB-CDPCP by fax (510-981-5345) daily until instructed otherwise by COB-CDPCP
- ☐ Submit a map/floor plan of your facility within 24 hours of reporting the outbreak.

Outbreak Control Recommendations

Surveillance

	Measure temperature and assess for symptoms of cough, shortness of breath, and sore throat at least twice daily among all patients/residents. For residents not known to be ill: • If oral thermometer used, wear new gloves for each patient. Perform hand hygiene before and after donning and doffing gloves. • Wear a face mask (procedure or surgical mask) if enough supplies. May wear the same mask for multiple resident encounters **if not touched by healthcare provider (HCP) and if no encounters with coughing patient.** If patient is coughing or HCP touches mask, remove gloves, discard mask, perform hand hygiene, and don a new mask.
	Institute symptom and temperature monitoring for staff when they to report to work. Exclude from work if **any** of the following symptoms: fever, cough, sore throat, or shortness of breath.

	Monitor and report staff absenteeism due to respiratory symptoms.
Diagnostic Testing	
	Collect NP swab specimens for influenza PCR testing (if not already done) and COVID-19 PCR testing. Use only synthetic fiber swabs with plastic or aluminum shafts. Calcium alginate swabs or swabs with wooden shafts are <u>not</u> acceptable. Place swabs immediately into sterile tubes containing 2-3 ml of viral transport media or universal transport media**.**
	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. See instructions in this packet.
	Send NP swabs for influenza testing through the facility's usual laboratory.
	Send NP swabs for COVID-19 testing at the Alameda County Public Health Lab (ACPHL). Testing must be approved in advance by COB-CDPCP at 510-981-5292. **Do not send specimens directly to the ACPHL without COB-CDPCP approval**.
Communication	
	In addition to notifying COB-CDPCP and Licensing & Certification, notify: • Infection Preventionist • Director of Nursing • Facility Administrator • Medical Director • Heath Services Director • HCP and care givers who work at the facility • Residents, family, and visitors
	Distribute an outbreak communication letter to residents and their families.
	Post signs at facility entrance. Post visual alerts instructing residents and staff to report symptoms of respiratory infection to a designated person.
Resident Placement and Movement Restrictions	
	For residents with suspected or confirmed COVID-19 place in a single-bed room with door closed. If single rooms are unavailable, cohort residents with laboratory-confirmed COVID-19 in the same room with at least 6 feet between beds and a privacy curtain drawn between them. If unable to separate beds by 6 feet, separate as far as possible, no less than 3 feet apart.
	Cohort residents with suspected or confirmed COVID-19 infection on the same unit, wing, or building.
	Suspend group activities and close communal dining areas.
	Residents should stay and be served meals in their rooms.
	If residents with symptoms of COVID-19 must leave their room, they must perform hand hygiene and wear a face mask before leaving the room.
Transmission-Based Precautions and Other Infection Control Measures	
	Use Standard + Droplet + Contact + Eye Protection precautions when caring for residents with suspected or confirmed COVID-19. If available, fit-tested N-95 respirators are preferred, and should be prioritized if respiratory aerosol-generating procedures are being performed. If N-95 respirators are not available, standard surgical masks are acceptable.

	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
	Continue Standard + Droplet + Contact + Eye Protection precautions for 7 days after the resident's illness onset or 72 hours after the resolution of fever or respiratory signs and symptoms, whichever is longer.
	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 with COVID-19.
	Educate HCP on hand hygiene, respiratory hygiene and 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.
	Identify dedicated HCP to care for residents with COVID-19 and ensure they are N-95 respirator fit-tested.
	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 and that it is easily accessible both inside and outside every patient room.
	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) and clean and disinfect between each use.
	Minimize the number of HCP assigned to patient care activities for residents with COVID-19.
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 list of products with label claims against COVID-19. *https://www.epa.gov/sites/production/files/2020-03/documents/sars-cov-2-list_03-03-2020.pdf*
	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.
Managing Staff Illness & Exposure	
	Instruct HCP to not report to work if they have fever or respiratory symptoms. HCP must report symptoms to their supervisor.
	Instruct HCP who develop fever or respiratory symptoms while at work to immediately stop work, put on a facemask, alert their supervisor, leave the facility, and self-isolate at home.
	Exclude HCP with confirmed COVID-19 infection. Notify COB-CDPCP 510-981-5377 to determine criteria for return to work.
	Exclude HCP with fever ≥100°F (37.8C) and other ILI symptoms and who have either a negative COVID-19 test or have not been tested for COVID-19. Exclude until at least 7 days after symptom onset or at least 72 hours after they no longer have a fever (without the use of fever reducing medicines) and symptoms have improved, whichever is longer.

	After returning to work, HCP should wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
	Plan for worker absences. Do not require a healthcare provider's note for employees who are sick to validate their illness.
	Follow CDC guidance to assess the level of exposure risk for HCP who are exposed to a resident or fellow employee with COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
	If HCP have had a high-risk exposure to COVID-19, they should be excluded if at all possible. If critical staffing shortages endanger resident safety, these HCP may work while asymptomatic with the following precautions for 14 days after their last exposure: • Wear a face mask at all times while in the facility • Supervisor must assess for fever and respiratory symptoms before each shift HCP who have had a medium-risk exposure to COVID-19 may work while asymptomatic with the same precautions as for HCP with high-risk exposures.
	Instruct exposed but asymptomatic HCP to notify all other employers of their exposure to COVID-19.
Admissions, Re-admissions, and Transferring Residents	
	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.
	Do not place new admissions on units with residents who have COVID-19 or other respiratory illness.
	Do not transfer asymptomatic residents to units with residents who have COVID-19 or other respiratory illness.
	Consult with medical director and COB-CDPCP to determine if the facility should be closed to new admissions during a suspected or confirmed COVID-19 outbreak. • The duration of closures or limiting admissions should 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.
	Assess residents being newly admitted for fever and respiratory symptoms. Follow recommendations above for resident placement and movement restrictions and infection control precautions.
	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 determined by the period of potential virus shedding or recommended duration of transmission-based precautions.
	For returning residents who were hospitalized for COVID-19 and are clinically ready for discharge from the hospital, implement Standard + Droplet + Contact + Eye Protection precautions for 7 days after the resident's illness onset or 72 hours after the resolution of fever or respiratory signs and symptoms, whichever is longer.
	Before transferring residents with suspected or confirmed COVID-19 to other departments or facilities, communicate symptoms, signs, and laboratory test results to transport personnel and other HCP accepting the resident using the Infection Control Interfacility Transfer form (http://www.acphd.org/media/500766/acphd-infection-control-transfer-form.pdf). Include test results, date of illness onset, infection control precautions, and indicate that your facility is experiencing a suspected or confirmed COVID-19 outbreak.

Managing Family, Visitors, and Volunteers in a COVID-19 Outbreak	
	Limit visitation to end-of-life situations or when a visitor is absolutely essential to the resident's well-being and care. Exclude visitors who have: • Signs or symptoms of respiratory infection such as fever, cough, shortness of breath or sore throat • In the last 14 days, had 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 COB-CDPCP should review practices, obstacles to fully implementing control measures, and additional actions. Surveillance for new cases will continue for 28 days after the last case's onset of illness.	

Additional resources:

CDPH COVID-19 Guidance for California SNF webinar recording: **https://youtu.be/gYNkUkrwu1c**

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 for long-term care facilities: https://www.cdc.gov/longtermcare/