Principles for COVID-19 Cohorting in Long-term Care

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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 that includes physical and procedural controls to separate infectious residents and decrease risk of transmission to uninfected 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 multidrug-resistant organism.
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).
- Admit only residents with confirmed COVID-19 to the unit. Residents who have tested positive by an antigen test may need a confirmatory RT-PCR test prior to placement in the COVID-19 unit. See COVID-19 Testing Recommendations for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf).
- Post signs prominently at the point of entry to the COVID-19 unit. Consider using Enhanced Respiratory Precautions (www.health.state.mn.us/diseases/coronavirus/hcp/ppepresign.pdf) signage.

Set up clear PPE donning and doffing stations

- 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, 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. Consider using the posters found at CDC: Using Personal Protective Equipment (PPE) (www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html).

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 are 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](https://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 create a plan to manage the 14-day quarantine of new admissions, readmissions, and residents with a known or suspected COVID-19 exposure. 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. MDH recommends placement of these residents in a single room. In situations where single rooms are not available, designating a separate observation area is recommended to prevent the introduction or spread of COVID-19. Having a dedicated space in the facility for an observation unit facilitates both the physical and procedural separation of residents during their quarantine period.

Create a plan to manage new admissions and readmissions

If the resident was SARS-CoV-2-positive within the last 90 days and has met criteria to discontinue Transmission-based Precautions, and is currently asymptomatic, the resident may return or be admitted to the facility with standard care.

If the resident is not known or suspected to be infected with SARS-CoV-2 at the time of admission:

- A negative SARS-CoV-2 test is not required prior to admission.
- Because the resident may have had an exposure to SARS-CoV-2 prior to admission, place the resident in Transmission-based Precautions in a separate observation area, or ideally, in a single-person room for 14 days after admission. See [CDC: Preparing for COVID-19 in Nursing Homes](https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html).
  - Depending on the facility layout, a separate observation area may mean a dedicated wing or unit or a designated block of rooms set aside for this purpose.
  - If the resident becomes ill or exhibits symptoms of COVID-19 at any point during the 14 days, they should be placed in a single-person room.
- 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.
- Residents can be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission).
As part of universal source control measures, all residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room or when staff are within 6 feet. See CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

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

If the resident has had an exposure to anyone with SARS-CoV-2 (being within 6 feet for longer than 15 minutes during a 24-hour period):

- Resident should remain or be placed in a single-person room when at all possible.
- Roommates of residents with COVID-19 should be considered exposed and potentially infected, and if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after they were separated from the positive roommate. If possible, leave the exposed resident in the room if their roommate is moved to the COVID-19 unit.
  - Exposed residents may be permitted to share a room with other exposed residents as a last resort if space is not available for them to remain in a single room. See considerations for placement, in the next section.
- 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. Change gloves and gown when moving between residents, and perform hand hygiene after each glove removal.
- Test quarantined residents by RT-PCR immediately upon development of signs and symptoms.
  - If positive, move to a COVID-19 unit. If negative, keep resident in quarantine. Retesting (e.g., in two days) may be considered if signs and symptoms or differential diagnosis is not determined.
- Test quarantined asymptomatic residents by RT-PCR for SARS-CoV-2 on day five, six, or seven after exposure.
  - If positive, move to COVID-19 unit. If negative, keep resident in quarantine.
- Retest quarantined asymptomatic residents still in quarantine by RT-PCR around day 12-14.
▪ If positive, move to COVID-19 unit. If negative, return to standard care on day 15 post-exposure. Negative test results should not lead to early discontinuation of the 14-day quarantine.

▪ Residents can be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). A negative RT-PCR test is not required for discontinuation of the 14-day quarantine, but is encouraged to increase probability that the resident is not infected.

▪ As part of universal source control measures, all residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room or when staff are within 6 feet. See CDC: Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

▪ 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. See section above for additional detail about screening of long-term care residents.

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 14-day 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.

Symptomatic residents or those suspected to have SARS-CoV-2 infection should be prioritized for placement in a single-person room.

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 (www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html).

▪ Residents recently recovered from COVID-19 within the previous 90 days who have been released from Transmission-based Precautions and are no longer symptomatic could be considered as a roommate for a quarantined resident. See CDC: Preparing for COVID-19 in Nursing Homes (www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html).

▪ For roommates not admitted on the same calendar day, the 14-day quarantine period of the first admitted resident should be restarted the day of the new roommate’s admission. For example: Newly admitted Resident B is placed in a shared room with Resident A on day five of quarantine. Resident A’s
14-day quarantine period would be restarted to begin on the day Resident B was placed in their room (i.e., five days plus 14 days equals 17 total days in quarantine for Resident A).

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 roommates, ensuring that they can be at least 6 feet apart.
- Assess new or additional engineering controls that may be put in place. For engineering control considerations, see Heating, Ventilation, and Air Conditioning (HVAC) and Fan Considerations for Long-term Care during COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/hvac.pdf).

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, etc.) between each resident use.
- Residents should wear a cloth face covering or facemask (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 MDH 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.

- Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf)
- If meals are served in the room, residents should remain at least 6 feet apart during meals.

**Testing**

- Testing at the end of a resident’s 14-day observation period can be considered to increase probability that the resident is not infected. However, one or more negative tests during the 14-day observation period would not shorten the duration of Transmission-based Precautions, as the resident would still be in their incubation 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.


**Resources**

  See COVID-19 Action Plan for Congregate Settings and other resources.

- Long-term Care: COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html)


