1. **Assess COVID-Preparedness -- Must have in place planning for managing PUI/COVID 19 resident in your building** 
   1. Review your plan for isolation and reduced exposure to other residents and staff
   2. Evaluate staffing needs and educational support
   3. Provide additional staff training
   4. Equipment that might be needed
   5. Medication that might be needed and alternates for any in short supply
   6. Communication plan for staff, residents, and families as well as community
   7. Review CDC guidance for managing COVID 19 in your facility
   8. Engage your staff and practitioners in this preparation and utilize this document to assist with management for “treat in place”.
   9. Reduce unnecessary medications and simplify regimens for all residents
   10. Discontinue prn nebulizers, convert nebs to MDI with or w/o spacer as appropriate, if nebs needed try to decrease frequency throughout the building.
2. **RESIDENT SURVEILLANCE: All residents should be screened at least twice a day using a standard tool. Active staff screening should also be in place.**
   1. Includes those on comfort care/hospice given being done for public health surveillance
   2. If residents refuse, consider quarantine and care plan refusal. Continue efforts and screen based on what observations you can make
   3. Responsible party should be aware of heightened surveillance policy for the facility
3. **IDENTIFICATION OF A COVID+ or COVID-SUSPICIOUS PATIENT:** If residents screen positive initiate a full concurrent review based on facility policies and procedures and notify the treating or covering practitioner.
   1. Nursing assessment to assess for other alternative causes of the symptoms including review of record for other diagnosis such as seasonal allergies, asthma, COPD, new medications that might cause cough, etc.
   2. If needed facilitate a practitioner remote visit to complement nursing assessment
   3. If suspicion of any infectious respiratory condition i.e. flu, ILI, COVID-19 initiate infection control precautions for infectious respiratory condition i.e. contact and droplet precautions and be sure to include EYE protection
      1. Move resident to separate room and do not expose them to another potential COVID positive patient until you have completed your evaluation-DO NOT COHORT THEM WITH ANOTHER ILL PATIENT UNTIL YOU DETERMINE CAUSE OF CURRENT SYMPTOMS.
      2. Roommate(s) without symptoms should remain in their room but should also isolate
   4. Initiate any work up ordered by the practitioner
      1. Lab work
      2. Chest x-ray
      3. Nasal swab for flu especially if flu prevalent in community and/or another flu case in the building
      4. Consider COVID-19 testing and initiate any procedures for PUI for COVID (notify DPH) and make sure your facility Infection Preventionist, DON, Administrator, and Medical Director are notified you have a PUI.
      5. PLEASE NOTE: A positive flu test does not rule out or pre-empt investigation for COVID at this time. Given shortage of swabs (same swab for both flu and COVID), as well as diminishing rates of flu throughout the state, influenza testing should not be automatic and should only be performed when practitioners believe positive flu will alter care or cohorting
      6. Follow P and P for obtaining specimens including appropriate use of PPE
   5. Initiate your facility respiratory illness line listing or add to any respiratory illness line listing you have initiated in your current surveillance efforts and identify this as an index COVID 19 case
   6. When decision is made to test for COVID they are now a PUI but should NOT be cohorted with a COVID positive resident until results available
4. **MANAGEMENT OF COVID+ or COVID-suspicious patients:** Management of PUI/COVID positive resident in your building need to be coordinated with treating practitioner and this guidance should be shared with them. Discuss with medical director if practitioner not comfortable with management in place with medically stable resident
   1. Review care directives/goals of care for treatment and consider changes given what is known about clinical course and prognosis given residents medical history. Fill out DMOST when appropriate.
   2. Make sure responsible party understands treat in place as a better alternative to ER/hospitalization while the resident is clinically stable. The reasons being 1. Even if a patient has coronavirus, patients with mild symptoms should be treated in their facility as there is not much more the hospital can do and 2. As there is a concentration of COVID-19 cases in the hospital, there is a chance even if you do not enter the hospital with COVID-19, you might contract the virus while you are there.
   3. Initiate full assessment every 4-8 hours including pulse oximetry
   4. Consider more frequent vital signs up to q2 hours if resident seems to be deteriorating particularly pulse oximetry where decline of greater than 3% from baseline may indicate impending respiratory failure(See below in Section 5 for Indications for Possible Transfer) Report changes to practitioner based on your practitioner notification parameters. If practitioner not available in timely fashion, contact your medical director for guidance based on your facility policy and procedure for practitioner notification of change in condition.
   5. Contact/droplet/private room with door closed/private bathroom. If you do not have a private room that can be used this may be a reason to consider transfer since you cannot meet the IC needs to protect other residents.
   6. Limit staff interacting with resident and cohort staff
5. **PUI/COVID positive treatment recommendations:** THERE ARE CURRENTLY NO APPROVED MEDICAL TREATMENTS FOR COVID 19. Generally, any treatment should only be done as part of a study at this point in time or in collaboration with hospital consultants. As this change’s guidance will be updated.
   1. Antipyretics to keep temperature below 100 if needed consider standing order to avoid the discomfort of temp spikes and help with fluid management) There is currently no evidence that NSAIDs are associated with any increased risk to the resident than baseline.
   2. Review all medications and discontinue any unneeded medications. If oral intake poor, consider stopping or lowering doses of diuretics to avoid dehydration.
   3. Avoid use of nebulizers and use MDI with a spacer if bronchodilators are felt to be needed. If needed, use sparingly. If you are to use nebulize, staff MUST wear N-95 mask during treatments.
   4. Use other symptomatic treatment such as nasal decongestants, cough medication as needed
   5. Antibiotic therapy may be needed if it appears resident has developed a bacterial infection based on new infiltrate, changing symptoms, and rising white blood cell count. Selection of antibiotics should be in keeping with your facility guidelines as part of your antibiotic stewardship program for bacterial pneumonia. To limit IV access, consider oral or IM regimens.
   6. Steroids have not demonstrated any benefit to date and should only be utilized if indicated for another underlying medical condition. Need to have careful discussion about changing the use of any immunosuppressants a resident may be taking regarding risks and benefits
   7. Maintain hydration but do not overhydrate. Try to avoid IVF because of the need for additional personnel. Consider establishing policy and procedure for hypodermoclysis which avoids the need for intravenous hydration
   8. Monitor blood work as needed
   9. Supplemental oxygen to maintain oxygen saturation greater than 92% or greater than 89% for those that may have low baseline sat because of underlying pulmonary disease
   10. Consider narcotics to manage dyspnea particularly for those where the plan is to treat in place and NOT transfer to the hospital. Be sure you will have ready access to palliative care medications in your building.
   11. For residents who deteriorate rapidly and arrest in house you will need to consider the need for additional PPE and perhaps a COVID positive cash cart.
   12. Update practitioner daily via phone or tele visit or more often as needed. CMS had a telemedicine tool kit for long-term care as a resource for practitioners and facilities.
   13. Update responsible party daily or with significant change. Attempt to arrange remote visit if resident or responsible party request but recognize need to limit traffic in the resident’s room

YOU WILL NEED SEPARATE IPAD/EQUIPMENT FOR PUI AND COVID POSITIVE RESIDENT COMMUNICATION FOR TELEVISITS AND FAMILY VISITS

1. **Indications for possible hospital transfer of PUI/COVID 19**

* NOTE:
* This guidance is to be used for non-emergency transfer indications only. Emergency transfers should be undertaken per existing facility protocols.
* Due consideration should be given for alternative diagnoses and interventions undertaken as appropriate.
* DNR/DNH/DNI directives should be revisited frequently and resident goals of care addressed.
* Decision for transfer should only be made after evaluation by an independently-licensed practitioner.
* Nothing in this guidance should be interpreted as to override the clinical judgment of the independently licensed practitioner responsible for the patient.
  1. Vitals and Clinical Presentation
     1. RR >28
     2. HR > 120 or >25% increase from baseline
     3. Systolic BP <90 or > 20% decrease from baseline
     4. Oxygen sat <92% on 6L or > 4% decrease from baseline if > 92%
     5. Core temperature <95 degrees Fahrenheit
     6. Altered mental status
  2. Labs and Studies (if performed)
     1. Increase in Creatinine>2X baseline
     2. Anion gap >24
     3. Metabolic abnormalities not improving despite appropriate intervention causing evidence of systemic insult
     4. Evidence of progressive end-organ damage
     5. EKG changes (if available based on clinical need)
  3. Ability to Care for the Patient
     1. Resident needs beyond facility capabilities
     2. Facility has implemented and exhausted all appropriate care measures

1. **Additional Actions for PUI/COVID 19** 
   1. Reassess goals of care yet again with resident and responsible party
   2. DO NOT INITIATE CPAP AND BIPAP in the building. If the resident has CPAP/BIPAP already you need to be using n-95 mask when in residents room given the risk of aerosolization to HCW. If you are a respiratory/ventilator unit with pulmonary support, you might be able to consider.
   3. If this is a patient who may benefit and meets criteria to hospitalize transfer early is preferred if they are deteriorating since COVID 19 residents can deteriorate quickly once they demonstrate respiratory deterioration.
   4. Facility is not able to manage isolation needs because of lack of PPE, room placement, volume of residents, the facility should should contact DPH immediately so they can provide additional advice/assistance
   5. Decision to transfer should only be made after a remote or face to face assessment by an independently-licensed practitioner
   6. Continue to reconsider alternative diagnosis and interventions as clinical course evolves.
2. For patients who require off site dialysis
   1. Notify the dialysis center that the patient is now a PUI or COVID positive. Dialysis centers have their own policies and procedures related to the COVID 19 emergency.
   2. Prior to any dialysis patient testing positive it is wise to have dialysis patients move to an area of your facility where you are cohorting new admission on quarantine because of possible preadmission exposure since these residents are leaving your building and are potentially exposed to others with COVID 19
3. Hospice and palliative care services
   1. Consider for residents who elect no hospital transfer and whose condition is deteriorating. Nursing homes should be thinking about palliative care as part of COVID 19 management even for those that are mildly symptomatic so the following might be considered
   2. Additional psychosocial support with facility staff or facility behavioral health services that can be done remotely with televists
   3. Additional palliative medications such as anxiolytics, narcotics, anti-nausea medications, medications to manage delirium as part of the illness may be needed. Typically, we avoid sedating medications that may impact respiratory drive, but these medications may be needed to manage symptoms in keeping with goals of care.
   4. Consider your formal hospice arrangements and hospice consultation. Facilities want to consider utilizing a preferred provider for any onsite visits that might be needed to limit traffic in your building to minimize risk to facility as well as hospice workers. Some hospice work can be done remotely.
4. Staff support/staffing needs/what PPE will it take/PUI or COVID positive/ should be determined in advance and plans in place to manage a PUI/COVID 19 positive resident