

Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19

Interim guidance
21 March 2020



Background

On 30 January 2020, WHO announced that the COVID-19 outbreak was a Public Health Emergency of International Concern. Initially, most cases were reported from China and among individuals with travel history to China. Please refer to the latest [situation reports for COVID-19](#).

COVID-19 is an acute respiratory illness caused by a novel human coronavirus (SARS-CoV-2, called COVID-19 virus), which causes higher mortality in people aged ≥ 60 years and in people with underlying medical conditions such as cardiovascular disease, chronic respiratory disease, diabetes and cancer.

Long-term care facilities (LTCFs), such as nursing homes and rehabilitative centers, are facilities that care for people who suffer from physical or mental disability, some of who are of advanced age. The people living in LTCF are vulnerable populations who are at a higher risk for adverse outcome and for infection due to living in close proximity to others. Thus, LTCFs must take special precautions to protect their residents, employees, and visitors. Note that infection prevention and control (IPC) activities may affect the mental health and well-being of residents and staff, especially the use of PPE and restriction of visitors and group activities. For further information on resilience during the time of COVID, see [Mental health and psychosocial considerations during COVID-19 outbreak](#).

This interim guidance is for LTCF managers and corresponding IPC focal persons in LTCF. The objective of this document is to provide guidance on IPC in LTCFs in the context of COVID-19 to 1) prevent COVID-19-virus from entering the facility, 2) prevent COVID-19 from spreading within the facility, and 3) prevent COVID-19 from spreading to outside the facility. WHO will update these recommendations as new information becomes available. All [technical guidance for COVID-19](#) is available online.

System and service coordination to provide long-term care

- Coordinate with relevant authorities (e.g. Ministry of Health, Ministry of Social Welfare, Ministry of Social Justice, etc.) should be in place to provide continuous care in LTCFs.

- Activate the local health and social care network to facilitate continuous care (clinic, acute-care hospital, day-care center, volunteer group, etc.)
- Facilitate additional support (resources, health care providers) if any older person in LTCFs is confirmed with COVID-19.

Prevention

IPC focal point and activities

LTCFs should ensure that there is an IPC focal point at the facility to lead and coordinate IPC activities, ideally supported by an IPC team with delegated responsibilities and advised by a multidisciplinary committee. WHO guiding principles for IPC can be found [online](#).

At a minimum, the IPC focal point should:¹

- Provide COVID-19 IPC training¹ to all employees, including:
 - an overview of COVID-19: <https://openwho.org>;
 - hand hygiene and respiratory etiquette;
 - standard precautions; and
 - COVID-19 transmission-based precautions.²
- Provide information sessions for residents on COVID-19 to inform them about the virus, the disease it causes and how to protect themselves from infection
- Regularly audit IPC practices (hand hygiene compliance) and provide feedback to employees.
- Increase emphasis on hand hygiene and respiratory etiquette:
 - Ensure adequate supplies of alcohol-based hand rub (ABHR) (containing at least 60% alcohol) and availability of soap and clean water. Place them at all entrances, exits and points of care
 - Post reminders, posters, flyers around the facility, targeting employees, residents, and visitors to regularly use ABHR or wash hands.
 - Encourage hand washing with soap and water for a minimum of 40 seconds or with ABHR for a minimum of 20 seconds.³
 - Require employees to perform hand hygiene frequently, in particular at the beginning of the workday, before and after touching residents, after using the toilet, before and after preparing food, and before eating.⁴

¹ Training videos on COVID-19, including IPC, can be found here:

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/online-training>.

- Encourage and support residents and visitors to perform hand hygiene frequently, in particular when hands are soiled, before and after touching other people (although this should be avoided as much as possible), after using the toilet, before eating, and after coughing or sneezing.
- Ensure adequate supplies of tissues and appropriate waste disposal (in a bin with a lid).
- Post reminders, posters, flyers around the facility, targeting employees, residents, and visitors to sneeze or cough into the elbow or to use a tissue and dispose of the tissue immediately in a bin with a lid.
- A guide to [local production of WHO-recommended ABHR](#) is available
- Maintain high standards of hygiene and sanitation practice. Guidance on [water, sanitation, laundry, and waste management for COVID-19](#) is available:.
- Provide annual influenza vaccination and pneumococcal conjugate vaccines to employees and staff, according to local policies, as these infections are important contributors to respiratory mortality in older people.

Physical distancing in the facility

Physical distancing in the facility should be instituted to reduce the spread of COVID-19:

- Restrict the number of visitors (see below)
- For group activities ensure physical distancing, if not feasible cancel group activities
- Stagger meals to ensure physical distance maintained between residents or if not feasible, close dining halls and serve residents individual meals in their rooms
- Enforce a minimum of 1 meter distance between residents
- Require residents and employees to avoid touching (e.g., shaking hands, hugging, or kissing).

Visitors

In areas where COVID-19 transmission has been documented, access to visitors in the LTCFs should be restricted and avoided as much as possible. Alternatives to in-person visiting should be explored, including the use of telephones or video, or the use of plastic or glass barriers between residents and visitors.

All visitors should be screened for signs and symptoms of acute respiratory infection or significant risk for COVID-19 (see screening, above), and no one with signs or symptoms should be allowed to enter the premises.

A limited number of visitors who pass screening should be allowed entry to long-term care only on compassionate grounds, specifically if the resident of the facility is gravely

ill and the visitor is their next-of-kin or other person required for emotional care. Visitors should be limited to one at a time to preserve physical distancing. Visitors should be instructed in respiratory and hand hygiene and to keep at least 1 meter distance from residents. They should visit the resident directly upon arrival and leave immediately after the visit.

Direct contact by visitors with residents with confirmed or suspected COVID-19 should be prohibited.

Note that in some settings, complete closure to visitors is under the jurisdiction of local health authorities.

Response

The response to COVID-19 in LTCFs settings is based on early recognition, isolation, care, and source control (prevention of onward spread for an infected person).

Early recognition

Early identification, isolation and care of COVID-19 cases is essential to limit the spread of the disease in the LTCFs.

Prospective surveillance for COVID-19 among residents and staff should be established:

- Assess health status of any new residents at admission to determine if the resident has signs of a respiratory illness including fever² and cough or shortness of breath.
- Assess each resident twice daily for the development of a fever ($\geq 38C$), cough or shortness of breath.
- Immediately report residents with fever or respiratory symptoms to the IPC focal point and to clinical staff.

Prospective surveillance for employees should be established:

- Ask employees to report and stay at home if they have fever or any respiratory illness.
- Follow up on employees with unexplained absences to determine their health status.
- Undertake temperature check for all employees at facility entrance.
- Immediately remove from service any employee who is visibly ill at work and refer them to their health care provider.
- Monitor employees and their contact with residents, especially those with COVID-19; use the [WHO risk assessment tool](#) to identify employees who have been at high risk of exposure to COVID-19.

Prospective surveillance for visitors should be established:

- All visitors should be screened before being allowed to see residents, including for fever, respiratory illness and if they have had recent contact with someone infected with COVID-19.
- Visitors with fever or any respiratory illness should be denied access to the facility.

² Older people, particularly those living with co-morbidities or frailty often present non-specific signs and symptoms in response to infection, including reduced alertness, reduced

mobility, or diarrhoea and sometimes do not develop fever: this may be true for COVID-19, so such changes should alert staff to the possibility of new COVID infection.

- Visitors with significant risk factors for COVID-19 (close contact to a confirmed case, recent travel to an area with community transmission [applies only to those areas that do not have current community transmission]) should be denied access to the facility.

Source control (care for the COVID-19 patient and prevention of onward transmission)

If a resident is suspected to have, or is diagnosed with, COVID-19, the following steps should be taken:

- Notify local authorities about any suspected case and isolate residents with onset of respiratory symptoms.
- Place a medical mask on the resident and on others staying in the room.
- Ensure that the patient is tested for COVID-19 infection according to local surveillance policies and if the facility has the ability to safely collect a biological specimen for testing.
- Promptly notify the patient and appropriate public health authorities if the COVID-19 test is positive.
- WHO recommends that COVID-19 patients be cared for in a health facility, in particular patients with risk factors for severe disease which include age over 60 and those with underlying comorbidities (see [Clinical management of severe acute respiratory infection \(SARI\) when COVID-19 disease is suspected](#)). A clinical assessment is required by a medical professional with respect to disease severity, for the potential patient transfer to an acute health facility. If this is not possible or indicated, confirmed patients can be isolated and cared for at the LTCF.
- Employees should use contact and droplet precautions (see below) when tending to the resident, entering the room, or when within 1 m of the resident.
- If possible, move the COVID-19 patient to a single room.
- If no single rooms are available, consider cohorting residents with suspected or confirmed COVID-19.
 - Residents with suspected COVID-19 should be cohorted only with other residents with suspected COVID-19; they should not be cohorted with residents with confirmed COVID-19.
 - Do not cohort suspected or confirmed patients next to immunocompromised residents.
- Clearly sign the rooms by placing IPC signs, indicating droplet and contact precautions, at the entrance of the room.⁵
- Dedicate specific medical equipment (e.g. thermometers, blood pressure cuff, pulse oximeter, etc.) for the use of medical professionals for resident(s) with suspected or confirmed COVID-19.
- Clean and disinfect equipment before re-use with another patient.⁶
- Restrict sharing of personal devices (mobility devices, books, electronic gadgets) with other residents.

Precautions and personal protective equipment (PPE)

When providing routine care for a resident with suspected or confirmed COVID-19, contact precaution and droplet precautions should be practiced. Detailed instructions on [precautions for COVID-19](#) are available.

- PPE should be put on and removed carefully following recommended procedures to avoid contamination.
- Hand hygiene should always be performed before putting on and after removing PPE.
- Contact and droplet precautions include the following PPE: medical mask, gloves, gown, and eye protection (goggles or face shield).
- Employees should take off PPE just before leaving a resident's room.
- Discard PPE in medical waste bin and preform hand hygiene.

When caring for any residents with suspected or confirmed COVID-19 practice contact plus airborne precautions during any aerosol-generating procedures (e.g. tracheal suctioning, intubation; refer to [Infection prevention and control during health care](#)). Airborne precautions include the use of N95, FFP2, or FFP3 respirators or equivalent level mask, gloves, gown and eye protection (goggles or face shield). Note: use N95 mask only if the LTCFs has a programme to regularly fit-test employees for the use of N95 masks.

Cleaners and those handling soiled bedding, laundry, etc., should wear PPE, including mask, gloves, long sleeve gowns, goggles or face shield, and boots or closed toe shoes. They should perform hand hygiene before putting on and after removing PPE.

Environmental cleaning and disinfection

Hospital-grade cleaning and disinfecting agents are recommended for all horizontal and frequently touched surfaces (e.g., light switches, door handles, bed rails, bed tables, phones) and bathrooms being cleaned at least twice daily and when soiled.

Visibly dirty surfaces should first be cleaned with a detergent (commercially prepared or soap and water) and then a hospital-grade disinfectant should be applied, according to manufacturers' recommendations for volume and contact time. After the contact time has passed, the disinfectant may be rinsed with clean water.

If commercially prepared hospital-grade disinfectants are not available, the LTCFs may use a diluted concentration of bleach to disinfect the environment. The minimum concentration of chlorine should be 5000 ppm or 0.5% (equivalent to a 1:9 dilution of 5% concentrated liquid bleach).⁸

Laundry

Soiled linen should be placed in clearly labelled, leak-proof bags or containers, after carefully removing any solid excrement and putting it in a covered bucket to be disposed of in a toilet or latrine.

Machine washing with warm water at 60–90°C (140–194°F) with laundry detergent is recommended. The laundry can then be dried according to routine procedures.

If machine washing is not possible, linens can be soaked in hot water and soap in a large drum using a stick to stir and being careful to avoid splashing. The drum should then be emptied, and the linens soaked in 0.05% (500 ppm) chlorine for approximately 30 minutes. Finally, the laundry should be rinsed with clean water and the linens allowed to dry fully in sunlight.

Restriction of movement/ transport

If a resident has suspected or confirmed COVID-19 infection, the LTCFs should:

- Confirmed patients should not leave their rooms while ill.
- Restrict movement or transport of residents to essential diagnostic and therapeutic tests only.
 - Avoid transfer to other facilities (unless medically indicated).
- If transport is necessary, advise transport services and personnel in the receiving area or facility of the required precautions for the resident being transported. Ensure that residents who leave their room for strictly necessary reasons wear a mask and adhere to respiratory hygiene.
- Isolate COVID-19 patients until they have two negative laboratory tests for COVID-19 taken at least 24 hours apart after the resident's symptoms have resolved. Where testing is not possible, WHO recommends that confirmed patients remain isolated for an additional two weeks after symptoms resolve.

LTCFs should be prepared to accept residents who have been hospitalized with COVID-19, are medically stable and are able to care for the patients in isolated rooms. LTCFs should use the same precautions, patient restrictions, environmental cleaning, etc., as if the resident had been diagnosed with COVID-19 in the LTCFs.

Reporting

Any suspected or confirmed COVID-19 cases should be reported to relevant authorities as required by law or mandate.

Minimizing the effect of IPC on mental health of residents, employees, and visitors

Considerations for care

- Guidance for the [clinical care for COVID-19 patients](#) is available.
- Older people, especially in isolation and those with cognitive decline, dementia, and those who are highly care-dependent, may become more anxious, angry, stressed, agitated, and withdrawn during the outbreak or while in isolation.
- Provide practical and emotional support through informal networks (families) and health care providers.
- Regularly provide updated information about COVID-19 to residents, employees, and staff.

Support health care workers and caregivers

- As much as possible, protect staff from stress both physically and psychologically so they can fulfil their roles, in the context of a high workload and in case of any unfortunate experience as a result of stigma or fear in their family or community.⁹
- Regularly and supportively monitor all staff for their wellbeing and foster an environment for timely communication and provision of care with accurate updates.
- Consider rest and recuperation and alternate arrangements as needed.
- Mental health and psychosocial support¹⁰ and psychological first aid training¹¹ can benefit all staff in having the skills to provide the necessary support in the LTCFs.
- Staff need to ensure that safety measures are in place to prevent excessive worries or anxiety within the LTCFs.

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WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire 2 years after the date of publication.

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