

# COVID-19 Patient/Resident Management in Post-acute Care Settings



COVID-19 has significantly impacted healthcare facilities, especially in the post-acute care setting. COVID-19 has a broad clinical presentation, an incubation period lasting up to 14 days, and can be transmitted by symptomatic, pre-symptomatic, or asymptomatic individuals. Several elements of infection prevention and control (IPC) can be utilized to limit the spread of SARS-CoV-2 (the virus that causes COVID-19) in a facility. These elements include encouraging all patients/residents and healthcare personnel (HCP) to remain up to date with all recommended COVID-19 vaccine doses, source control, testing, and [empiric transmission-based precautions \(TBP\)](#) or isolation measures for individuals with suspected or confirmed SARS-CoV-2 infection. Facilities should review or **establish a plan** for how SARS-CoV-2 exposures will be investigated and managed and how contact tracing will be performed. Outbreak response plans should include control measures such as appropriate placement of patients/residents, staffing, and personal protective equipment (PPE) use. Refer to CDC [Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 and Influenza Viruses are Co-circulating](#) for additional considerations when applicable.

## Patient/resident management

Cohorting is only one element of IPC used for outbreak control. The facility should routinely monitor and update its facility-specific outbreak response plan. This plan should consider resources, including the availability of testing, vaccines, PPE, equipment (such as stethoscopes and blood pressure machines), and staffing. Refer also to the [Appendix: Patient/Resident Management Decision Tree](#) for additional information on the management of patients/residents.

### SARS-CoV-2 positive patients/residents

These individuals include symptomatic and asymptomatic (including pre-symptomatic) patients/residents who test positive for SARS-CoV-2, regardless of vaccination status. Any admissions known to be positive who have not met the criteria for discontinuation of TBP should be managed as a positive SARS-CoV-2 patient/resident. SARS-CoV-2 positive patients/residents should be placed in a single-person room. If limited single rooms are available patients/residents should remain in their current location. The door should be kept closed (if safe to do so). Ideally, the patient/resident should have a dedicated bathroom. Facilities could consider designating entire units within a facility, with dedicated HCP, to care for patients/residents with SARS-CoV-2 infection when the number of patients/residents with SARS-CoV-2 infection is high. Refer to the NJDOH [Quick Reference: Discontinuation of Transmission-Based Precautions for Persons with COVID-19 in Healthcare Settings](#) for criteria to end TBP.

### Symptomatic patients/residents being evaluated for COVID-19

Regardless of vaccination status, anyone with even mild symptoms consistent with COVID-19 should receive a viral test for SARS-CoV-2 as soon as possible. Patients/residents with suspected COVID-19 should be placed in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient/resident should have a dedicated bathroom. If limited single rooms are available, or if numerous patients/residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, they should remain in their current location pending the return of test results. These patients/residents should not be cohorted with patients/residents with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.

The decision to discontinue empiric TBP by excluding the diagnosis of current SARS-CoV-2 infection for a patient/resident with symptoms of COVID-19 can be made based upon having negative results from at least one viral test:

- If using nucleic acid amplification test (NAAT) (e.g., molecular), a single negative test is sufficient in *most* circumstances. **If a higher level of clinical suspicion for SARS-CoV-2 infection exists (e.g., close contact), consider maintaining TBP and confirming with a second negative NAAT.**

- If using an antigen test, a negative result should be confirmed by either a negative NAAT or a second negative antigen test taken at least 48 hours after the first negative test.

Because NAAT can sometimes remain positive for a prolonged period of time, those patients/residents who become symptomatic after having had COVID-19 within the past 90 days should receive an antigen test to identify a new infection.

**Symptomatic patients/residents who are also identified as having had close contact with someone with SARS-CoV-2 should receive a series of three viral tests.** Testing is recommended immediately and, if negative, again 48 hours after the first negative test and, if also negative, again 48 hours after the second negative test. While the decision to discontinue empiric TBP may be made following a second negative viral test, all these patients/residents should continue viral testing with a third viral test. All these individuals should also continue wearing well-fitting source control for 10 days after exposure.

Symptomatic patients/residents who are also identified as having had close contact with someone with SARS-CoV-2 who, for whatever reason, are not tested as per the preceding paragraph, should be maintained on empiric TBP for 10 days from symptom onset.

#### **Asymptomatic patients/residents who have had close contact with someone with SARS-CoV-2**

These patients/residents should wear source control for 10 days after exposure, and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested.<sup>1</sup> Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, 48 hours after the second negative test. **Testing will typically be on day 1 (where the day of exposure is day 0), day 3, and day 5.**

In general, room restrictions for these individuals are not required; however, empiric TBP may be considered when the patient/resident is:

- Unable to be tested or wear source control as recommended for the 10 days following their exposure
- Moderately to severely immunocompromised
- Residing on a unit with others who are moderately to severely immunocompromised, and/or
- Residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Asymptomatic patients/residents who have had close contact with someone with SARS-CoV-2 infection and are **placed in empiric TBP** should be maintained in TBP for the following time periods:

- Patients/residents can be removed from TBP after day 7 following the exposure (count the day of exposure as day 0) if they **do not develop symptoms** and all viral testing (as described for asymptomatic individuals following close contact) is negative.
- If viral testing is not performed, patients/residents can be removed from TBP after day 10 following the exposure (count the day of exposure as day 0) if they **do not develop symptoms**.

**Asymptomatic admissions** should be managed based on facility policy/procedure and risk assessment.

## **Outbreak response**

The approach to an outbreak investigation could involve either **contact tracing** or a **broad-based approach** (e.g., targeting a unit, floor, or other specific areas of the facility); however, a **broad-based approach is preferred if:**

- All potential close contacts cannot be identified; or

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<sup>1</sup> Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

- All close contacts and HCP with higher-risk exposures cannot be managed with contact tracing; or
- Contact tracing fails to halt transmission

**Source control** is recommended for individuals in healthcare settings who reside or work in a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days.

### Contact tracing approach

Contact tracing should be conducted to identify close contacts (any patient/resident/visitor spending at least 15 cumulative minutes at a distance less than 6 feet to an infected person during a 24-hour period, regardless of whether either/both of them were wearing masks) of laboratory-confirmed or probable COVID-19 cases:

- For symptomatic cases, contact tracing efforts should focus on any exposures to the case from **48 hours prior to symptom onset** until the case meets the criteria for discontinuation of TBP.
- For asymptomatic cases, contact tracing should include identifying any exposures to that case from **48 hours before the first positive viral test** until the case meets the criteria for discontinuation of TBP.

Perform SARS-CoV-2 viral testing for all patients/residents identified as close contacts who have not been previously positive within the past 30 days. Patients/residents with close contact should have **a series of three viral tests** for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after exposure) and, if negative, 48 hours after the first negative test and, if also negative, again 48 hours after the second negative test. **This will typically be on days 1, 3, and 5 (where the day of exposure is day 0).** For HCP exposures, refer to the NJDOH [Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel](#).

### Broad-based approach

Perform SARS-CoV-2 **testing for all** patients/residents and staff on the affected unit(s) - who have not been previously positive within the past 30 days - immediately and, if negative, again 48 hours after the first negative test and, if also negative, again 48 hours after the second negative test. If additional cases are identified, testing should continue on the affected unit(s) or facility-wide **every 3-7 days until there are no new cases for 14 days**. If antigen testing is used, more frequent testing (every 3 days) should be considered. Refer to the NJDOH [Outbreak Management Checklist](#) for outbreak control measures: Communication and Reporting; Screening, Testing, and Response; Infection Prevention and Control; Contact Tracing or Broad-based Approach; Patient/Resident Management; and Staff Management.

### Cohorting

Cohorting is the practice of grouping patients/residents infected or colonized with the same infectious agent to confine their care to one area and prevent contact with susceptible patients/residents. During outbreaks, HCP may be assigned to a cohort of patients/residents to limit opportunities for transmission further. To the extent possible, the same HCP should be responsible for the care and services provided to individual cohorts. Ensure HCP prioritize rounding in a "well to ill" flow to minimize the risk of cross-contamination (i.e., beginning with patients/residents on standard precaution and working towards patients/residents on TBP, then finally outbreak areas). In outbreak areas/units, HCP caring for COVID-19 positive patients/residents should be dedicated to this care unit/area when it is in use. If possible, HCP should avoid working on the COVID-19 care unit and other units during the same shift.

When resources permit, facilities should dedicate equipment to individual cohorts. Equipment **should not be shared between individuals on TBP and those cared for with standard precautions**. If this is not possible, equipment should be used by rounding in a "well to ill" flow to minimize the risk of cross-contamination. Facilities may consider using disposable equipment for individuals on TBP. All equipment should be **appropriately cleaned and disinfected** according to the manufacturer's instructions between patient/resident use. Refer to the Environmental Protection Agency (EPA) website for more information on [List N: Disinfectants for Coronavirus \(COVID-19\)](#) and [Selected EPA-Registered Disinfectants](#) to ensure coverage for commonly seen pathogens.

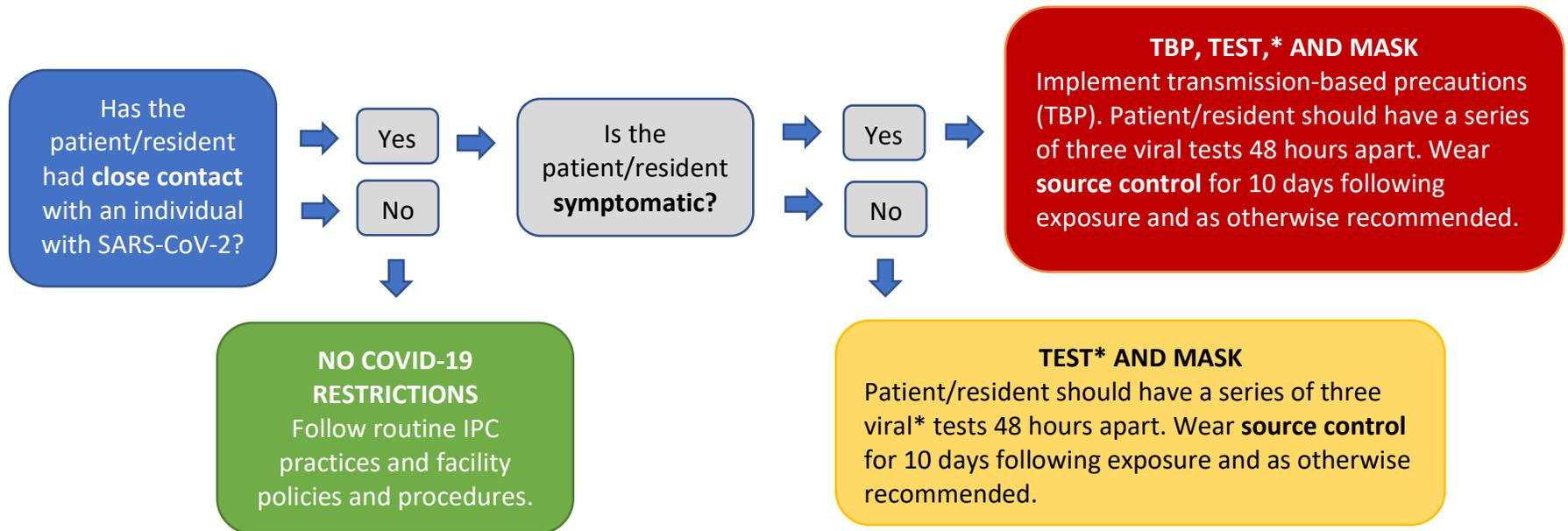
## Resources

CDC *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic* <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

CDC *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)* <https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html>

## Appendix: Patient/Resident Management Decision Tree

This decision tree is intended to guide management of all patients/residents during the SARS-CoV-2 pandemic.



\* Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test (instead of a NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.