Washington State Department of Health

Updated September 8, 2021

Recommendations for Cohorting in Long-Term Care Facilities During the COVID-19 Pandemic

Using infection prevention and control measures is critical to prevent entry and spread of COVID-19 in long-term care facilities.

Cohorting is an infection prevention and control measure that groups together residents with the same infectious condition and no other infection.

Benefits of Cohorting residents with known or suspected COVID-19:

- Limits the risk of spreading COVID-19 by using dedicated staff to care for only COVID-19 positive residents.
- Allows for conservation of PPE resources and extended use of personal protective equipment (PPE) such as respirators, face masks and eye protection when supplies are limited.

This guidance outlines best practices, definitions, and considerations for cohorting long-term care residents during the COVID-19 pandemic, including:

- Definitions
- Isolation vs. Quarantine for Long-term Care Facility Residents
- COVID-19 Unit Best Practices
- Observation/Quarantine Best Practices

Definitions:

Cohorting: Creating distinct roommates or small groups of COVID-19 positive residents that stay together to ensure minimal or no interaction with other residents. This practice can help prevent the spread of COVID-19 by limiting cross-over of residents and health care personnel (HCP).

COVID-19 Unit: Several rooms or a dedicated area for cohorting a larger number of COVID-19 positive residents during a COVID-19 outbreak.

Extended Use: The practice of wearing the same PPE continuously between encounters with multiple patients with the same illness, without changing PPE between patient encounters. PPE is doffed and discarded, and new PPE is donned for the next set of encounters. Extended use is well-suited to situations when multiple patients with the same infectious disease diagnosis are cohorted. Staff should change PPE between caring for residents with COVID-19 and without COVID-19.

Exposure: For residents in long-term care facilities, within 6 ft and cumulative 15 minutes or more in 24-hr period of someone with COVID-19. For HCP, refer to CDC's Interim U.S. Guidance

for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2.

Fully Vaccinated: A person who is ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine.

Isolation: Physically separating someone who has COVID-19 away from those who do not have COVID-19 to prevent spreading it to others.

Quarantine: Physically separating someone who might have been exposed to COVID-19 away from all others to prevent spreading COVID-19 to others.

Reuse (N95): The practice of using the same N95 or other type of filtering facepiece respirator (FFR) for multiple encounters with patients but removing it (doffing) after each encounter and storing it for use in the next encounters. Reuse may be considered crisis capacity strategy per CDC's Strategies for Optimizing the Supply of N95 Respirators. Also, refer to CDC's Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages and DOH PPE use during COVID-19 Pandemic – Personal Protective Equipment (PPE) for Long-Term Care Settings.

Isolation vs. Quarantine for Long-term Care Facility Residents

QUARANTINE: Is the transmission-based precaution (TBP) used to keep someone who might have been exposed to COVID-19, away from all others to prevent spreading COVID-19.

ISOLATION: Is the TBP used to keep someone who has COVID-19, away from others to prevent transmission to others.

	Quarantine	Isolation
Days	**14 Day Quarantine** for: • Resident, regardless of vaccination status, with exposure to someone with COVID-19 and not symptomatic • Resident is newly admitted and not fully vaccinated • Current resident with high-risk activity in the community and not fully vaccinated **Facility may use the DOH risk assessment tool to guide decisions**	**Isolation** ends for residents who are not severely immunocompromised when: • At least 10 days have passed since symptoms first appeared **AND** • At least 24 hours have passed since last fever without the use of fever reducing medications **AND** • Symptoms (for example cough, shortness of breath) have improved
Reason for TBP	The time from exposure to COVID-19 to symptom onset, or incubation period, is thought to be 2-14days. Practicing Quarantine for the full 14 days, helps prevent spread of disease that can occur before a person knows	It takes about 10 days for someone to stop being infectious after they become ill with COVID-19, which is why it is recommended that someone who tests positive for COVID-19 isolates for 10 days.

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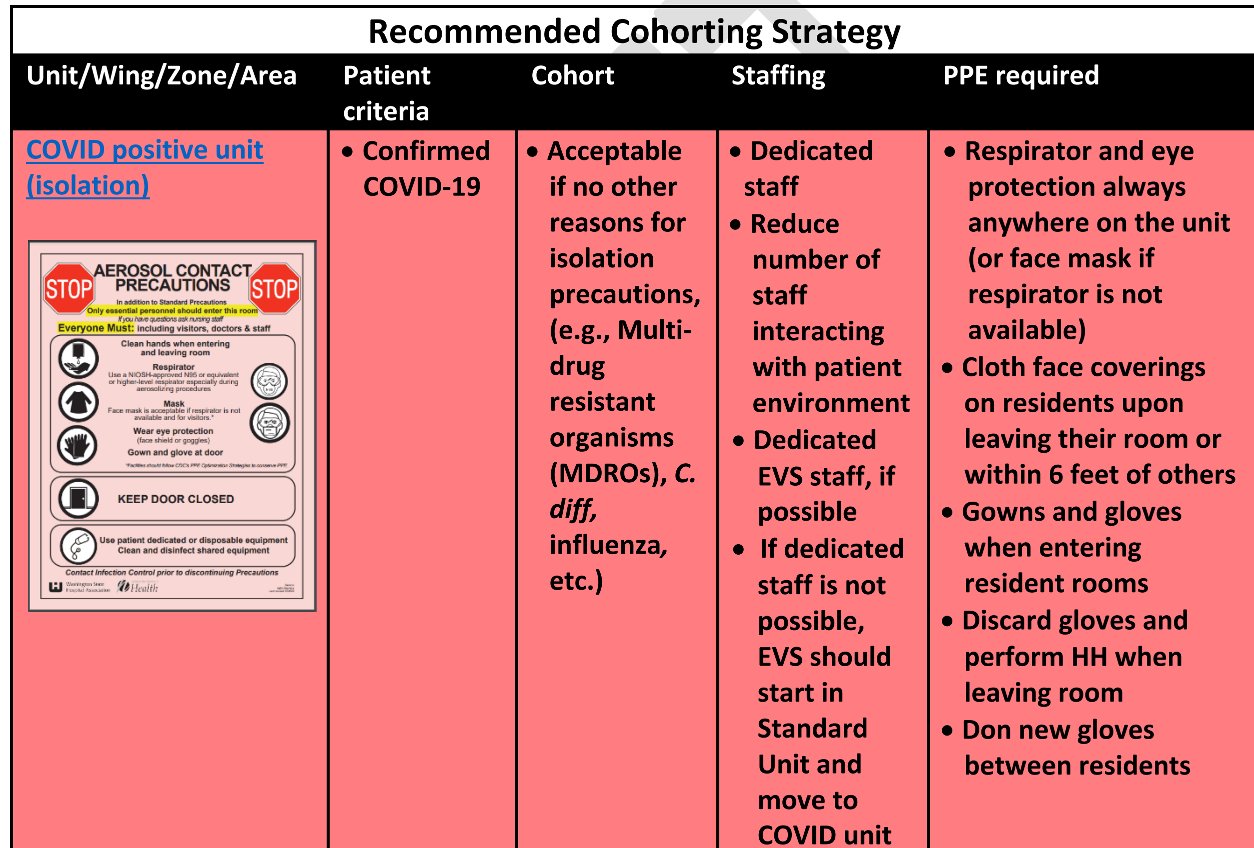
	they are sick or if they are infected with the virus without feeling symptoms	

COVID-19 Unit Best Practices

Cohorting positive residents in a single area allows dedicated HCP to work with only with resident with known or suspected COVID-19. This decreases the risk of spreading the virus from infected to uninfected residents. Facilities should prepare their COVID-19 dedicated unit following this guidance: Preparing your Long-term Care Facility COVID-19 Unit.



Recommended Cohorting Strategy				
Unit/Wing/Zone/Area	**Patient criteria**	**Cohort**	**Staffing**	**PPE required**
COVID positive unit (isolation)	• **Confirmed COVID-19**	• **Acceptable if no other reasons for isolation precautions, (e.g., Multi-drug resistant organisms (MDROs), *C. diff*, influenza, etc.)**	• **Dedicated staff** • **Reduce number of staff interacting with patient environment** • **Dedicated EVS staff, if possible** • **If dedicated staff is not possible, EVS should start in Standard Unit and move to COVID unit**	• **Respirator and eye protection always anywhere on the unit (or face mask if respirator is not available)** • **Cloth face coverings on residents upon leaving their room or within 6 feet of others** • **Gowns and gloves when entering resident rooms** • **Discard gloves and perform HH when leaving room** • **Don new gloves between residents**

Notes:

- N95s and other tight-fitting respirators must be fit-tested. Follow CDC Strategies for Optimizing the Supply of N95 Respirators if supplies are limited. N95 and other respirators should be prioritized for (HCP) caring for residents with known or suspected COVID-19 and HCP directly involved in aerosol generating procedures.
- If active outbreak in the facility, all HCP should wear fit-tested, NIOSH-approved N95 (or surgical mask if N95s are limited).
- Eye protection should be worn for all resident encounters.
- Facilities should follow CDC Strategies to Mitigate Healthcare Personnel Staffing Shortages if experiencing staff shortages.

Observation/Quarantine Best Practices

This section outlines considerations for managing admissions, readmissions and residents exposed to COVID-19.

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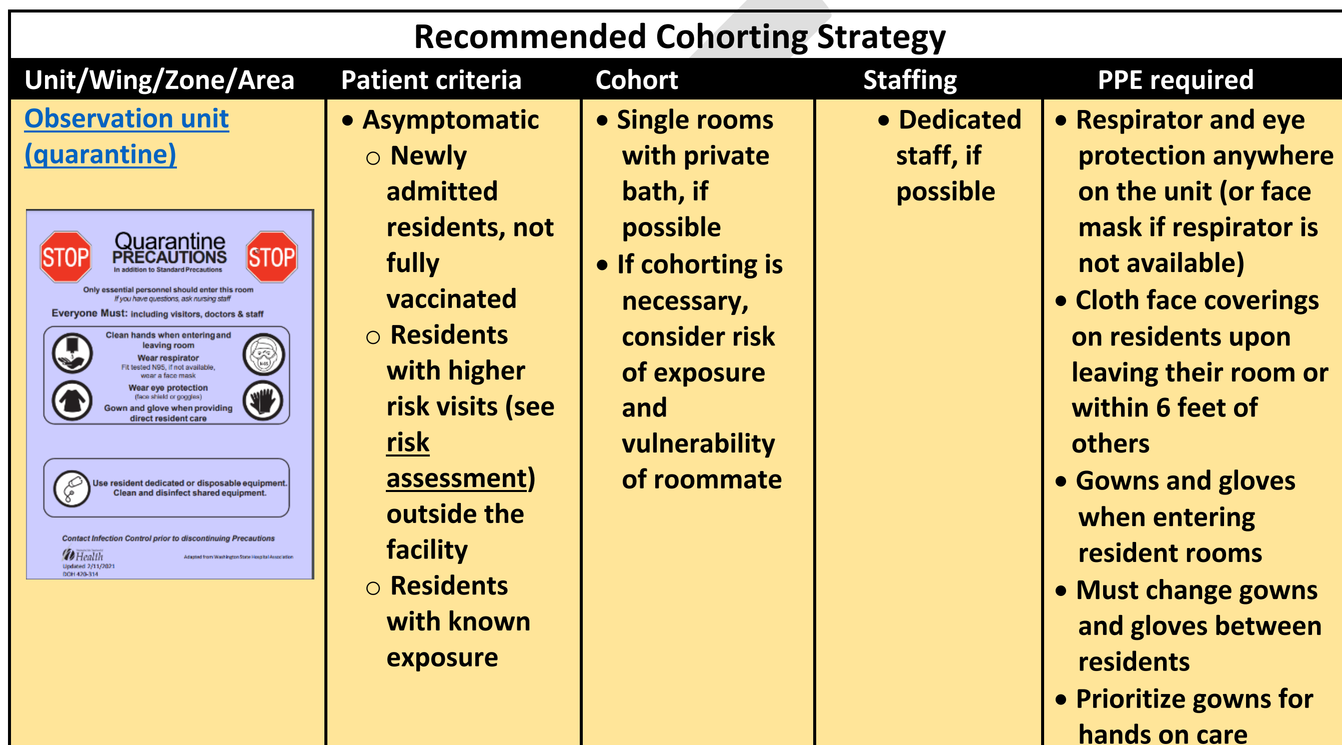
- A negative SARS-CoV-2 test is not required prior to admission. See DOH Interim Guidance for Long-Term Care: Transferring between Long-Term Care and other Healthcare Settings.
- Quarantine is no longer recommended for residents upon admission IF they are fully vaccinated AND have had no exposures in the past 14 days. See CDC Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.



Recommended Cohorting Strategy				
Unit/Wing/Zone/Area	**Patient criteria**	**Cohort**	**Staffing**	**PPE required**
Observation unit (quarantine)	• **Asymptomatic** ○ **Newly admitted residents, not fully vaccinated** ○ **Residents with higher risk visits (see risk assessment) outside the facility** ○ **Residents with known exposure**	• **Single rooms with private bath, if possible** • **If cohorting is necessary, consider risk of exposure and vulnerability of roommate**	• **Dedicated staff, if possible**	• **Respirator and eye protection anywhere on the unit (or face mask if respirator is not available)** • **Cloth face coverings on residents upon leaving their room or within 6 feet of others** • **Gowns and gloves when entering resident rooms** • **Must change gowns and gloves between residents** • **Prioritize gowns for hands on care**

Notes:

- N95s and other tight-fitting respirators must be fit-tested. Follow CDC Strategies for Optimizing the Supply of N95 Respirators if supplies are limited. N95 and other respirators should be prioritized for HCP caring for residents with known or suspected COVID-19 and HCP directly involved in aerosol generating procedures.
- If active outbreak in the facility, all staff should wear fit-tested, NIOSH-approved N95 (or surgical mask if N95s are limited)
- Eye protection should be worn for all resident encounters
- Facilities should follow CDC Strategies to Mitigate Healthcare Personnel Staffing Shortages if experiencing staff shortages

Placement

- If the resident is not fully vaccinated at the time of admission or if the resident has had an exposure to SARS-CoV-2 prior to admission, place the resident in transmission-based precautions in a separate observation area (ideally, in a single-person room) for 14 days after admission. See CDC's Preparing for COVID-19 in Nursing Homes.
  - 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.
- The resident should remain or be placed in a single-person room when at all possible

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- Roommates of residents with COVID-19 should be considered exposed and potentially infected and 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. Leave the exposed resident in the room if their roommate is moved to the COVID-19 unit. Clean and disinfect the room with a product on [EPA list N, Disinfectants for COVID-19]. 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.
- 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)
- Staff should be dedicated to observation/quarantine unit if staffing resources allow.

Observation/Quarantine Best Practices when single-person room is unavailable

This section outlines considerations for deciding when and how to place newly admitted, re-admitted, or exposed residents together in a shared room when single-person rooms are not an option.

- Symptomatic residents and those exposed or potentially exposed to SARS-CoV-2 infection should be prioritized for placement in a single-person room.
- Placing residents in a shared room during their 14-day quarantine period increases the risk of exposure to SARS-CoV-2 and should be considered only on a limited, case-by-case basis.
- When making resident management decisions, the person responsible for infection control measures should review the **following list of considerations** (*Note: this list is not exhaustive*):

Considerations for Cohorting When a Single Room is not Available	

Resident Status	• Appropriate roommate for quarantined resident:
	  ◦ Recovered from COVID-19 within previous 90 days
	  ◦ Released from transmission-based precautions
	  ◦ No longer symptomatic
	• Avoid pairing residents at higher risk of severe illness

Community Status	• Rate of COVID-19 in surrounding community • Risk level of previous setting of cohorting residents • Partner with local facilities for single room placement

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Facility Layout and Capacity	• Dedicate space for observation/quarantine that separates residents (can be a wing, unit or block of rooms) • Provide at least 6 feet between residents • Assess engineering/ventilation improvements

For more information:

- CDC's People with Certain Medical Conditions
- CDC's Preparing for COVID-19 in Nursing Homes
- CDC's Ventilation in Buildings
- DOH Ventilation and Air Quality for Reducing Transmission of COVID-19

Testing

- Test quarantined residents immediately upon development of signs and symptoms. If positive, move to a COVID-19 unit. If negative, keep resident in quarantine. Retesting may be considered if alternative diagnosis is not determined.
- If known to be exposed, consider testing quarantined asymptomatic residents for SARS-CoV-2 around day 5 – 7 to after exposure. If positive, move to COVID-19 unit. If negative, keep resident in quarantine for 14 days following the last exposure.
- Consider retesting quarantined asymptomatic residents during days 12 - 14. If positive, move to COVID-19 unit. If negative, return to standard care on day 15 post-exposure.
- A negative RT-PCR test is not required for discontinuation of the 14-day quarantine but is encouraged to increase confidence that the resident is not infected.
- Negative test results should not lead to early discontinuation of the 14-day quarantine
- A negative SARS-CoV-2 test is not required prior to admission. See DOH Interim Guidance for Long-Term Care: Transferring between Long-Term Care and other Healthcare Settings.
- Refer to CDC's Considerations for Interpreting Antigen Test Results in Nursing Homes to determent when confirmatory PCR testing is indicated following antigen testing.

PPE

- Staff should wear a fit tested 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 eyes and face), gloves, and gown when caring for residents who are either COVID positive or in quarantine.
- Staff should change gloves and gown when moving between residents and perform hand hygiene after glove removal.

Source Control

- As part of universal source control measures, all residents should wear a well-fitting cloth face covering or facemask (if tolerated) whenever they leave their room or when staff are within 6 feet. See CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic and DOH SARS-CoV-2 Source Control in Healthcare Settings.

More COVID-19 Information and Resources

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Stay up-to-date on the current COVID-19 situation in Washington, Governor Inslee's proclamations, symptoms, how it spreads, and how and when people should get tested. See our Frequently Asked Questions for more information.

A person's race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data are revealing that communities of color are being disproportionately impacted by COVID-19- this is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer opportunities to protect themselves and their communities. Stigma will not help to fight the illness. Share accurate information with others to keep rumors and misinformation from spreading.

- WA State Department of Health 2019 Novel Coronavirus Outbreak (COVID-19)
- WA State Coronavirus Response (COVID-19)
- Find Your Local Health Department or District
- CDC Coronavirus (COVID-19)
- Stigma Reduction Resources

Have more questions about COVID-19? Call our hotline: **1-800-525-0127,** Monday – Friday, 6 a.m. to 10 p.m., Weekends: 8 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language.** For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

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