Question	Answer
1. Partner websites for COVID-19 resources and Q&A links	The slides and Q&A will also be available at the Adult Family Home Council site: https://www.adultfamilyhomecouncil.org/covid-19-updates-best-resources/ Leading Age COVID Resource page. https://www.leadingagewa.org/ill_pubs_articles/copy-resources-preparing-your-community-staff-residents-and-families-for-the-coronavirus/ WHCA website: https://www.whca.org/covid-19-resources/"
2. New CDC guidance for memory care units	https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html
3. Hospital Elder Link Program (HELP) resources - great resources for preventing, screening for and managing delirium	https://www.hospitalelderlifeprogram.org/news/covid-19-and-delirium-help-resources/
4. American Geriatrics Society resources for COVID-19	https://www.americangeriatrics.org/covid19
5. "The epidemic within the pandemic - Delirium"	https://www.nytimes.com/2020/05/10/opinion/coronavirus-hospital-delirium.html
6. CDC guidance for testing in nursing homes	https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
7. It is common for LTC staff to inappropriately assume all delirium is due to UTI. Should we be always testing for COVID-19 in LTC residents with new delirium?	We don't have enough data right now make this recommendation to test any LTC resident with new delirium for COVID-19. As we currently understand, isolated delirium with no other symptoms like fever or respiratory symptoms would still be an atypical presentation. If your facility already has cases of COVID-19 and if you are dealing with an older adult particularly for those aged 80+, it would be reasonable to send a test as a part of a delirium work up.
8. what is the safe medication for acute delirium post COVID-19 patient?	There are no safe medications to truly address delirium. Most sedating medications do not treat or prevent delirium, but address severe symptoms of delirium such as acute agitation. The only times you should be using a medication such as an anti-psychotic are instances in which behavioral agitation is causing harm to the patient or to the people around them. Always try non pharmacologic strategies first and verbal de-escalation. The Hospital Elder Life program has a pamphlet that can walk you through verbal de-escalation. If you are in a position that you need to use an antipsychotic, it depends on the patient. First generation

	antipsychotics such as a haloperidol or haldol have more anticholinergic effects (sedating, physical symptoms like urinary retention, constipation, mouth dryness) and thus ultimately can cause more side effects and take longer to clear. Quetiapine or seroquel has lesser anticholinergic effects among the antipsychotic agents however can be more sedating. For a patient who has significant emotional distress / paranoia / delusions, olanzapine may be preferred. The rule of thumb is to start at the lowest doses possible. As discussed in the presentation, it is helpful if you have access to ECGs to obtain a baseline ECG and a follow up ECG (e.g. within 3-5 days) to monitor QTc intervals.
9. **On the statistic of 20-30% people of all ages showing delirium, is this true at home?**	This data comes from hospitalized patients. There was recent JAMA neurology study of patients in Wuhan that found that 40% of hospitalized had delirium. For patients at home, I don't believe this has been studied but I would expect that delirium incidence at home would be lower than in the hospital because it is a familiar environment.
10. **Not--age related: Why do we think there seems to be an effect on memory in recovered COVID-19 patients? Even nurses recovered are seeing memory issues 7 weeks post infection**	We're still learning more about the pathology of COVID-19, however based on some earlier studies of patients with severe cases of COVID-19 who have died of COVID-19 it appears that can be damage to neurons and brain tissue. Memory loss may be a symptom of prolonged delirium or may be related to decreased oxygen supply to the brain from COVID-19 infection. In these instances, it can take 6 months to a year to adequately assess recovery of memory.
11. **I run a SNF. I would like to know if there is a "standard of practice" for window visits. So far I have had family members taking screens out of windows to "pass items" to a resident, and last night when a staff member tried to shut the window the family member put his hand in it to prevent closing and stated " So now you are going to close it on my hand?". We have educated residents in the facility, staff and have called our families about our window visit policy. We can assist then at any time of day, they need to keep the window shut and use an electronic device to speak**	I don’t believe there is any formal guidance on window visit standards of practice. Certainly, the directive to limit visitation is to limit exposure to COVID and so visiting across an open widow should be discouraged/prevented. Visitors should be encouraged to use a phone or video device to communicate through a closed window. One commenter reported that there have been facilities that used hardware to prevent full window opening, this is a reasonable approach if visitors refuse to adhere to your policy, assuming you have made sure the adjustment meets all safety standards.

communicate. We have the policy posted on each window facing out IN LARGE print in EACH room.	
12. Re window visits, if the visitor and the resident are 6 feet apart from each other, and are not touching each other, the open window is still off limits?	Yes, at this time there are no guidelines that I am aware of allowing for visitation six feet apart through a window or otherwise. Given the duration of this crisis visitation standards are something that should be addressed, but have not been to date.
13. Any update on visitor policy and how long we should plan to be closed to visitors?	No updates that I am aware of.
14. I think that's no different than having visitors inside the building...what would we identify as the difference?	I assume this is referring to the open window visits, and yes, I agree this is not recommended. Although it is somewhat safer than having visitors inside the building as the visitor outside the window would pose less risk to others inside the building, not counting the people int he room they are visiting, than if they had come inside.
15. Remember residents have the right to leave. Outside visits might be the answer in keeping them safe.	Outside visits are certainly something that deserves further thought and consideration, at this time it is not recommended.
16. A SNF Resident on droplet precautions pending COVID lab test results, resident is allowed to walk around facility wearing a mask - is this acceptable? The resident is pending test results walking around with a mask - the resident was not symptomatic but exposed. The droplet precautions refer to staff entering the room, but then the resident walks around with a mask. This is confusing.	This is a complicated question. In this specific instance it sounds like this person was exposed and is asymptomatic but has a pending lab test. First let me address the test that was performed, this may not have been appropriate depending on the timing of the exposure as the PCR test will be unlikely to become positive until at least a few days after exposure and so if the exposure occurred that day or the day before likely would not be useful. If this test was being done a week or more after the exposure it is reasonable. Re wearing a mask and leaving the room, ideally this person would be under quarantine given the exposure and so would not leave their room unless necessary. That being said if the resident would greatly benefit from getting out of their room for a walk if this is planned when there will be limited or no other around and can be supervised this would be reasonable. They should certainly wear a mask when they leave the room as should other residents when cases of COVID have been confirmed in the facility.
17. It is common for LTC staff to inappropriately assume all delirium is due to UTI. Should we be always testing for COVID-19 in LTC residents with new delirium.	See answer #8

18. The Whatcom Health Department said we could have limited visit with protocols: however, the state said it was against the governor's no visitation	I would defer to the LHJ and DSHS but I would reconsult them and make sure you understood the stipulations on their visitation recommendation. Also, you should talk to both them and DSHS and if there is disagreement between their recommendations, I would refer them to discuss with each other. Visitation, according to the governor's mandate, should be limited to compassionate care situation which is open to interpretation.
19. When do we consider someone non- infectious after they were diagnosed with COVID-19?	There is unfortunately no perfect answer to this question, but at this time recommended guidance on this has been provided by CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html. There is both a symptom-based strategy and a test-based strategy, at this time given limited access to test supplies I would recommend using symptom based strategy.
20. The governor has issued guidelines for opening restaurants in phase 3. Will there be guidelines issued specifically for dining in Assisted Living from the Dept. of Health?	Not that I am aware of.
21. I have a resident that has a new brace and shoes waiting for her at the Hanger clinic. she has to go in to make sure the brace fits correctly. would it be okay to take her in. No coved issues at our home.	This would depend on the importance of this to her overall health/care. I would consult with your medical director and the resident's physician to make this determination. They should certainly wear a mask if they leave to go to a clinic visit and consider quarantine upon return to the facility.
22. How do we deal with a resident who just went out for an appointment and came back? Do we need to isolate for 14 days?	That is the current recommendation per CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html. It is not explicit, but under the section titled: "Considerations for new admissions or readmissions to the facility" (a little less than halfway down the page) it states that "readmissions" should undergo the 14 day quarantine, a conservative interpretation of this would be that anyone who leaves for a medical appointment is then readmitted, and has a potential exposure.
23. We have a dental clinic inside our SNF. We will be installing cubicle curtains in the clinic dividing the dental chairs. Are the curtains with mesh on top of curtains appropriate for the dental clinic	Given there is concern that many dental procedures result in aerosolization of particles this would likely not be appropriate. Ideally you would just have one resident int he dental clinic at a time.

24. Any specific guidelines for providers (dentists, optometrist, etc) visiting residents at nursing homes.	It is reasonable to allow providers into facilities to provide essential care for residents. They should be subjected to the same screening and IP requirements that your staff would be. This includes symptoms screening, wearing a mask at all times while in the facility, and adherence to appropriate TBP (i.e. if you have cases of COVID wearing all appropriate PPE for all patient care). If the practitioner provides care to a facility with COVID residents consider requiring full PPE for all patient care even if this is not standard practice in your facility at that time.
25. Is it possible to have a podiatrist come into a covid positive building, or even trim nails of past covid positive residents?	If the podiatrist has access to full PPE and able to follow appropriate infection control measures this may be acceptable. If your facility has access to Telemedicine capabilities, you may consider ways to have podiatry provide recommendations for management virtually. Prioritize management of active lesions / foot ulcers as this would require more urgent podiatry care.
TESTING RELATED QUESTIONS	
26. I understand the new recommendation from white house that states consider testing all employees and residents in nursing homes within the next two weeks. If this happens will it include assisted living facilities.	At this time it is specific to Skilled Nursing facilities, but this may change in the near future.
27. In regards to the recommendation from White House for testing all employee and residents in nursing home within the next 2 weeks - will we be receiving guidance from WA DOH on how this should happen? Or if it is going to happen?	Yes, further communication will be forthcoming.
28. I heard some facilities are testing all residents weekly regardless of symptoms - is this a standard practice? What is the scope of prevalence & prevalence testing in LTC facilities?	This is recommended for facilities with cases for a period of time - see CDC guidance on this issue here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html. See number three regarding point prevalence testing. At this time this recommendation is specific to nursing homes.
29. Will there be DOH support with testing?	If it is mandated by the governor, yes.
30. What if a resident or a staff member refuses to be tested?	All persons have the right to refuse care, your individual facility will need to determine what your policy for individuals who refuse testing. I.e. would residents who refuse testing be placed on TBP?

	Would staff who refuse testing be required to work with full PPE and if they meet any symptoms criteria be excluded according to symptom-based criteria? Would not be appropriate to penalize residents who refuse testing outside of placing them on TBP.
31. If the Governor directs everyone to get tested will there be some consideration for facilities that have already done testing of their residents and staff. We have done all residents and 1/2 of the staff (based on symptoms) I don't think we should retest those who have already be tested and since our testing was in March I don't know the efficacy of testing the other 1/2 of the staff now when they don't have symptoms. Isn't there a risk of doing a NP swab and getting dead virus? How will this help us mitigate an outbreak?	Likely facilities that have done testing in the past 4 weeks will not be required to retest. As your testing was in March you will likely be required to retest those that previously tested negative or were not previously tested. There is risk that testing is positive but the individual is not longer shedding transmissible virus, but you do not know that based on available testing so while you may exclude some individuals who are non-infectious you will likely exclude others who are infectious which will help mitigate the outbreak. With regard to staff they are much more likely to be asymptomatic than residents and they are much less likely to shed RNA for extended periods of time, so a positive test in a staff member is more likely to represent someone who is infectious or at least recently was infectious.
32. If nursing homes have already tested their residents and staff, do they need to do it again in 2 weeks?	See above answer, likely facilities that have completed testing within 4 weeks of when the mandate is announced will not be required to re-test.
33. Regarding the nursing home testing? Will the quarantine recommendations be the same as for general public. In a small facility we all work closely. So a single positive result for staff could affect many of us.	Yes they will be similar. Work with your DSHS representative to help identify potential staffing support avenues.
34. Follow up to my question is if there is support will the support be for test kits only or test kits and people resources to preform testing?	Definitely test kits, likely people to support testing initially, but as testing will be an ongoing need we will need to develop infrastructure within facilities to perform their own testing moving forward.
35. What if a resident or a staff member refuses to be tested? At a nursing home	Residents do have the right to refuse. Staff would also have this right. The facility may put safety measures in place if needed when a resident or staff decline to take the test. Also see answer to 32
36. What about staff that refuse?	See answer to 38 and 32
37. Why is there a discrepancy of supplies between facilities? Testing supplies that is - even SNF with Covid has difficulties obtaining tests	I am not sure I understand the question but testing supplies are limited everywhere. Right now in King county we are prioritizing SNFs for the supplies we do have for full facility testing, but we will assist

	with testing of symptomatic individuals in facilities that have confirmed cases or clusters of symptomatic people as we are able.
38. Would it be more valuable to do antibody testing instead of the antigen testing?	Ag testing I do not believe is widely available. With regard to PCR testing this tells you if you are actively shedding viral RNA (not this does not confirm infectivity) and antibody test tells you if you have previously or perhaps are currently infected. The problem with Ab testing is that we do not yet know if previous infection provides immunity and there are many Ab tests currently on the market that are unreliable.
39. Do you guys (dept of health/county) go into SNF to test residents and staff or do we have to do it on our own.?	At King county we will assist with testing ideally we will train your staff to do testing moving forward on your own. Given how prolonged this crisis is likely to be and that ongoing testing will be needed, we will need facilities to develop testing infrastructure to ongoing testing.
40. A lot of the Adult family homes have nurse delegators providing nursing oversight and if these could be trained to do the testing in AFH's they might be part of trainings ...and be available for this.	Agree this is a good idea,
41. If they do not get tested, would they need to be quarantined?	I assume this relates to the people who refuse testing please refer to answers 32 and 38
42. Are the nasal swabs for COVID-19 the same as the mid-turbinate swabs that SCAN has been using?	Yes, essentially. At this time there is no preference per CDC and FDA re anterior nasal swabs (front of nose) mid-turbinate swabs (mid-nose; somewhat uncomfortable - between anterior nasal and NP), and nasopharyngeal swabs (very far back, painful) although NP samples are probably the most reliable.
43. For assisted living residents are MD orders necessary for COVID testing? Does DOH or LHJ mandate supersede the need for an MD order?	Yes and Not at this time. Additionally, Nurse practitioners and pharmacists can order testing as well as MDs.
44. I have a client who just had a procedure at a hospital and will be discharged soon. Do, they test for covid-19 before discharge?	They do not require testing, but it is not unreasonable.