Key Points for COVID-19 in Long-term Care Settings

Long-term care facilities are at high risk for severe COVID-19 outbreaks due to their congregate nature and vulnerable population (e.g., older adults with multiple co-morbidities). Ill healthcare personnel (HCP) or visitors are the most likely sources of introduction of COVID-19 into the facility. **To protect this fragile population, the Ohio Department of Health is urging ALL long-term care facilities to immediately take the following actions to reduce the risk of COVID-19 infection in your residents and staff.** If you have a resident with known or suspected COVID-19 infection, your local health jurisdiction may recommend you take additional actions to those listed below.

- **Keep COVID-19 from entering and spreading your facility. All facilities should:**
  - Prohibit all visitors except for compassionate care situations (e.g., end of life). Facilities should offer alternative methods of visitation (Skype, FaceTime, etc.), if available.
  - Restrict all non-essential personnel and volunteers (e.g., barbers, delivery person) from entering the building.
  - Actively screen all staff for fever and respiratory symptoms before starting each shift; send them home if they are ill and follow CDC's return to work criteria.
  - Cancel all group activities, communal dining, and field trips.
  - Strengthen hand hygiene adherence. Place alcohol-based hand rub in every resident room to facilitate hand hygiene by staff. Keep sinks stocked with soap, water, and paper towels.
  - Make tissues, facemask, and no-touch receptacle available for people with a cough.
  - Educate HCP about adherence to infection prevention and control measures, including hand hygiene and selection and use of PPE.
  - Have HCP demonstrate competency with putting on and removing PPE.
    - Consider using shaving cream on their PPE as a visual marker to assess PPE removal without self-contamination.
- **Identify infections early:**
  - Actively screen all residents at least daily for fever and respiratory symptoms (e.g., shortness of breath, cough, sore throat); immediately isolate anyone who is symptomatic.
    - Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs).
  - Elderly residents with COVID-19 may not show typical symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, diarrhea, or sore throat.
    - Identification of these symptoms should prompt isolation and further evaluation for COVID-19. Have a low threshold of suspicion for COVID-19 testing.
  - Residents with known or suspected COVID-19 should ideally be placed in a private room with their own bathroom and do not need to be placed into an airborne infection isolation room (AIIR).
  - Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario.

Contact your facility's designated infection control person if you need assistance with decisions about resident placement.
    - Notify the local health department if: instances of severe respiratory infection, clusters (≥2 residents and/or HCP) of respiratory infection, or individuals with known or suspected COVID-19 are identified.
- **Prevent spread of COVID-19:**
    - When COVID-19 is reported in your facility, implement use of universal facemask by all staff while in the facility;
        - If facemasks are in short supply, they should be prioritized for direct care personnel. All HCP should be reminded to practice social distancing (at least 6 feet apart) when in break rooms or common areas.
    - Staff who work in multiple healthcare facilities may pose a higher risk and should be asked about exposure to facilities with confirmed COVID-19 cases.
    - Geographically cohort staff by assigning dedicated staff to specific units.
    - Minimize entries into patient rooms by bundling care and treatment activities.
    - If COVID-19 is identified in your facility, restrict all residents to their room.
    - To care for patients with confirmed or suspected COVID-19, staff should use gown, gloves, eye protection (such as goggles or face shield) and a facemask/surgical mask (N95 respirator if the facility has a fit testing program).
        - Consider having HCP wear PPE for all resident interactions if there are multiple cases in the facility.
    - Work with your health department to determine who else may need to be tested for COVID-19.
    - Ensure disinfectants in use are EPA-registered, hospital-grade with a claim against the virus are available for frequent cleaning of high-touch surface areas and shared resident care equipment. See EPA list N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2.
- **Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply:**
    - For example, extended use of facemasks and eye protection or prioritization of gowns for certain resident care activities https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.
- **Communicate**
    - Communicate to residents and families advising them about actions that the facility is taking in response to COVID-19. This could include:
        - Informing about visitor restrictions to the families and residents (sample letter included).
    - Communicate to residents about what they need to do – such as social distancing, informing personnel immediately if they feel ill, importance of hand hygiene and cough etiquette.
    - Communicate to residents about other changes that will take place with regards to their care such as higher frequency of monitoring of symptoms.

Thank you very much for everything you are doing to keep your residents safe and healthy.

Help Keep our Residents Safe from COVID-19

A message from: [FACILITY NAME]

Dear Residents, Families, Friends, and Volunteers:

We are committed to keeping our residents safe and we need your help. The virus causing Coronavirus Disease 2019 (abbreviated COVID-19) can cause outbreaks in nursing homes. Many of our residents are elderly and may have medical conditions putting them at high risk of becoming sick or severely ill with COVID-19. Visitors and healthcare personnel (HCP) are the most likely sources of introduction of the virus that causes COVID-19 into a facility.

To protect our vulnerable residents, even before COVID-19 is seen in our community, we are immediately taking the following actions to reduce the risk of COVID-19 in our residents and staff:

1. **Effective immediately: We are restricting all visitation.**
   All visitation is being restricted (in accordance with Governor DeWine's order) except for end of life situations. These visitors will first be screened for fever and respiratory symptoms before being allowed entry. We know that your presence is important for your loved one but, per guidance from the Centers for Disease Control and Prevention (CDC), this is a necessary action to protect their health.
   - We are introducing alternative methods of visitation (such as Skype and FaceTime) so that you can continue to communicate with your loved ones.
   - Visitors who are permitted to enter the building will be required to frequently clean their hands, limit their visit to a designated area within the building, and wear a facemask. As the situation with COVID-19 is rapidly changing, we will continue to keep you updated.

2. **We are monitoring healthcare personnel and residents for symptoms of respiratory illness.**
   Healthcare personnel will be actively monitored for fever and symptoms of respiratory infection. Ill healthcare personnel will be asked to stay home. You may see healthcare personnel wearing facemasks, eye protection, gown, and gloves in order to prevent germs from spreading and help keep residents safe. Healthcare personnel will clean their hands frequently.

   We are assessing residents daily for fevers and symptoms of respiratory infection to quickly identify ill residents and implement additional infection prevention activities. When ill residents are identified, they will be monitored closely, asked to stay in their rooms or wear a mask.

3. **We are limiting activities within the facility.**
   We are cancelling all group activities within the building, community outings and communal meals. We will be helping residents to practice social distancing and frequently cleaning their hands.

We encourage you to review the CDC website for information about COVID-19, including its symptoms, how it spreads, and actions you can take to protect your health: https://www.cdc.gov/corona- virus/2019-ncov/index.html.

Thank you very much for everything you are doing to keep our residents and facility staff safe and healthy. We continue to monitor the situation in our community; we will keep you informed about any new precautions we think are necessary to keep your loved one safe.

Please contact us with additional questions at **[PHONE NUMBER].**

Sincerely,

[FACILITY ADMINISTRATOR]

Key Points for COVID-19 in Assisted Living Facilities

Multiple states have identified suspected and confirmed cases of COVID-19 among residents of Assisted Living, Residential Care, and Independent Living Facilities (subsequently referred to here as ALFs). The Ohio Department of Health (ODH) recommends adapting the Center for Disease Control and Prevention's (CDC) "Preparing for COVID-19: Long-term Care Facilities, Nursing Homes" to guide COVID-19 preparation, prevention and control efforts. The structure and care provided within ALFs can be distinctly different than nursing homes. Implementing this guidance may present some unique challenges or additional considerations. Some ALFs share a building or campus with a CMS certified nursing home or Skilled Nursing Facility and have access to a trained infection control nurse that can assist with COVID-19 prevention and control efforts. Others are standalone facilities that may have limited access to these resources. Additional considerations for ALFs include:

1. ALF staffing is varied. They may have full- or part-time nursing staff, contract personnel, vendors, or use outpatient providers. Documentation of resident conditions/problems may not be centralized within the facility. Therefore, cluster identification may be delayed.
    - ALF staff should be vigilant for fever or respiratory symptoms (e.g., shortness of breath, new or change in cough, and sore throat) among their residents.
    - ALFs should implement active monitoring for fever and respiratory symptoms for all residents (at least once per shift).
    - ALFs should implement active monitoring for fever and respiratory symptoms for all staff (upon arrival and departure daily).
    - ALFs should designate one staff member to report identified illnesses.
    - Notify the local health department if: instances of severe respiratory infection, clusters (≥2 residents and/or HCP) of respiratory infection, or individuals with known or suspected COVID-19 are identified.

2. Given the independence and ambulatory status of residents in ALFs, staff may encounter challenges implementing guidance related to restrictions of resident movement (inside or outside the facility), family members/other visitors to residents, or contract HCP to the ALF. Share COVID-19 guidance for persons in the community with residents. Examples include: "How to Protect Yourself", and "Are You at Higher Risk for Severe Illness?". ALF staff could post notices directed at older adults to stay in the room and to restrict visitation.

3. ALF housekeeping or cleaning services should follow environmental cleaning and disinfection practices similar to nursing homes. If facility policies, procedures and products for environmental cleaning and disinfection for healthcare settings are not in place, at a minimum use the "Interim Recommendations for US Households with Suspected/Confirmed Coronavirus Disease 2019" including the use EPA-registered disinfectants.

Thank you very much for everything you are doing to keep your residents safe and healthy.

Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings

Nursing homes and other long-term care facilities can take steps to assess and improve their preparedness for responding to coronavirus disease 2019 (COVID-19). Each facility will need to adapt this checklist to meet its needs and circumstances based on differences among facilities (e.g., patient/resident characteristics, facility size, scope of services, hospital affiliation). This checklist should be used as one tool in developing a comprehensive COVID-19 response plan. Additional information can be found at www.cdc.gov/COVID-19. Information from state, local, tribal, and territorial health departments, emergency management agencies/authorities, and trade organizations should be incorporated into the facility's COVID-19 plan. Comprehensive COVID-19 planning can also help facilities plan for other emergency situations.

This checklist identifies key areas that long-term care facilities should consider in their COVID-19 planning. Long-term care facilities can use this tool to self-assess the strengths and weaknesses of current preparedness efforts. Additional information is provided via links to websites throughout this document. However, it will be necessary to actively obtain information from state, local, tribal, and territorial resources to ensure that the facility's plan complements other community and regional planning efforts. This checklist does not describe mandatory requirements or standards; rather, it highlights important areas to review to prepare for the possibility of residents with COVID-19.

A preparedness checklist for hospitals, including long-term acute care hospitals is available.
https://www.cdc.gov/coronavirus/2019-ncov/downloads/hospital-preparedness-checklist.pdf

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings:
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF):
https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

1. Structure for planning and decision making

	Completed	In Progress	Not Started
▪ COVID-19 has been incorporated into emergency management planning for the facility.			
▪ A multidisciplinary planning committee or team* has been created to specifically address COVID-19 preparedness planning.			
List committee's or team's name:			
**An existing emergency or disaster preparedness team may be assigned this responsibility.*			
continue on next page			

cont.	Completed	In Progress	Not Started
▪ People assigned responsibility for coordinating preparedness planning, hereafter referred to as the COVID-19 response coordinator. **Insert name(s), title(s), and contact information:** ▪ Members of the planning committee include the following: (Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist.) ▪ Facility administration ▪ Medical director ▪ Director of Nursing ▪ Infection control ▪ Occupational health ▪ Staff training and orientation ▪ Engineering/maintenance services ▪ Environmental (housekeeping) services ▪ Dietary (food) services ▪ Pharmacy services ▪ Occupational/rehabilitation/physical therapy services ▪ Transportation services ▪ Purchasing agent ▪ Facility staff representative ▪ Other member(s) as appropriate (e.g., clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff including consultant services, union representatives) ▪ The facility's COVID-19 response coordinator has contacted local or regional planning groups to obtain information on coordinating the facility's plan with other COVID-19 plans. **Insert groups and contact information:**			

2. Development of a written COVID-19 plan.

	Completed	In Progress	Not Started
▪ A copy of the COVID-19 preparedness plan is available at the facility and accessible by staff. ▪ Relevant sections of federal, state, regional, or local plans for COVID-19 or pandemic influenza are reviewed for incorporation into the facility's plan. ▪ The facility plan includes the Elements listed in #3 below. ▪ The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.			

3. Elements of a COVID-19 plan.

	Completed	In Progress	Not Started

General:

- A plan is in place for protecting residents, healthcare personnel, and visitors from respiratory infections, including COVID-19, that addresses the elements that follow.
- A person has been assigned responsibility for monitoring public health advisories (federal and state) and updating the COVID-19 response coordinator and members of the COVID-19 planning committee when COVID-19 is in the geographic area. For more information, see https://www.cdc.gov/coronavirus/2019-ncov/index.html.

Insert name, title, and contact information of person responsible.

- The facility has a process for inter-facility transfers that includes notifying transport personnel and receiving facilities about a resident's suspected or confirmed diagnosis (e.g., presence of respiratory symptoms or known COVID-19) prior to transfer.
- The facility has a system to monitor for, and internally review, development of COVID-19 among residents and healthcare personnel (HCP) in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting), see CDC guidance on respiratory surveillance: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf.
- The facility has infection control policies that outline the recommended Transmission-Based Precautions that should be used when caring for residents with respiratory infection. (In general, for undiagnosed respiratory infection, Standard, Contact, and Droplet Precautions with eye protection are recommended unless the suspected diagnosis requires Airborne Precautions; see: https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html.) For recommended Transmission-Based Precautions for residents with suspected or confirmed COVID-19, the policies refer to CDC guidance; see: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.
- The facility periodically reviews specific IPC guidance for healthcare facilities caring for residents with suspected or confirmed COVID-19 (available here: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html) and additional long-term care guidance (available here: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html).

Facility Communications:

- Key public health points of contact during a COVID-19 outbreak have been identified. (Insert name, title, and contact information for each.)

Local health department contact:

State health department contact:

State long-term care professional/trade association:

continue on next page

cont.	Completed	In Progress	Not Started
▪ A person has been assigned responsibility for communications with public health authorities during a COVID-19 outbreak. **Insert name and contact information:**			
▪ Key preparedness (e.g., Healthcare coalition) points of contact during a COVID-19 outbreak have been identified. **Insert name, title, and contact information for each:**			
▪ A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of COVID-19 in the facility. (Having one voice that speaks for the facility during an outbreak will help ensure the delivery of timely and accurate information.)			
▪ Contact information for family members or guardians of facility residents is up to date.			
▪ Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., consultants, sales and delivery people) about the status of COVID-19 in the facility.			
▪ A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals and hospital emergency medical services, relevant community organizations—including those involved with disaster preparedness) with whom it will be necessary to maintain communication during an outbreak. Attach a copy of contact list.			
▪ A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during an outbreak.			
Supplies and resources:			
The facility provides supplies necessary to adhere to recommended IPC practices including:			
▪ Alcohol-based hand sanitizer for hand hygiene is available in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).			
▪ Sinks are well-stocked with soap and paper towels for hand washing.			
▪ Signs are posted immediately outside of resident rooms indicating appropriate IPC precautions and required personal protective equipment (PPE).			
▪ Facility provides tissues and facemasks for coughing people near entrances and in common areas with no-touch receptacles for disposal.			
▪ Necessary PPE is available immediately outside of the resident room and in other areas where resident care is provided. **continue on next page**			

cont.	Completed	In Progress	Not Started
▪ Facilities should have supplies of facemasks, respirators (if available *and* the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).			
▪ Trash disposal bins should be positioned near the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another resident in the same room.			
▪ Facility ensures HCP have access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. ▪ *Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.*			
▪ The facility has a process to monitor supply levels.			
▪ The facility has a contingency plan, that includes engaging their health department and healthcare coalition when they experience (or anticipate experiencing) supply shortages. Contact information for healthcare coalitions is available here: https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx			
Identification and Management of Ill Residents:			
▪ The facility has a process to identify and manage residents with symptoms of respiratory infection (e.g., cough, fever, sore throat) upon admission and daily during their stay in the facility, which include implementation of appropriate Transmission-Based Precautions.			
▪ The facility has criteria and a protocol for initiating active surveillance for respiratory infection among residents and healthcare personnel. CDC has resources for performing respiratory surveillance in long-term care facilities during an outbreak, see: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf			
▪ Plans developed on how to immediately notify the health department for clusters of respiratory infections, severe respiratory infections, or suspected COVID-19.			
▪ The facility has criteria and a protocol for: limiting symptomatic and exposed residents to their room, halting group activities and communal dining, and closing units or the entire facility to new admissions.			
▪ The facility has criteria and a process for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units.			
Considerations about Visitors:			
▪ The facility has plans and material developed to post signs at the entrances to the facility instructing visitors not to visit if they have fever or symptoms of a respiratory infection.			
▪ The facility has criteria and protocol for when visitors will be limited or restricted from the facility.			

continue on next page

cont.	Completed	In Progress	Not Started
▪ Should visitor restrictions be implemented, the facility has a process to allow for remote communication between the resident and visitor (e.g., video-call applications on cell phones or tablets) and has policies addressing when visitor restrictions will be lifted (e.g., end of life situation). **For more information about managing visitor access and movement in the facility see:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html			
Occupational Health:			
▪ The facility has sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill healthcare personnel (HCP) to stay home.			
▪ The facility instructs HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of respiratory infection, as a part of routine practice.			
▪ The facility has a process to actively screen HCP for fever and symptoms when they report to work.			
▪ The facility has a process to identify and manage HCP with fever and symptoms of respiratory infection.			
▪ The facility has a plan for monitoring and assigning work restrictions for ill and exposed HCP. (See: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)			
▪ The facility has a respiratory protection plan that includes medical evaluation, training, and fit testing of employees.			
Education and Training:			
▪ The facility has plans to provide education and training to HCP, residents, and family members of residents to help them understand the implications of, and basic prevention and control measures for, COVID-19. Consultant HCP should be included in education and training activities.			
▪ A person has been designated with responsibility for coordinating education and training on COVID-19 (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance). **Insert name, title, and contact information:**			
▪ Language and reading-level appropriate materials have been identified to supplement and support education and training programs to HCP, residents, and family members of residents (e.g., available through state and federal public health agencies such and through professional organizations), and a plan is in place for obtaining these materials.			

continue on next page

cont.	Completed	In Progress	Not Started
▪ Plans and material developed for education and job-specific training of HCP which includes information on recommended infection control measures to prevent the spread of COVID-19, including: ▪ Signs and symptoms of respiratory illness, including COVID-19. ▪ How to monitor residents for signs and symptoms of respiratory illness. ▪ How to keep residents, visitors, and HCP safe by using correct infection control practices including proper hand hygiene and selection and use of PPE. Training should include return demonstrations to document competency. ▪ Staying home when ill. ▪ HCP sick leave policies and recommended actions for unprotected exposures (e.g., not using recommended PPE, an unrecognized infectious patient contact).			
▪ See: "Strategies to prevent the spread of COVID-19 in long-term care facilities,' available at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html			
▪ The facility has a plan for expediting the credentialing and training of non-facility HCP brought in from other locations to provide resident care when the facility reaches a staffing crisis.			
▪ Informational materials (e.g., brochures, posters) on COVID-19 and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic.			
Surge Capacity:			
Staffing			
▪ A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.			
▪ A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during a COVID-19 outbreak. **Insert name, title, and contact information:**			
▪ Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law.			
▪ The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.			
continue on next page			

cont.	Completed	In Progress	Not Started
Consumables and durable medical equipment and supplies			
▪ Estimates have been made of the quantities of essential resident care materials and equipment (e.g., intravenous pumps and ventilators, pharmaceuticals) and personal protective equipment (e.g., masks, respirators, gowns, gloves, and hand hygiene products), that would be needed during an eight-week outbreak.			
▪ Estimates have been shared with local, regional, and tribal planning groups to better plan stockpiling agreements.			
▪ A plan has been developed to address likely supply shortages (e.g., personal protective equipment), including strategies for using normal and alternative channels for procuring needed resources.			
▪ A strategy has been developed for how priorities would be made in the event there is a need to allocate limited resident care equipment, pharmaceuticals, and other resources.			
▪ A process is in place to track and report available quantities of consumable medical supplies including PPE.			
Postmortem care:			
▪ A contingency plan has been developed for managing an increased need for postmortem care and disposition of deceased residents.			
▪ An area in the facility that could be used as a temporary morgue has been identified.			
▪ Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.			

Nursing Home Infection Prevention Assessment Tool for COVID-19

The following infection prevention and control assessment tool should be used to assist nursing homes with preparing to care for residents with COVID-19. Elements should be assessed through a combination of interviews with staff and direct observation of practices in the facility if possible.

Which of the following situations apply to the facility? (Select all that apply) □ No cases of COVID-19 currently reported in their community □ Cases reported in their community □ Sustained transmission reported in their community □ Cases identified in their facility (either among HCP or residents)		
Visitor restrictions		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility restricts all visitation except certain compassionate care situations, such as end of life situations. Decisions about visitation during an end of life situation are made on a case by case basis. • Potential visitors are screened prior to entry for fever or respiratory symptoms. Those with symptoms are not permitted to enter the facility. • Visitors that are permitted inside, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They are also reminded to frequently perform hand hygiene.		
Facility has sent a communication (e.g., letter, email) to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations, and that alternative methods for visitation (e.g., video conferencing) will be facilitated by the facility.		
Facility has provided alternative methods for visitation (e.g., video conferencing) for residents.		
Facility has posted signs at entrances to the facility advising that no visitors may enter the facility.		
Education, monitoring, and screening of healthcare personnel (HCP)		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**

Facility has provided education and refresher training to HCP (including consultant personnel) about the following:
• COVID-19 (e.g., symptoms, how it is transmitted)
• Sick leave policies and importance of not reporting or remaining at work when ill
• Adherence to recommended IPC practices, including:
    o Hand hygiene,
    o Selection and use including donning and doffing PPE,		

◦ Cleaning and disinfecting environmental surfaces and resident care equipment • Any changes to usual policies/procedures in response to PPE or staffing shortages		
Non-essential personnel including volunteers and non-essential consultant personnel (e.g., barbers) are restricted from entering the building.		
All HCP are reminded to practice social distancing when in break rooms or common areas.		
Facility screens all HCP (including consultant personnel) at the beginning of their shift for fever and respiratory symptoms (actively takes their temperature and documents absence of shortness of breath, new or change in cough, and sore throat). • If they are ill, they are instructed to put on a facemask and return home.		
Facility keeps a list of symptomatic HCP and their disposition		
Education, monitoring, and screening of residents		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility has provided education to residents about the following: • COVID-19 (e.g., symptoms, how it is transmitted) • Importance of immediately informing HCP if they feel feverish or ill • Actions they can take to protect themselves (e.g., hand hygiene, covering their cough, maintaining social distancing) • Actions the facility is taking to keep them safe (e.g., visitor restrictions, changes in PPE, canceling group activities and communal dining)		
Facility assesses residents for fever and symptoms of respiratory infection upon admission and at least daily throughout their stay in the facility. • Residents with suspected respiratory infection are immediately placed in appropriate Transmission-Based Precautions. • Facility knows that Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 if it is circulating in the community.		
Facility has taken action to stop group activities inside the facility and field trips outside of the facility.		
Facility has taken action to stop communal dining.		
Facility has residents who must regularly leave the facility for medically necessary purposes (e.g., residents receiving		

hemodialysis or chemotherapy) wear a facemask whenever they leave their room, including for procedures outside of the facility.		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) • Residents are encouraged to remain in their room. If there are cases in the facility, residents are restricted (to the extent possible) to their rooms except for medically necessary purposes. If residents leave their room, they wear a facemask, perform hand hygiene, limit movement in the facility and perform social distancing. • Consider implementing protocols for cohorting ill residents with dedicated HCP. • Facility has implemented universal use of facemasks for HCP (for source control) while in the facility. If facemasks are in short supply, they are prioritized for direct care personnel.		

Availability of PPE and Other Supplies		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility has assessed current supply of PPE and other critical materials (e.g., alcohol-based hand rub, EPA-registered disinfectants, tissues).		
If PPE shortages are identified or anticipated, facility has engaged their healthcare coalition for assistance. https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx		
Facility has implemented measures to optimize current PPE supplies, which include options for extended use, reuse, and alternatives to PPE. For example, under extended use, the same facemask and eye protection may be worn during the care of more than one resident. Gowns could be prioritized for select activities such as activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP. Additional options and details are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html		
Hand hygiene supplies are available in all resident care areas. • Alcohol-based hand sanitizer* with 60-95% alcohol is available in every resident room and other resident care and common areas.		

• Sinks are stocked with soap and paper towels. *If there are shortages of ABHS, hand hygiene using soap and water is still expected.		
PPE is available in resident care areas (e.g., outside resident rooms). PPE includes: gloves, gowns, facemasks, N-95 of higher-level respirators (if facility has a respiratory protection program and HCP are fit-tested) and eye protection (face shield or goggles).		
EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. *See EPA List N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2		
Tissues are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.		
Infection Prevention and Control Practices		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
HCP perform hand hygiene in the following situations: • Before resident contact, even if PPE is worn • After contact with the resident • After contact with blood, body fluids or contaminated surfaces or equipment • Before performing sterile procedure • After removing PPE		
HCP wear the following PPE when caring for residents with confirmed of suspected COVID-19: • Gloves • Isolation gown • Facemask (or N95 respirator if available and fit tested) • Eye protection (e.g., goggles or face shield)		
PPE are removed in a manner to prevent self-contamination, hand hygiene is performed, and new PPE are put on after each resident except as noted below.		
Non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use.		
EPA-registered disinfectants are prepared and used in accordance with label instructions.		
Communication		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility communicates information about known or suspected COVID-19 patients to appropriate personnel (e.g., transport personnel, receiving facility) before transferring them to healthcare facilities.		
Facility notifies the health department about any of the following:		

• COVID-19 is suspected or confirmed in a resident or healthcare provider • A resident has severe respiratory infection • A cluster (e.g., ≥ 3 residents or HCP with new-onset respiratory symptoms over 72 hours) of residents or HCP with symptoms of respiratory infection is identified.		

Self-Monitoring of Asymptomatic Healthcare Personnel (HCP)

Instructions: HCP should check their temperature and complete this form twice daily for 14 days after the date of the last exposure. If temperature is above or equal to 38.0°C/100.0°F, HCP report subjective fevers, or any of the following symptoms, they should self-isolate and notify their healthcare facility or call their local public health department. They should ensure their temperature is below 38.0°C/100.0°F and that they don't have any of the following symptoms before they leave home and report to work.

Name	Employee ID #	Phone	Email	Job Title	Supervisor	Date of last exposure

Day # After Exposure	Date	Time	Temp	Symptoms (check if you have any of the following)													
				Subjective Fever	Cough	Sore throat	Shortness of breath	Runny Nose	Chills	Muscle aches	Headache	Fatigue	Abdominal Pain	Nausea or Vomiting	Diarrhea	None	Other
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Evaluation of Asymptomatic Healthcare Personnel (HCP)

Instructions: HCP can start work if temperature is below 38.0°C/100.0°F, and no subjective fever or any of the following symptoms are reported.

Name	Employee ID #	Phone	Email	Job Title	Supervisor	Date of last exposure	Screening Personnel Name

Day # After Exposure	Date	Time	Temperature	Symptoms (check if you have any of the following)														Screening Personnel Name and Signature
				Subjective Fever	Cough	Sore throat	Shortness of breath	Runny Nose	Chills	Muscle aches	Headache	Fatigue	Abdominal Pain	Nausea or Vomiting	Diarrhea	None	Other	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		

Guidelines for Cleaning and Disinfection for SARS-CoV-2 (the virus that causes COVID-19)

- Dedicated medical equipment should be used for resident care.
- All non-dedicated, non-disposable medical equipment used for resident care should be cleaned and disinfected according to the manufacturer's instructions for use (IFUs) and facility policy between residents.
  - If there are no IFUs for cleaning/disinfecting, consider it for individual use only.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. Audit staff (observe and document) and provide written feedback to personnel.
- Use EPA-approved disinfection products from "List N: Disinfectants for Use Against SARS-CoV-2" available at https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2.
- Follow the IFUs of all cleaning and disinfection products (e.g., concentration, application method, contact time, and use appropriate PPE).
- Clean the surface first, and then apply the disinfectant as instructed on the disinfectant manufacturer's label. Ensure adequate contact time for effective disinfection.
- Adhere to safety precautions and other label recommendations as directed (e.g., allowing adequate ventilation in confined areas, proper disposal of unused product or used containers and donning appropriate PPE). Do not mix chemicals.
- Wear disposable gloves when cleaning. Always perform hand hygiene before putting on and after removing gloves.
  - Staff should perform hand hygiene, wash hands with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer that contains 60 to 95% alcohol. Soap and water should be used if the hands are visibly soiled.
- Treat multi-occupancy rooms as different rooms, meaning that one set of gloves and cleaning cloths are used to clean each resident's section of the room. This will minimize cross-contamination. The bathroom should be treated as a separate space with fresh gloves and cloths. If a cleaning cloth is used to clean the toilet, a fresh cloth should be used to clean the handrails.
- Terminal cleaning should include changing/cleaning of privacy curtains.
- Management of laundry, food service utensils, and medical waste should also be performed in according to IFU and facility policy.

Best Practices for Long-Term Care Facilities:

- Establish written cleaning/disinfection policies which include routine and terminal cleaning of resident rooms, cleaning when contact/droplet precautions are in place, high-touch surfaces and common areas, and handling of shared equipment (e.g. blood pressure cuffs, rehab therapy equipment, etc.).
- Establish policies and procedures to ensure that reusable medical devices (e.g. blood glucose meters, wound care equipment, etc.) are cleaned and reprocessed appropriately prior to use on another resident.
- Dedicated reusable medical devices are considered a "best practice." If a facility decides to use dedicated equipment (e.g. glucometers), each device should be labeled with the resident's name for resident safety. Dedicated equipment should be cleaned and disinfected prior to storage.

- Avoid using product application methods that cause splashing or generate aerosols.
- Cleaning activities should be supervised and inspected periodically to ensure correct procedures are followed.
- Review cleaning and disinfection products and protocols with floor staff and housekeeping:
    - Ensure they understand the necessary contact time/treatment time
    - Differences between porous and non-porous surfaces
- Room cleaning:
    - Daily cleaning
    - High touch surfaces every shift (door handles, bedside tables, bed rails, TV remote, call button, light switches)
- Facilities should consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who will already be in the room providing care to the resident.
- When cleaning, work from the least to most dirty, and highest to lowest. Start with the least dirty areas such as mirrors and proceed through the resident's room to the dirtiest spots, such as bathroom/toilet to reduce the risk of cross-contamination and spread of infection-causing pathogens.

Resources:

- Infection prevention and control guidance for COVID-19 can be found on CDC's website: "Healthcare Infection Prevention and Control FAQs for COVID-19" located at https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html and "Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings" located at https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
- Detailed information on environmental infection control in healthcare settings can be found in CDC's "Environmental Cleaning and Disinfection Recommendations" located https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html
- Additional tools for environmental cleaning in healthcare settings are available at: https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/services.html https://www.cdc.gov/hai/pdfs/toolkits/environmental-cleaning-checklist-10-6-2010.pdf
- The Minnesota Hospital Association has an example of an effective cleaning guidebook which can be modified to include representative pictures of furniture in your facility to customize training for Environmental Services Staff available at: https://www.mnhospitals.org/Portals/0/Documents/ptsafety/CDICleaning/4.%20Environmental%20Services%20Cleaning%20Guidebook.pdf

Personal Protective Equipment (PPE) Competency Validation

Donning and Doffing – Gown, Gloves, Mask or Respirator, Eye Protection

Donning PPE	Correct	Incorrect
1. **Perform Hand Hygiene**		
2. Don Gown: • Fully covering torso from neck to knees, arms to end of wrists • Fasten in the back of neck and waist		
3. Don Mask or NIOSH approved, fit-tested N95 (or equivalent) • Secure ties/elastic bands at middle of head & neck • Fit flexible band to nose bridge • Fit snug to face and below chin		
4. Don Goggles or Face Shield: • Place over face and eyes and adjust to fit		
5. Don Gloves: • Extend to cover wrist of gown		
Doffing PPE		
1. Remove Gloves: • Using a gloved hand, grasp outside of glove with opposite gloved hand; peel off • Hold removed glove in the opposite gloved hand • Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove • Discard gloves in waste container • Outside of the gloves are contaminated. If your hands get contaminated during glove removal, immediately wash your hands or use alcohol-based hand sanitizer		
2. Remove Goggles or Face Shield: • Remove from the back by lifting head band or ear pieces • Discard in designated receptacle if re-processed or in waste container • Outside of the goggles or face shield are contaminated. If your hands get contaminated during goggles or face shield removal, immediately wash your hands or use alcohol-based hand sanitizer		
3. Remove Gown: • Unfasten ties/fastener taking care that sleeves don't contact your body when reaching for ties • Pull away from neck and shoulders, touching inside of gown only • Turn gown inside out • Fold or roll into bundle and discard • Gown front and gown sleeves are contaminated. If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer		
4. Remove Mask NIOSH approved, fit-tested N95 (or equivalent): • Front of the mask is contaminated – DO NOT TOUCH! • If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer • Grasp bottom, then top ties or elastics and remove without touching the front of the mask • Discard in waste container		
5. Perform Hand Hygiene after removing all PPE • Wash hands with soap and water for at least 20 seconds OR • Use an alcohol-based hand sanitizer • Perform hand hygiene between steps if hands become contaminated		

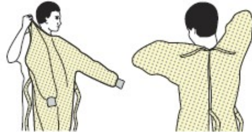
Standard Precautions & Transmission Based Precautions	Correct	Incorrect
23. Staff correctly identifies the appropriate PPE for the following scenarios:		
a. Standard Precautions (PPE to be worn based on anticipated level of exposure)*		
b. Contact/Contact Enteric Precautions (gown & gloves)		
c. Droplet Precautions (surgical mask with eye protection)		
d. Airborne Precautions (OSHA approved, fit-tested respirator if applicable)		

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

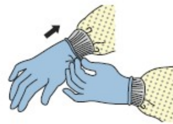
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

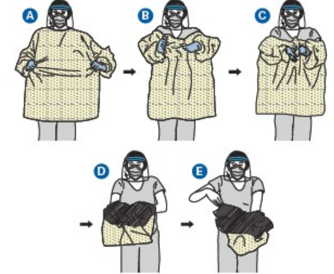
CS250672-E

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



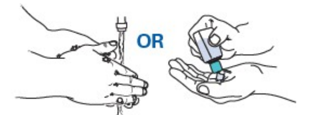
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CS250672-E

https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf

Comments or follow up actions:

Facility Name: Date of Assessment:

Name of person conducting assessment:

Number of staff involved in infection prevention and control: ____________

What is your current process and training around hand hygiene?

- Evaluate hand sanitizer locations:
  Inside room _______ Outside room______ Facility Entrances _________

  Common areas:________________

What is your current process for training staff on hand hygiene and PPE? Have you done any recent training?

How many do you currently have on site?

  - Masks:
  - Gowns:
  - Face shield:
  - Goggles:
  - Gloves:
- How many of each would you need, to have enough supplies (using one complete set of PPE for each patient care encounter: 1 mask, 1 gown, 1 face shield, 2 gloves) for double your current number of residents in the facility for 5-7 days? Use the answers to estimate how long your PPE can last, per Appendix of this document.

What is your current plan for maximizing these PPE resources? (See Appendix)

Do you have places to discard PPE? Inside room:________________ Outside rooms:__________________

What is your process for monitoring hand hygiene adherence?

What is your process for monitoring PPE adherence?

What is your process around cleaning and disinfecting in areas with symptomatic residents? (Discuss with EVS)

What is your process for use and cleaning and disinfecting of shared medical equipment? (Discuss with EVS and front-line nursing staff)

What is your current process for monitoring & documenting residents for symptoms?

- Recommend temp check, pulse oximetry (if available) and symptom checks in every shift
- Consider checking pulse oximetry for residents (prioritizing residents with respiratory symptoms)
- Recommend temp check and symptom screen for all employees at start of shift (at the minimum).

What is your current screening process for visitors?

- Recommend single entry for all visitors, limiting visitation to general public

Walk through the facility and document any infection control issues (IPC infrastructure, observations, training needs)

Appendix

Facilities need to anticipate and monitor their PPE usage to (1) place new orders before running out, (2) understand the impact of changing PPE use requirements, and (3) predict the impact of increased patient census requiring enhanced PPE practices, and (4) anticipate the need to implement PPE use optimization strategies (including 'batching' care provision to decrease the number of times a HCW enters a patient room needing full PPE) and extending the life of limited existing supplies. Here are two approaches to help you plan PPE usage:

The first approach is to:

- check item counts in each PPE category (gloves, gowns, face shields or goggles, and mask or respirator) over several days (or extract historic information from electronic inventory systems if available),
- determine average daily consumption of each, and
- divide the result into total current PPE item counts to estimate the # days of remaining supply in each PPE category.
- The strength of this approach is that it reflects true historic consumption, but each facility will need to factor in potential increases in COVID-19 patient census to predict future PPE needs.

The second approach helps predict future PPE needs and provides a basis for discussing the impact of PPE optimization strategies like batching care tasks together to minimize the number of HCW entries into a patient room thus reducing the amount of PPE used without compromising patient care:

- Determine the 'typical' number of patient room entries made each shift by each category of caregiver. **For example**, RN = 4x/shift, CNA = 15x/shift, housekeeper = 1x/shift, food service = 2x/shift = 22 separate patient room entries thus 22 complete PPE ensembles needed per shift under 'typical' circumstances.
- Multiply those numbers by the number of shifts in a day: 22 PPE sets x 3 shifts per day = 66 sets of PPE per day
- Multiply that result by the number of each PPE element required for each patient room entry:
  - Total PPE needed for 1 day of patient care: 66 gowns, 66 isolation masks or N95 respirators, 66 face shields, 132 gloves.
  - This result is the estimated total amount of PPE needed to care for a COVID-19 patient or PUI for one day.
- By batching care and minimizing room entries, the total amount of PPE consumed can dramatically be reduced:
  - For example: If the CNA can combine tasks while in the room, perhaps the number of entries per shift could be reduced, for the purposes of illustration here, from 15 to 10.
  - If either the nurse or CNA can take in the food and remove the trash, two more room entries per shift could be eliminated for this example.
  - A reduction of room entries per shift from 22 to 14 would result in >35% reduction in daily PPE use per patient.

CDC has published guidance on strategies for optimizing the supply of personal protective equipment (PPE), available on the CDC website here.

Standard Precautions: Observation of Hand Hygiene Provision of Supplies

Instructions: Observe patient care areas or areas outside of patient rooms. For each category, record the observation. In the column on the right, sum (across) the total number of "Yes" and the total number of observations ("Yes" + "No"). Sum all categories (down) for overall performance.

	Standard Precautions: Observation Categories	Room 1	Room 2	Room 3	Room 4	Room 5	Summary of Observations	
							Yes	Total Observed
1	Are functioning sinks readily accessible in the patient care area?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
2	Are all handwashing supplies, such as soap and paper towels, available?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
3	Is the sink area clean and dry?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
4	Are any clean patient care supplies on the counter within a splash-zone of the sink?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
5	Are signs promoting hand hygiene displayed in the area?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
6	Are alcohol dispensers readily accessible?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
7	Are alcohol dispensers filled and working properly?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
Total YES and TOTAL OBSERVED								

Standard Precautions: Observation of Hand Hygiene Provision of Supplies

Date:_______________

Observer Role: ☐ Nurse ☐ Tech ☐ Other___________ Initials:______

Location/Unit:_____________

Notes and comments:

Standard Precautions: Observation of Personal Protective Equipment Provision

Instructions: Observe patient care areas or areas outside of patient rooms. For each category, record the observation. In the column on the right, sum (across) the total number of "Yes" and the total number of observations ("Yes" + "No"). Sum all categories (down) for overall performance.

	Standard Precautions: Observation Categories	Room 1	Room 2	Room 3	Room 4	Room 5	Summary of Observations	
							Yes	Total Observed
1	Are gloves readily available outside each patient room or any point of care?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
2	Are cover gowns readily available near each patient room or point of care?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
3	Is eye protection (face shields or goggles) readily available near each patient room or point of care?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
4	Are face masks readily available near each patient room or point of care?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
5	Are alcohol dispensers readily accessible and functioning?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No		
Total YES and TOTAL OBSERVED								

Date:________________

Observer Role: ☐ Nurse ☐ Tech ☐ Other___________ Initials:______

Location/Unit:_____________

Notes and comments:

Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19

Background

Long-term care facilities with known cases of COVID-19 or multiple cases of unexplained respiratory illness should monitor and track vital signs of residents. If residents have new symptoms or worsening trends in vital signs, they should be placed on transmission-based precautions and monitored more frequently. Clinical evaluation should be considered. Transfer to higher level care should be based on clinical evaluation of the patient and not solely on test results.

CDC March 23 Guidance: Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)

Disposition of Patients with COVID-19:

Patients can be discharged from the healthcare facility whenever clinically indicated.

If discharged to home:

- Isolation should be maintained at home if the patient returns home before discontinuation of transmission-based precautions. The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations. Guidance on implementing home care of persons who do not require hospitalization and the discontinuation of home isolation for persons with COVID-19 is available.

If discharged to a long-term care or assisted living facility, AND

- Transmission-based precautions are still required, they should go to a facility with adequate personal protective equipment supplies and an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed at a facility that has already cared for COVID-19 cases, in a specific unit designated to care for COVID-19 residents
- Transmission-based precautions have been discontinued, but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room
- Transmission-based precautions have been discontinued and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19

Discontinuation of Transmission-Based Precautions for Patients with COVID-19:

Hospitalized patients may have longer periods of SARS-CoV-2 RNA detection compared to patients with mild or moderate disease. Severely immunocompromised patients (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV) may also have longer periods of SARS-CoV-2 RNA detection and prolonged shedding of infectious recovery. These groups may be contagious for longer than others. In addition, placing a patient in a setting where they will have close contact with individuals at risk for severe disease warrants a conservative approach. Hence, a test-based strategy is preferred for discontinuation of transmission-based precautions for patients who are hospitalized, severely immunocompromised, or being transferred to a long-term care or assisted living facility.

Test-based strategy:

- Resolution of fever without the use of fever-reducing medications **AND**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **AND**
- Negative results of a COVID-19 molecular assay from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens)

If testing is not readily available facilities may choose to use the non-test-based strategy for discontinuation of transmission-based precautions or extend the period of isolation beyond the non-test-based-strategy duration, on a case by case basis in consultation with local and state public health authorities.

Non-test-based strategy:

- At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**,
- At least 7 days have passed since symptoms first appeared

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. If possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room).

The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.

FROM:

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
- https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf

For further information on the care of persons diagnosed with COVID-19 in LTCF settings, please see the following guidance from CDC and CMS:

- CDC: Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes: https://www.cdc.gov/coronavirus/2019- ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
- CMS: Guidance for Infection Control and Prevention of COVID-19 in nursing homes: https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

Report of Concern for COVID-19 in a High-Risk Setting

Section I. Facility Information

Facility Name:

Address:	City:
Contact Person (last, first):	Title:

Phone:	Fax:	Email:

Facility type (check one):

☐ Acute care hospital ☐ Long-term care/rehab facility ☐ Behavioral health inpatient/residential
☐ Homeless shelter ☐ Dialysis center ☐ First responder ☐ Correctional facility ☐ Community health clinic/FQHC
☐ Adult family home ☐ Childcare ☐ Other: ____
If long-term care, select type: ☐ Skilled nursing ☐ Rehab/short-stay ☐ Assisted living ☐ Independent living

Which acute care facilities are non-staff generally routed to?

Reason for call/concern:

Does the concern meet the criteria for investigation?
Refer to criteria currently used by triage or call center staff ☐ Yes ☐ No

Section II. Illness and Testing Information

Non-staff (e.g., residents, patients, inmates)	**Staff**
Total number:	Total number:
First onset date: ____/____/____ Ongoing? Y/N	First onset date: ____/____/____ Ongoing? Y/N
Total # symptomatic: _____ ☐ Fever >100°F PLUS cough or sore throat ☐ Severe respiratory illness or pneumonia requiring hospitalization ☐ Other___________________________________	Total # symptomatic: _____ ☐ Fever >100°F PLUS cough or sore throat ☐ Severe respiratory illness or pneumonia requiring hospitalization ☐ Other___________________________________
# who visited ED:	# who visited ED:
# hospitalized:	# hospitalized:
# in ICU:	# in ICU:
# died since first onset date:	# died since first onset date:
# tested:	# tested:

	Positive	**Negative**	**Pending**		**Positive**	**Negative**	**Pending**
COVID-19				COVID-19			
Influenza A				Influenza A			
Influenza B				Influenza B			

Section III. Infection Control

Date control measures implemented: ____/____/____ Date control measures stopped: ____/____/____