**COVID-19 Personal Protective Equipment (PPE)**

**Staff Practice**

**Implementation Checklist**

**Implementation Checklist: COVID-19 Personal Protective Equipment (PPE) – Staff Practice**

| **Requirement** | **Suggested Action** |
| --- | --- |
| **F880 §483.80 Infection Control**“The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: 1. A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
2. When and to whom possible incidents of communicable disease or infections should be reported;
3. Standard and transmission-based precautions to be followed to prevent spread of infections;
4. When and how isolation should be used for a resident; including but not limited to:
	1. (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
	2. (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
5. The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
6. The hand hygiene procedures to be followed by staff involved in direct resident contact.”

“Personal protective equipment (PPE)”: protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission.”• “How to use standard precautions and how and when to use transmission-based precautions (i.e., contact precautions, droplet precautions, airborne isolation precautions). The areas described below are part of standard and transmission-based precautions40 which are further described under their respective sections. For example: o Hand hygiene (HH) (e.g., hand washing and/or ABHR): consistent with accepted standards of practice such as the use of ABHR instead of soap and water in all clinical situations except when hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected Clostridium (C.) difficile or norovirus infection during an outbreak, or if infection rates of C. difficile infection (CDI) are high; in these circumstances, soap and water should be used;47 NOTE: According to the CDC, strict adherence to glove use is the most effective means of preventing hand contamination with C. difficile spores as spores are not killed by ABHR and may be difficult to remove even with thorough hand washing. For further information on appropriate hand hygiene practices see the following CDC website: <http://www.cdc.gov/handhygiene/providers/index.html> o The selection and use of PPE (e.g., indications, donning/doffing procedures) and the clinical conditions for which specific PPE should be used (e.g., CDI, influenza); o Addressing the provision of facemasks for residents with new respiratory symptoms”**“**Education and competency assessment: facilities must ensure staff follow the IPCP’s standards, policies and procedures. Therefore, staff must be informed and competent. Knowledge and skills pertaining to the IPCP’s standards, policies and procedures are needed by all staff in order to follow proper infection control practices (e.g., hand hygiene and appropriate use of personal protective equipment)”1 | * The DON, Infection Preventionist or designee develop a policies and procedures for :
	+ PPE use
	+ Universal Source Control
	+ Calculating Rate
	+ Ordering PPE
	+ Restocking PPE
	+ Optimizing PPE based upon current CDC, CMS, or State guidance
* The Infection Preventionist or Designee will direct all staff education and verification of competency on PPE use
* The Infection Preventionist or Designee will complete ongoing process surveillance audits on PPE donning, doffing and use
 |
| **CDC summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages**“These strategies offer a continuum of options using the framework of surge capacity when PPE supplies are stressed, running low, or absent. When using these strategies, healthcare facilities should:* Consider these options and **implement them sequentially**
* Understand their current PPE inventory, supply chain, and [utilization rate](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html)
* Train healthcare personnel on PPE use and have them demonstrate competency with donning and doffing any PPE ensemble that is used to perform job responsibilities
* Once PPE availability returns to normal, promptly resume conventional practices

Conventional Capacity: strategies that should already be in place as part of general infection and control plans in healthcare settingsContingency Capacity: strategies that can be used during periods of anticipated PPE shortagesCrisis Capacity\*: strategies that can be used when supplies cannot meet the facility’s current or anticipated PPE utilization rate”2\*Not commensurate with U.S, standards of care” | * The Infection Preventionist or Designee will complete the burn rate calculator to identify utilization rate of PPE, need and supply chain information
* The Administrator, DON and Administrator will review the utilization rate and need and put together a plan for accessing adequate PPE
* The Infection Preventionist will put together a plan to outline options for surge capacity when PPE supplies are stressed, running low, or absent to include strategies for conventional, contingency and crisis capacity.
* The Infection Preventionist will determine if the facility is at conventional, contingency or crisis capacity.
* During the COVID-19 Pandemic, facility will:
	+ Limit employees to those only directly necessary for resident care
	+ Practice consistent assignment whenever possible
 |
| **United States Department of Labor, Occupational Safety and Health Administration (OSHA) Standard 1910 Respiratory Protection** “[1910.134(a)(1)](https://www.osha.gov/laws-regs/interlinking/standards/1910.134%28a%29%281%29)In the control of those occupational diseases caused by breathing air contaminated with harmful dusts, fogs, fumes, mists, gases, smokes, sprays, or vapors, the primary objective shall be to prevent atmospheric contamination. This shall be accomplished as far as feasible by accepted engineering control measures (for example, enclosure or confinement of the operation, general and local ventilation, and substitution of less toxic materials). When effective engineering controls are not feasible, or while they are being instituted, appropriate respirators shall be used pursuant to this section.[1910.134(a)(2)](https://www.osha.gov/laws-regs/interlinking/standards/1910.134%28a%29%282%29)A respirator shall be provided to each employee when such equipment is necessary to protect the health of such employee. The employer shall provide the respirators which are applicable and suitable for the purpose intended. The employer shall be responsible for the establishment and maintenance of a respiratory protection program, which shall include the requirements outlined in paragraph (c) of this section. The program shall cover each employee required by this section to use a respirator.” “[1910.134(c)(1)](https://www.osha.gov/laws-regs/interlinking/standards/1910.134%28c%29%281%29)In any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory protection program with worksite-specific procedures.  The program shall be updated as necessary to reflect those changes in workplace conditions that affect respirator use.”“1910.134(c)(2)(ii) An employer may provide respirators at the request of employees or permit employees to use their own respirators, if the employer determines that such respirator use will not in itself create a hazard. If the employer determines that any voluntary respirator use is permissible, the employer shall provide the respirator users with the information contained in Appendix D to this section ("Information for Employees Using Respirators When Not Required Under the Standard"); and[1910.134(c)(2)(ii)](https://www.osha.gov/laws-regs/interlinking/standards/1910.134%28c%29%282%29%28ii%29)In addition, the employer must establish and implement those elements of a written respiratory protection program necessary to ensure that any employee using a respirator voluntarily is medically able to use that respirator, and that the respirator is cleaned, stored, and maintained so that its use does not present a health hazard to the user. Exception: Employers are not required to include in a written respiratory protection program those employees whose only use of respirators involves the voluntary use of filtering facepieces (dust masks).1910.134(c)(3)The employer shall designate a program administrator who is qualified by appropriate training or experience that is commensurate with the complexity of the program to administer or oversee the respiratory protection program and conduct the required evaluations of program effectiveness.[1910.134(c)(4)](https://www.osha.gov/laws-regs/interlinking/standards/1910.134%28c%29%284%29)The employer shall provide respirators, training, and medical evaluations at no cost to the employee.”“[1910.134(f)](https://www.osha.gov/laws-regs/interlinking/standards/1910.134%28f%29)***Fit testing.*** This paragraph requires that, before an employee may be required to use any respirator with a negative or positive pressure tight-fitting facepiece, the employee must be fit tested with the same make, model, style, and size of respirator that will be used.”  | * It is recommended that the DON, Administrator and Infection Preventionist or Designee, implement a written, facility specific respiratory protection program that includes:
	+ Medical Evaluation
	+ Fit Testing
	+ Training
* Identify the trained Respiratory Protection Program administrator (Infection Preventionist or Designee)
* The Infection Preventionist will complete a risk assessment to identify employees that could be at risk of exposure to airborne hazards
* Implementation of the Respiratory Protection Program
	+ Resource: Occupational Safety and Health Administration (OSHA®) “Respiratory Protection Guidance for the Employers of Those Working in Nursing Homes, Assisted Living, and Other Long-Term Care Facilities During the COVID-19 Pandemic”: <https://www.osha.gov/sites/default/files/respiratory-protection-covid19-long-term-care.pdf>
 |
| Nursing Home Reopening Recommendations for State and Local Officials (QSO-20-30-NH) (May 18, 2020) (Revised September 28, 2020) | * Download at:<https://www.cms.gov/files/document/qso-20-30-nh.pdf-0>
* Create a Performance Improvement Project (PIP) Team to review existing policies, procedures, tools, and practices; develop and test alternatives; finalize policies, procedures, tools, and practices as needed.
* Use trustworthy resources in developing/revising any policies, procedures, or practices:
* Centers for Medicare and Medicaid Services (CMS)
* Centers for Disease Control and Prevention (CDC)
* World Health Organization (WHO)
* Agency for Healthcare Research and Quality (AHRQ)
* Occupational Safety and Health Administration (OSHA)
* U.S. Food and Drug Administration (FDA)
* The Infection Preventionist and at least one additional facility leader should be designated to monitor federal, state, and local websites at least weekly to identify regulations or recommended guidance affecting facility policy, procedure, or practice related to COVID-19 screening and monitoring of residents, staff, and visitors.
 |
| **Phases 1, 2, and 3 of Reopening** |  |
| Universal Source Control* Everyone in the facility (including residents and visitors) wear a cloth face covering or facemask.

**NOTE:** Cloth face coverings are not PPE.**NOTE:** Staff, or Healthcare Personnel (HCP): “HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).”3 | * Actions may include, but are not limited to, the following measures:
	+ Write/Revise a COVID-19 PPE Staff Practice Policy and Procedure
* Include Universal Source Control for residents and visitors
* Develop/Revise and present education for staff (including agency staff and new employees)
* Post signs regarding universal source control
* Communicate policies and procedures with staff members working off-site or at home and remind them they will be subject to universal source control should they enter the building for any reason
* Communicate with staffing agencies regarding universal source control
* Communicate with hospice, emergency medical services, rehabilitative services, lab, x-ray, pharmacy, and other clinical vendors regarding universal source control
* Communicate with residents and visitors regarding universal source control measures
* Schedule Infection Preventionist and/or designee(s) for active participation in education and monitoring of universal source control practices
* Ensure adequate supply of cloth face coverings and masks, cleaning/sanitizing materials
* Audit for compliance through record reviews, interviews, and observations
 |
| **Phase 1 of Reopening** |  |
| All staff wear appropriate PPE when they are interacting with residents to the extent PPE is available and consistent with CDC guidance on optimization of PPE. Staff wear cloth face covering if facemask is not indicated.**NOTE:** Cloth face coverings are not PPE.**NOTE:** Staff, or Healthcare Personnel (HCP): “HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).”3 | Actions may include, but are not limited to, the following measures:* Write/Revise a COVID-19 PPE Staff Practice Policy and Procedure
* Develop/Revise and present education for staff (including agency staff and new employees)
* Post signs regarding isolation precautions in use
* Communicate policies and procedures with staff members working off-site or at home and remind them they will be subject to PPE staff practices should they enter the building for any reason
* Communicate with staffing agencies regarding isolation precautions in use and PPE expectations and status
* Communicate with hospice, emergency medical services, rehabilitative services, lab, x-ray, pharmacy, and other clinical vendors regarding isolation precautions in use and PPE expectations and status
* Communicate with residents and visitors regarding reopening phase
* Schedule Infection Preventionist and/or designee(s) for active participation in education and monitoring of staff PPE practice
* Ensure adequate supply of PPE equipment, cleaning/sanitizing materials
* Calculate PPE burn rate at least weekly and whenever transitioning from one reopening phase to another
* Report to federal, state, local agencies as mandated
* Audit for compliance through record reviews, interviews, and observations
 |
| **Phases 2 and 3 of Reopening** |  |
| All staff wear appropriate PPE when indicated. Staff wear cloth face covering if facemask is not indicated, such as administrative staff.**NOTE:** Cloth face coverings are not PPE.**NOTE:** Staff, or Healthcare Personnel (HCP): “HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).”3 | Actions may include, but are not limited to, the following measures:* Write/Revise a COVID-19 PPE Staff Practice Policy and Procedure
* Develop/Revise and present education for staff (including agency staff and new employees)
* Post signs regarding isolation precautions in use
* Communicate policies and procedures with staff members working off-site or at home and remind them they will be subject to PPE staff practices should they enter the building for any reason
* Communicate with staffing agencies regarding isolation precautions in use and PPE expectations and status
* Communicate with hospice, emergency medical services, rehabilitative services, lab, x-ray, pharmacy, and other clinical vendors regarding isolation precautions in use and PPE expectations and status
* Communicate with residents and visitors regarding reopening phase
* Schedule Infection Preventionist and/or designee(s) for active participation in education and monitoring of staff PPE practice
* Ensure adequate supply of PPE equipment, cleaning/sanitizing materials
* Calculate PPE burn rate at least weekly and whenever transitioning from one reopening phase to another
* Report to federal, state, local agencies as mandated
* Audit for compliance through record reviews, interviews, and observations
 |

**References and Resources**

1Centers for Medicare & Medicaid Services. State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

2Centers for Disease Control and Prevention. Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages. Updated Dec. 29, 2020: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html>

Centers for Disease Control and Prevention. Hospital Respiratory Protection Program Toolkit Resources for Respirator Program Administrators (May 2015): <https://www.cdc.gov/niosh/docs/2015-117/pdfs/2015-117.pdf?id=10.26616/NIOSHPUB2015117>

Centers for Disease Control and Prevention. Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators (October 19, 2020): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>

Centers for Disease Control and Prevention. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. Updated Feb. 10, 2021: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

Centers for Disease Control and Prevention. Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings: <https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html>

Centers for Disease Control and Prevention. Strategies for Optimizing the Supply of N95 Respirators (Updated February 10, 2021): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

Centers for Medicare and Medicaid Services. Nursing Home Reopening Recommendations for State and Local Officials (QSO-20-30-NH) (May 18, 2020) (Revised September 28, 2020)

<https://www.cms.gov/files/document/qso-20-30-nh.pdf-0>

Centers for Medicare and Medicaid Services. Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID19 Focused Survey Tool (QSO-20-38-NH) (August 26, 2020)

<https://www.cms.gov/files/document/qso-20-38-nh.pdf>

Occupational Safety and Health Administration. Temporary Enforcement Guidance - Healthcare Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak (March 14, 2020)

<https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit>

Occupational Safety and Health Administration. Transcript for the OSHA Training Video Entitled Respirator Fit Testing:

<https://www.osha.gov/video/respiratory_protection/fittesting_transcript.html>

Video <https://www.osha.gov/video/respiratory_protection/fittesting.html>

U. S. Food and Drug Administration. Enforcement Policy for Face Masks and Respirators During the Coronavirus Disease (COVID-19) Public Health Emergency (Revised) (May 2020): <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/enforcement-policy-face-masks-and-respirators-during-coronavirus-disease-covid-19-public-health>

U. S. Food and Drug Administration. Face Masks, Including Surgical Masks, and Respirators for COVID-19 (Current content as of 11/24/2020): <https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/face-masks-including-surgical-masks-and-respirators-covid-19>

U. S. Food and Drug Administration. Personal Protective Equipment EUAs (Current content as of 12/4/2020): <https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas>