Infection Prevention and Control Manual
Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)

Coronavirus-(COVID-19)

The Centers for Disease Control has published interim guidance entitled, "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" Updated February 21, 2020, stating, "This guidance is based on the currently limited information available about coronavirus disease 2019 related to disease severity, transmission efficiency, and shedding duration. This cautious approach will be refined and updated as more information becomes available and as response needs change in the United States. This guidance is applicable to all U.S. healthcare settings."[1]

This information had been utilized, to develop the following policy and procedure.

Policy

It is the policy of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Standard, Contact and Airborne Precautions, including the use of eye protection. If facility is not equipped with an Airborne Infection Isolation Room (AIIR) maintained in accordance with current guidelines, resident will be transferred as soon as possible to a facility where an AIIR is available.

Note: All healthcare personnel will be correctly trained and capable of implementing infection control procedures and adhere to requirements.

Criteria to Guide Evaluation of Persons Under Investigation (PUI) for COVID-19[2]:

"Local health departments, in consultation with clinicians, should determine whether a patient is a PUI for COVID-2019. The CDC clinical criteria for COVID-19 PUIs have been developed based on available information about this novel virus, as well as what is known about Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). These criteria are subject to change as additional information becomes available.

Clinical Features	&	Epidemiologic Risk
Fever[1] **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including healthcare workers[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset
Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	AND	A history of travel from affected geographic areas[5] (see below) within 14 days of symptom onset
Fever[1] with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)[6]	AND	No source of exposure has been identified

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Affected Geographic Areas with Widespread or Sustained Community Transmission
Last updated February 28, 2020

- China (Level 3 Travel Health Notice)
- Iran (Level 3 Travel Health Notice)
- Italy (Level 3 Travel Health Notice)
- Japan (Level 2 Travel Health Notice)
- South Korea (Level 3 Travel Health Notice)

"The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria."[2]

Footnotes

[1]Fever may be subjective or confirmed

[2]For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).

[3]Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Additional information is available in CDC's updated Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings.

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings as described in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19.

[4]Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.

[5]Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. See all COVID-19 Travel Health Notices.

[6]Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which COVID-19 is being considered"[2]

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Procedure

1. Prior to admission, identify on the preadmission screen if resident is exhibiting symptoms of any respiratory infection (i.e. cough, fever, shortness of breath, etc.) to determine appropriate placement.

2. For new residents (or residents with recent travel) obtain a detailed travel history, contact with anyone with lab confirmed COVID-19 and identify if resident exhibits fever and acute respiratory illness.

3. A resident with known or suspected COVID-19, immediate infection prevention and control measures will be put into place. Resident will be placed in an AIIR that is constructed and maintained in accordance with current guidelines. Once in the AIIR, the resident's facemask may be removed and resident movement and/or transport will be limited to only essential purposes. If movement and/or transport is necessary, the resident is to wear a facemask.
    a. Use caution when performing aerosol-generating procedures, including respiratory protection, limiting the number of staff present during procedures to only essential employees and clean and disinfect procedure room surfaces promptly
    b. Contact public health department on duration of airborne precautions for both patients under investigation (PUI) or residents with confirmed COVID-19
    c. Diagnostic respiratory specimen collection should be completed in an AIIR with the door closed and PPE.

4. If no AIIR is available in the facility, the resident should be transferred as soon as possible to a facility with an AIIR. While awaiting transfer, place a facemask on the resident and place resident in a private room with the door closed, preferably not in a room where room exhaust is recirculated within the building without HEPA filtration. No aerosol-generating procedures will be performed in the absence of an AIIR.

5. In the event of a facility outbreak when AIIR rooms are not available in the community, institute outbreak management protocols:
    a. Define authority (Infection Preventionist, DON, Administrator, Medical Director, etc.)
        i. **Immediate** reporting/notification and consultation with the Local/State Public Health Department for specific directions to include, for example:
            1. Place residents in private rooms on contact precautions.
            2. Cohort residents identified with same symptoms/COVID-19 confirmation
            3. Implement consistent assignment of employees
            4. Only essential staff to enter rooms/wings
            5. Group activities will cease on unit:
                a. Dining
                b. Activities
                c. Therapy
            6. Admissions will be suspended during a COVID-19 outbreak.

6. Limit only essential personnel to enter the room with appropriate PPE and respiratory protection.
    a. PPE includes:
        i. Gloves
        ii. Gown
        iii. Respiratory Protection (Fit-tested NIOSH-certified disposable N95 filtering facepiece respirator prior to entry and removal after exiting). If disposable respirator is used, it should be removed and discarded after exiting the resident room and closing the door. Perform hand hygiene after discarding. If reusable respirator is used, clean and disinfect according the manufacturer's recommendations. If facility is using Fit-tested NIOSH-certified disposable N95 filtering respirators, staff must be medically cleared and fit-tested and trainer prior to use.

    iv. If no Fit-Tested NIOSH-Certified N95 respirators available or used in facility, the Infection Preventionist will identify appropriate mask that will be donned when entering and after exiting resident room:
   1. Examples include:
      a. https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html

    v. Eye Protection that covers both the front and sides of the face. Remove before leaving resident room. Reusable eye protection will be cleaned and disinfected according to manufacturer's recommendation. Disposable eye protection will be discarded after use

b. Hand Hygiene using Alcohol Based Hand Sanitizer before and after all patient contact, contact with infectious material and before and after removal of PPE, including gloves. If hands are soiled, washing hands with soap and water is required for at least 20 seconds.

7. Dedicated or disposable patient-care equipment should be used. If equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to manufacturer's recommendations.

8. Visitors will be encouraged to refrain from entering the room of a resident with known or suspected COVID-19.
   a. Alternative communication interaction interventions will be discussed.

9. Facilities will keep a log of all persons who enter the room, including visitors and those who care for the resident.
   a. Employees who have unprotected exposure to a resident with COVID-19 should report to the Infection Preventionist or designee. (Exclude from work for 14 days after last exposure)

10. Signs will be posted at the entrances, elevators and breakrooms to provide residents, staff and visitors if an outbreak is identified, instructions on hand hygiene, respiratory hygiene and cough etiquette. Facemasks, Alcohol-based hand rub (ABHR), tissues and a waste receptacle will be available at the facility entrance.

11. Visitors with known or suspected COVID-19 will be restricted from entering the facility. The facility will monitor visitors entering the facility for signs and symptoms and will encourage them to follow respiratory hygiene and cough etiquette precautions.

12. Exposed visitors should be educated on self-quarantine instructions and to report fever, cough, shortness of breath or sore throat to their health care provider for at least 14 days following exposure.

13. Discontinuation of Isolation Precautions will be determined on a case-by-case basis in conjunction with the local, state and federal health authorities.

14. Cleaning and disinfecting room and equipment will be performed using products that have EPA-approving emerging viral pathogens claims that have demonstrated effectiveness against viruses similar to COVID-19 on hard non-porous surfaces.

15. Employees who develop symptoms to COVID-19 (fever, cough, shortness of breath or sore throat) will be referred to public health authorities for testing, medical evaluation recommendations and return to work instructions.

**The CDC has published a "Healthcare Personnel Preparedness Checklist for 2019-nCoV that can be downloaded and completed by the Infection Preventionist at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp-preparedness-checklist.pdf

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References and Resources

[1]Centers for Disease Control and Prevention. 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 February 21, 2020: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

[2]Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Evaluating and Reporting Persons Under Investigation (PUI). Updated February 27, 2020: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Information for Healthcare Providers. https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

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Room Log: Residents with Suspected or Confirmed Coronavirus (COVID-19)
Resident Name: _____   Room #: _____

Employee or Visitor Name (print)	Date:	Time in:	Time out:	Initials

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COVID-19 Proactive Preparation Planning

Items to Review	Yes	No	N/A	Comments
1. Trustworthy Resources Utilized to Develop Plan • CDC, WHO, APIC, CMS, etc.				

2. Review current Emergency Preparedness Plan to identify
• Pandemic Response
• Leadership (Identify and define authority)
• Contact Names and Numbers
    o Facility Leadership
        o Administrator
        o DON
        o Infection Preventionist
        o Nurse Managers
        o Dietary Manager
        o Housekeeping Manager
        o Social Service Manager
        o Environmental Services
        o Recreational Therapy
    o Medical Director
    o Pharmacy Consultant
    o Local and State Public Health Contacts
    o Hospital Partner Contacts
    o Pharmacy
    o Medical Supply
• Prepare a list of essential positions necessary for day-to-day operations
• Prepare a list of essential functions for emergency management of care
• Review business interruption protocols and review with leadership team members				

3. Set up a meeting to collaborate with local hospital partners				
4. Encourage a meeting with post-acute care colleagues on collabortive efforts in the event of a Pandemic				
5. Meet with pharmacy and pharmacy consultant to identify pharmaceutical needs				
6. Meet with Medical Equipment suppliers to identify and prepare for needs to include: o Personal Protective Equipment				

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o Hand Hygiene Supplies
    o Oxygen
    o Resident care supply needs based upon unique resident population				

7. Meet with supplier of disinfectants and cleaners to prepare for needs				
8. Meet with food suppliers to identify and prepare for food needs				
9. Familiarize clinical leadership team with testing protocols as established by State and/or Local Public Health o Contact Public Health for contact numbers and questions				
10. Review and identify staff deployment (i.e. consistent assignment)				
11. Review facility sick leave policies and revise as necessary to encourage ill staff to remain home o Educate Staff on sick leave policy				

12. Re-train all employees on Infection Prevention and Control
    o Hand Hygiene
    o PPE
        o *Remind employees not to touch their face*
    o COVID-19
    o Respiratory Hygiene/Cough Etiquette				

13. Prepare facility communications for residents, resident representatives, families and visitors				
14. Develop a plan for prioritizing resources o Educate Team				
15. Meet with local transport agencies to collaborate on a plan for safe transport if necessary				

16. Complete the "Healthcare Professional Preparedness Checklist for Transport and Arrival of Patients With Confirmed or Possible COVID-19" from CDC:
https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp-preparedness-checklist.pdf
    • For facilities without an Airborne Infection Isolation Rooms (AIIR), deny admissions for residents with suspected or confirmed COVID-19
    • Communicate with key stakeholders the admissions will be closed for suspected or confirmed COVID-19				

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References and Resources:

- Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19) Strategies for Optimizing the Supply of N95 Respirators. February 29, 2020: https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-supply-strategies.html
- Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Pandemic Preparedness Resources: https://www.cdc.gov/coronavirus/2019-ncov/php/pandemic-preparedness-resources.html
- Centers for Disease Control and Prevention. Understand the Difference (Surgical Mask, N95 Respirator, Elastometric Half Facepiece Respirator: https://www.cdc.gov/niosh/npptl/pdfs/UnderstandingDifference3-508.pdf
- Minnesota Department of Health. Patient Care Strategies for Scarce Resource Situations: https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf

Additional CDC resources:

- https://www.cdc.gov/nonpharmaceutical-interventions/tools-resources/planning-guidance-checklists.html

- https://www.cdc.gov/flu/pandemic-resources/national-strategy/severity-assessment-framework.html