**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.”1

“**Personal protective equipment (PPE)”:** refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission.”1<https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf>  | * The DON, Infection Preventionist or designee develop a policies and procedures for:
	+ PPE use
	+ Source Control
	+ Calculating Rate
	+ Ordering PPE
	+ Restocking PPE
* 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
* The Infection Preventionist or Designee will complete the burn rate calculator to identify utilization rate of PPE, need and supply chain information and report any supply concerns to the administrator
* 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 when PPE supplies are stressed, running low, or absent
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| **Source Control Options for Healthcare personnel:*** “A NIOSH-approved particulate respirator with N95 filters or higher
* A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated);
* A barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks; OR
* A well-fitting facemask.

When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned.”3“When SARS-CoV-2 [Community Transmission](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk) levels are high, source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients.* HCP could choose not to wear source control when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms) if they do not otherwise meet the criteria described below and [Community Levels](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=CommunityLevels&null=CommunityLevels) are not also high. When [Community Levels](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=CommunityLevels&null=CommunityLevels) are high, source control is recommended for everyone.

When SARS-CoV-2 [Community Transmission](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk) levels are **not** high, healthcare facilities could choose not to require universal source control.  However, even if source control is not universally required, it remains recommended for individuals in healthcare settings who:* Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
* Had [close contact](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#closecontact) (patients and visitors) or a [higher-risk exposure](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure; or
* Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or
* Have otherwise had source control recommended by public health authorities.”3
 | * The DON, Infection Preventionist or designee develop a policies and procedures for:
	+ Source Control
* The Infection Preventionist or Designee will direct all staff education and verification of competency on source control and PPE use to include:
	+ When an N95, respirator approved under standards in other countries, a barrier face covering or a well-fitting facemask is used SOLELY for source control, they can be used the entire shift unless:
		- Soiled
		- Damaged
		- Hard to breathe through
	+ When a NIOSH-approved N95 or higher respirator is used when caring for a resident with suspected or confirmed COVID-19, during a surgical procedure or droplet precautions, they should be removed and discarded after the patient care encounter and a new one should be donned
* The Infection Preventionist or Designee will complete ongoing process surveillance audits on source control, PPE donning, doffing and use
* Instruct all staff that when SARS-CoV-2 Community Transmission levels are high, everyone in the facility is recommended to wear source control
	+ Educate all staff on requirements for well-defined areas restricted from resident access
* Determine considerations for PPE, consistent with CDC guidance when Community Transmission is high
	+ Educate staff when NIOSH-approved N95 or higher respirators are to be work by staff for:
		- All aerosol-generating procedures
		- Surgical procedures that might pose higher risk for transmission
		- Working with residents unable to wear source control and area is poorly ventilated
		- When healthcare associated COVID-19 transmission is identified
		- During all resident care encounters or in specific units/areas of the facility at higher risk of COVID-19 transmission
	+ Eye protection such as goggles or face shield that covers the front and side of the face worn during all resident care encounters
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| **Universal Use of Personal Protective Equipment for Healthcare Personnel****“**If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow [Standard Precautions](https://www.cdc.gov/hicpac/recommendations/core-practices.html) (and [Transmission-Based Precautions](https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html) if required based on the suspected diagnosis).As community transmission levels increase, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases.   In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during patient care encounters.  For example, facilities located in counties where [Community Transmission](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk) is high should also consider having HCP use PPE as described below:* NIOSH-approved particulate respirators with N95 filters or higher used for:
	+ All aerosol-generating procedures (refer to [Which procedures are considered aerosol generating procedures in healthcare settings?](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control)).
	+ All surgical procedures that might pose higher risk for transmission if the patient has SARS-CoV-2 infection (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract).
	+ NIOSH-approved particulate respirators with N95 filters or higher can also be used by HCP working in other situations where additional risk factors for transmission are present, such as the patient is unable to use source control and the area is poorly ventilated.  They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place.
	+ To simplify implementation, facilities in counties with high transmission may consider implementing universal use of NIOSH-approved particulate respirators with N95 filters or higher for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.
* Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters.”3
 | * The Infection Preventionist will monitor the community transmission levels to determine source control use for employees, residents and visitors
* The Infection Preventionist will monitor the community transmission levels to determine N95 and eye protection guidance for patient care encounters
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| **Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 Infection****Personal Protective Equipment*** HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to [Standard Precautions](https://www.cdc.gov/hicpac/recommendations/core-practices.html) and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
* Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration’s (OSHA) Respiratory Protection standard ([29 CFR 1910.134](https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134))”3
 | * Review and revise as necessary facility policy and procedure for PPE use when caring for a resident with suspected or confirmed COVID-19 infection
	+ NIOSH-approved particulate respirator with N95 filters or higher,
	+ Gown,
	+ Gloves, and
	+ Eye protection (i.e., goggles or a face shield that covers the front and sides of the face).
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| **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.”2 “[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.”2“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.”2“[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.”2  | * 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>
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**\*\*PLEASE NOTE: The following CDC COVID-19 Guidance indicates, “CDC is reviewing this page to align with updated guidance”:**

* Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html>
* Strategies for Optimizing the Supply of N95 Respirators: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>
* Strategies for Optimizing the Supply of Facemasks: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>
* Strategies for Optimizing the Supply of Eye Protection: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html>
* Strategies for Optimizing the Supply of Gowns: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html>
* Strategies for Optimizing the Supply of Gloves: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/gloves.html>

**It is recommended that facilities continue to monitor all updates of guidance from CDC and CMS.**

**References and Resources**

1Centers for Medicare & Medicaid Services. State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities, Advanced Copy, 06/29/22: <https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf>

2United States Department of Labor, Occupational Safety and Health Administration (OSHA) Standard 1910 Respiratory Protection: <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134>

3Centers for Disease Control and Prevention. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic), Updated Sept. 23, 2022: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

Centers for Disease Control and Prevention. Hospital Respiratory Protection Program Toolkit Resources for Respirator Program Administrators . Updated APRIL 2022: <https://www.cdc.gov/niosh/docs/2015-117/pdfs/2015-117revised042022.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>

U. S. Food and Drug Administration. Face Masks, Including Surgical Masks, and Respirators for COVID-19 (Current content as of 08/26/2022): <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 09/29/2022): <https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas>