

Thank you so much for participating in the CDC's COVID-19 (SAR—CoV-2) tele and video infection prevention assessment and consultation last Thursday with [REDACTED]. We were tremendously grateful for your patience and especially for your sharing and walking through the Infection Prevention and Control strategies for preventing transmission of COVID-19 in your facility. We noted several strengths during our discussion including:

- Strong leadership team with devoted time for COVID-19 preparedness
- You are the designated individual responsible for Infection Prevention and Control Program activities.
- The facility has designated staff (known as “staff champions”) responsible for HCP education, return demonstration and practice audits for hand hygiene, PPE selection and use, environmental surface cleaning and disinfection and reusable resident equipment cleaning and disinfection
- Frequent communication and education for residents, their families and visitors about COVID-19 prevention

Our recommendations and resources for your facility, based on current guidelines as of October 2, 2020 include the following:

1. It was noted that KN95 masks covered with surgical masks are being used for the care of newly admitted residents. For the care of newly admitted or readmitted residents who are not known or suspected (e.g., no documented symptoms or exposure) to have SARS-CoV-2 infection for 14 days after admission.

The CDC Guidance states “HCP should wear N95 or higher-level respirator, eye protection, gown, and gloves for the care of newly admitted or readmitted residents who are not known or suspected to have SARS-CoV-2 infection for 14 days after admission.

“All recommended COVID-19 PPE should be worn during care of residents under observation which includes:

- N95 or higher-level respirator (or facemask if a respirator is not available)
- Eye protection (i.e., goggles or a face shield that covers the front and sides of the face)
- Gloves
- Gown
- Cloth face coverings are not considered PPE and should not be worn when PPE is indicated.”

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html>

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

2. HCP performing symptom and temperature monitoring of those entering the building should wear a facemask. For HCP working in areas with moderate to substantial community transmission, eye protection should also be worn. In general, if there is no direct contact between screener and the person being screened, then gowns and gloves are not necessary, but hand hygiene should occur between each encounter.

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

3. HCP should wear N95 or higher-level respirator, eye protection, gown, and gloves for SARS-CoV-2 laboratory specimen collection.

“HCP in the room for specimen collection area should wear:

- An N95 or higher-level respirator (or facemask if a respirator is not available)
- Eye protection.
- A single pair of gloves
- Gown
- Gloves should be changed and hand hygiene performed between each person being swabbed.
 - o Gowns should be changed when there is more than minimal contact with the person or their environment. The same gown may be worn for swabbing more than one person provided the HCP collecting the test minimizes contact with the person being swabbed. Gowns should be changed if they become soiled. Consider having an observer who does not engage in specimen collection but monitors for breaches in PPE use throughout the specimen collection process.
- HCP who are handling specimens, but are not directly involved in collection (e.g., self-collection) and not working within 6 feet of the individual being tested, should follow Standard Precautions; gloves are recommended, as well as a facemask for source control.”

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-facility-wide-testing.html>

<https://www.cdc.gov/coronavirus/2019-ncov/lab/faqs.html>

4. HCP should wear N95 or higher-level respirator, eye protection, gown, and gloves during potentially aerosol generating procedures (AGPs) for residents under Transmission-Based Precautions for SARS-CoV-2.

“The PPE recommended when caring for a resident with suspected or confirmed COVID-19 includes the following:

- N95 or higher-level respirator
 - o N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol generating procedure
- Eye protection (i.e., goggles or a face shield that covers the front and sides of the face)
- Gloves
- Gown”

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

[https://www.cdc.gov/coronavirus/2019-](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html)

[ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html)

5. HCP should wear N95 or higher-level respirator, eye protection, gown, and gloves during potentially aerosol generating procedures (AGPs) for any resident in areas with moderated to substantial community transmission.
“HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection.
They should also...;
- Wear an N95 or equivalent or higher-level respirator, instead of a facemask, for aerosol generating procedures.”

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

[https://www.cdc.gov/coronavirus/2019-](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html)

[ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html)

6. Disposal of PPE is determined by State and Territorial regulations.
OSHA’s Bloodborne Pathogens Standard, 29 CFR 1910.1030, has provisions for the protection of employees during the containment, storage, and transport of regulated waste other than contaminated sharps. The bloodborne pathogens standard defines regulated waste as liquid or semi-liquid blood or other potentially infectious material (OPIM); contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed; items that are caked with dried blood or OPIM and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or OPIM. Regulated wastes require special handling and must be disposed of in a manner to prevent spilling of contents or spreading of infectious materials during handling, storage, transport, or shipping.

Based on the OSHA definition of “regulated waste,” much of the PPE used during resident care would not fall into the category of regulated medical waste requiring disposal in a biohazard bag and could be discarded as routine non-infectious waste. However, healthcare facilities and personnel should be mindful of local or state regulations that may be more restrictive than this federal standard.

Source: [https://www.osha.gov/laws-](https://www.osha.gov/laws-regs/standardinterpretations/standardnumber/1910/1910.1030%20-%20Index/result)

[regs/standardinterpretations/standardnumber/1910/1910.1030%20-%20Index/result](https://www.osha.gov/laws-regs/standardinterpretations/standardnumber/1910/1910.1030%20-%20Index/result)

7. For your information, please see the following definitions for terminology in CDC guidance:

Extended use is “the practice of wearing the same PPE device for repeated close contact encounters with several different residents, without removing the PPE device between resident encounters.” Depending upon the PPE device, it is considered either a contingency or crisis capacity PPE optimization strategy.

Reuse refers to “the practice of one HCP using the same PPE device for multiple encounters with a resident but removing it (‘doffing’) after each encounter.” The PPE device “is stored in between encounters to be put on again (‘donned’) prior to the next encounter with a resident.” The limited reuse of PPE devices that are otherwise intended for disposable or laundering after each use is considered a crisis capacity strategy.

Sources:

<https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>

Note: Most facilities will combine the practices of extended and reuse of PPE meaning they will wear a PPE device such as a facemask for encounters with multiple different residents, but instead of removing the device after each encounter will only remove and store the device at breaks or at the end of a shift. HCP will then redon the used PPE device when returning to work. This practice may or may not be considered acceptable depending upon factors such as the PPE device, current PPE supply, and resident population they are caring for (e.g., caring only for residents with confirmed SARS-CoV-2 infection).

Source:

<https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html>

Definitions:

Conventional capacity: measures consisting of engineering, administrative, and PPE controls that should already be implemented in general infection prevention and control plans in healthcare settings.

Contingency capacity: measures that may be used temporarily during periods of anticipated PPE shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility’s current or anticipated utilization rate, there may be uncertainty if future supply will be adequate and, therefore, contingency capacity strategies may be needed.

Crisis capacity: strategies that are not commensurate with U.S. standards of care but may need to be considered during periods of known PPE shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity strategies when the supply is not able to meet the facility’s current or anticipated utilization rate.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/general-optimization-strategies.html>

8. If HCP are practicing the extended and/or reuse of PPE as part of contingency and crisis strategies, HCP should not wear PPE, that would have otherwise been disposed of or laundered under conventional strategies, while eating or drinking. For example, HCP should not hang facemasks or respirators from the earlobe or place these devices under the chin or on the forehead. If not discarded, this PPE should be stored in a designated area and not placed directly on tables next to food and drink.

Sources:

<https://www.cdc.gov/flu/avianflu/h5/worker-protection-ppe.htm>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

9. "Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing."

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

<https://www.cdc.gov/niosh/docs/2015-117/default.html>

Medical Evaluations prior to fit-testing and respirator use are required by the OSHA Respiratory Protection Standard: "1910.134(e)(1) General. The employer shall provide a medical evaluation to determine the employee's ability to use a respirator, before the employee is fit tested or required to use the respirator in the workplace."

Source:

https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=12716&p_table=STANDARDS

10. "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. The employer shall include in the program... Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance."

Source:

https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=12716&p_table=STANDARDS

11. The extended use of respirators is recommended as part of a contingency capacity strategy during expected shortages.

“Extended use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several different residents, without removing the respirator between resident encounters. Extended use is well suited to situations wherein multiple residents with the same infectious disease diagnosis, whose care requires use of a respirator, are cohorted (e.g., housed on the same unit)...When practicing extended use of N95 respirators, the maximum recommended extended use period is 8–12 hours... N95 respirators should be removed (doffed) and discarded before activities such as meals and restroom breaks.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

12. The reuse of respirators is recommended as part of a crisis capacity strategy during known shortages.

“Re-use refers to the practice of using the same N95 respirator by one HCP for multiple encounters with different residents but removing it (i.e. doffing) after each encounter. This practice is often referred to as “limited reuse” because restrictions are in place to limit the number of times the same respirator is reused.”

“During limited reuse, the respirator is stored in between encounters to be put on again (donned) prior to the next encounter with a resident.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

13. HCP should track how many times they put on (i.e., don) the same disposable respirator and dispose of it after the suggested number of reuses.

“To reduce the chances of decreased protection caused by a loss of respirator functionality, respiratory protection program managers should consult with the respirator manufacturer regarding the maximum number of donnings or uses they recommend for the N95 respirator model(s) used in that facility. If no manufacturer guidance is available, preliminary data suggests limiting the number of reuses to no more than five uses per device to ensure an adequate safety margin...Healthcare facilities should provide staff clearly written procedures to:

- Follow the manufacturer’s user instructions, including conducting a user seal check.
- Follow the employer’s maximum number of donnings (or up to five if the manufacturer does not provide a recommendation) and recommended inspection procedures.
- Discard any respirator that is obviously damaged or becomes hard to breathe through.
- Pack or store respirators between uses so that they do not become damaged or deformed”

Source:

<https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html>

14. “Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize potential cross-contamination,

store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly.”

Source:

<https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html>

15. “It is important to consult with the respirator manufacturer regarding the maximum number of donnings or uses they recommend for the N95 respirator model. If no manufacturer guidance is available, data suggest limiting the number of reuses to no more than five uses per device to ensure an adequate safety margin. N95 and other disposable respirators should not be shared by multiple HCP.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

16. “N95 Filtering Facepiece Respirator (FFR) decontamination will not increase the number of times or hours that an FFR can be worn. Decontamination of an N95 FFR inactivates viruses and bacteria on the device, but does not restore the N95 FFR to “new” performance. Decontamination studies have evaluated the effect of the decontamination process on the fit and filtration performance of N95 FFRs; however, these studies did not consider the likelihood that N95 FFRs worn by healthcare personnel are likely donned and doffed multiple times before undergoing decontamination. N95 FFR performance will decrease as the number of hours and number of donnings and doffings increase. Repeated decontamination and handling of FFRs can damage the fit and filtration performance of N95 FFRs. Fit performance during limited reuse, including decontaminated FFRs, should be monitored by the respiratory protection program manager or appropriate safety personnel.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>

17. “Extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different residents, without removing the facemask between resident encounters.
 - The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
 - HCP must take care not to touch their facemask. If they touch or adjust their facemask, they must immediately perform hand hygiene.
 - HCP should leave the resident care area if they need to remove the facemask.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>

18. “Limited re-use of facemasks is the practice of using the same facemask by one HCP for multiple encounters with different residents but removing it after each encounter. As it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, care

should be taken to ensure that HCP do not touch outer surfaces of the mask during care, and that mask removal and replacement be done in a careful and deliberate manner.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- Not all facemasks can be re-used.
 - o Facemasks that fasten to the provider via ties may not be able to be undone without tearing and should be considered only for extended use, rather than re-use.
 - o Facemasks with elastic ear hooks may be more suitable for re-use.
- HCP should leave resident care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>

19. “HCP should leave resident care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.”

Like reused respirators, reused facemasks should be kept in a designated storage area within the facility.

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>

20. “The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.” Otherwise the number of times a facemask can be reused is not well-defined. Ideally facilities without facemask shortages would discard the facemask after each removal and not reuse.

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>

21. “Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.”

“Ensure that eye protection is compatible with the respirator so there is not interference with proper positioning of the eye protection or with the fit or seal of the respirator.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

22. “Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different residents, without removing eye protection between resident encounters. Extended use of eye protection can be applied to disposable and reusable devices.”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html>

23. Some eye protection is intended for reprocessing and reuse such as goggles and reusable face shields, while some such as single use disposable face shields are not. As part of PPE optimization strategies, facilities may choose to reprocess and reuse disposable eye protection.

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html>

24. “Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer’s reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse.”

“When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields, consider:

- While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe.
- Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution.
- Wipe the outside of face shield or goggles with clean water or alcohol to remove residue.
- Fully dry (air dry or use clean absorbent towels).
- Remove gloves and perform hand hygiene.”

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html>

25. “Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.”

After cleaning and disinfecting eye protection, HCP should store it in a designated clean area within the facility. It should not be stored in the same breathable containers housing used respirators or facemasks.

“If a disposable face shield is reprocessed, it should be dedicated to one HCP.”

“Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).”

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html>

26. “Several fluid-resistant and impermeable protective clothing options are available in the marketplace for HCP. These include isolation gowns and surgical gowns. When selecting the most appropriate protective clothing, employers should consider all of the available information on recommended protective clothing, including the potential limitations. Nonsterile, disposable resident isolation gowns, which are used for routine resident care in healthcare settings, are appropriate for use by HCP when caring for residents with suspected or confirmed COVID-19. In times of gown shortages, surgical gowns should be prioritized for surgical and other sterile procedures. Current U.S. guidelines do not require use of gowns that conform to any standards. In March 2020, FDA issued an enforcement policy for gowns and other apparel during the COVID-19 pandemic. In May 2020, FDA issued an Emergency Use Authorization regarding the use of certain gowns in healthcare settings. Reusable (i.e., washable) gowns are typically made of polyester or polyester-cotton fabrics. Gowns made of these fabrics can be safely laundered after each use according to routine procedures and reused.

Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles. Systems are established to:

- routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties)
- replace reusable gowns when needed (e.g., when they are thin or ripped)
- store laundered gowns in a manner such that they remain clean until use.”

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html>

<https://www.cdc.gov/niosh/npptl/topics/protectiveclothing/>

<https://www.fda.gov/media/136540/download> <https://www.fda.gov/media/138326/download>

<https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html#g6>

27. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices.” Otherwise the frequency of disposal will depend upon current extended and reuse practices. Under conventional gown use strategies, “disposable gowns should be discarded after each use.”

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html>

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

28. “Isolation gowns should be removed before leaving the resident care area to prevent possible contamination of the environment outside the resident’s room. Isolation gowns should be removed in a manner that prevents contamination of clothing or skin. The outer, “contaminated”, side of the gown is turned inward and rolled into a bundle, and then discarded into a designated container for waste or linen to contain contamination.”

In some instances, gowns may need to be worn outside the resident room for certain activities as dictated by Standard Precautions.

Sources:

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/prevention.html>

<https://www.cdc.gov/hicpac/recommendations/core-practices.html>

29. "Gloves are not a substitute for hand hygiene.
- If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the resident or the resident environment.
 - Perform hand hygiene immediately after removing gloves.
 - Change gloves and perform hand hygiene during resident care, if gloves become damaged,
 - gloves become visibly soiled with blood or body fluids following a task,
 - moving from work on a soiled body site to a clean body site on the same resident or if another clinical indication for hand hygiene occurs.
 - Never wear the same pair of gloves in the care of more than one resident.
 - Carefully remove gloves to prevent hand contamination."

Source: <https://www.cdc.gov/handhygiene/providers/index.html>

30. It is important to make sure that hand hygiene is performed at the appropriate times before and after touching a resident, between residents and frequently during care. Placing wall mounted dispensers within the workflow of personnel can help them do hand hygiene at the right times. Resources to improve hand hygiene are located on the Clean Hands Count website, along with the current guidance and frequently asked questions from CDC.

For facilities using individual pocket-sized dispensers:

Individual pocket-sized dispensers may be an alternative to wall mounted dispensers. Instructions for appropriate use of individual pocket-sized dispensers for personnel are available on the Clean Hands Count promotional materials website. These dispensers must remain with the healthcare personnel and resident access to these dispensers should be supervised. Consider conducting brief and regular audits to make sure healthcare personnel keep their pocket-sized dispensers with them.

Sources:

<https://www.cdc.gov/patientsafety/features/clean-hands-count.html>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html>

"Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled. Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where resident care is being delivered."

CDC has created a video, "Clean Hands: Combat COVID-19" that can be used to teach frontline long-term care personnel about the importance of hand hygiene.

Sources:

<https://www.cdc.gov/hicpac/recommendations/core-practices.html>

<https://www.youtube.com/watch?v=xmYMUly7qiE>

31. All EPA-registered, hospital-grade disinfectants list a contact time in the directions. A contact time is how long a surface should remain wet to ensure the product is effective. Disinfectants must be used according to the label instructions. Some products have long contact times as long as 10 minutes which can be difficult to accomplish. It is important for facilities to know that their product is appropriate (e.g., on the EPA's List N) and is being used for the entire contact time. Everyone who cleans surfaces should know how long the surfaces should stay wet for the disinfectant to work.

Source: <https://www.epa.gov/sites/production/files/2020-04/documents/disinfectants-onepager.pdf>

Also, some disinfectant agents such as liquid bleach require a cleaning step prior to use in order to remove “foreign material (e.g., soil, and organic material).” This is considered a two-step process.

A one-step product allows personnel to clean and disinfect at the same time. Generally, one-step processes are easier for personnel to follow. Facilities should check their product label to determine if their disinfectant agent is a one or two-step agent.

Sources:

<https://www.cdc.gov/infectioncontrol/guidelines/disinfection/cleaning.html>

<https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html>

32. “Since October 2005, the Centers for Medicare and Medicaid Services (CMS) has required nursing homes participating in Medicare and Medicaid programs to offer all residents influenza and pneumococcal vaccines and to document the results. According to requirements, each resident is to be vaccinated unless contraindicated medically, the resident or legal representative refuses vaccination, or the vaccine is not available because of shortage.

In the majority of seasons, influenza vaccines will become available to long-term care facilities beginning in September, and influenza vaccination should be offered by the end of October. Informed consent is required to implement a standing order for vaccination, but this does not necessarily mean a signed consent must be present. Although vaccination by the end of October is recommended, influenza vaccine administered in December or later, even if influenza activity has already begun, is likely to be beneficial in the majority of influenza seasons because the duration of the season is variable, and influenza activity might not occur in certain communities until February or March.

In the event that a new patient or resident is admitted after the influenza vaccination program has concluded in the facility, the benefits of vaccination should be discussed,

educational materials should be provided, and an opportunity for vaccination should be offered to the new resident as soon as possible after admission to the facility.”

Sources:

<https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm>

<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

33. "Screen visitors for fever ($T \geq 100.0F$), symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility."

"Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19."

Sources:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html

<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

34. "People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19:

- Fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea

This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.”

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

35. "Properly manage anyone with suspected or confirmed SARS-CoV-2 infection or who has had contact with someone with suspected or confirmed SARS-CoV-2 infection." For example, ill individuals would not be allowed to enter the building, and procedures should be put in place to determine what further evaluation is needed.

Source: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

36. “Decisions about return to work for HCP with SARS-CoV-2 infection should be made in the context of local circumstances. In general, a symptom-based strategy should be used. A

test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Symptom-based strategy for determining when Symptomatic HCP can return to work.

- HCP with mild to moderate illness who are not severely immunocompromised:
 - o At least 10 days have passed since symptoms first appeared and
 - o At least 24 hours have passed since last fever without the use of fever-reducing medications and
 - o Symptoms (e.g., cough, shortness of breath) have improved
- HCP with severe to critical illness or who are severely immunocompromised:
 - o At least 10 days and up to 20 days have passed since symptoms first appeared and
 - o At least 24 hours have passed since last fever without the use of fever-reducing medications and
 - o Symptoms (e.g., cough, shortness of breath) have improved
 - o Consider consultation with infection control experts

Test-Based Strategy for Determining when Symptomatic HCP Can Return to Work.

In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

The criteria for the test-based strategy are:

- o HCP who are symptomatic:
- o Resolution of fever without the use of fever-reducing medications and
- o Improvement in symptoms (e.g., cough, shortness of breath), and
- o Results are negative from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

Definitions:

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO₂) $\geq 94\%$ on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO₂ $<94\%$ on room air at sea level (or, for residents with chronic hypoxemia, a decrease from baseline of $>3\%$), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO₂/FiO₂) <300 mmHg, or lung infiltrates $>50\%$.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Severely Immunocompromised: Some conditions, such as being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ

transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and require actions such as lengthening the duration of HCP work restrictions. Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions. Ultimately, the degree of immunocompromise for HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.”

Sources:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html
<https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html>

37. “Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas.” “Maintain physical distance as much as possible:
- Use video conferencing and increase workstation spacing.
 - Reduce the number of individuals allowed in common areas such as breakrooms and on elevators.”

Routine auditing of social distancing practices in breakrooms, nursing stations, smoking areas can help ensure HCP are adhering to facility policies.

Sources:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.html>

Additional information

We understand that you routinely provide training to your staff. We would like to share these CDC LTC mini webinars for frontline staff if not already in use:

- a. Sparkling Surfaces - <https://youtu.be/t7OH8ORr5lg>
- b. Clean Hands - <https://youtu.be/xmYMUly7qiE>
- c. Closely Monitor Residents - <https://youtu.be/1ZbT1Njv6xA>
- d. Keep COVID-19 Out! <https://youtu.be/7srwrF9MGdw>
- e. PPE Lessons - <https://youtu.be/YTATw9yav4>

If not already in use could consider use of this respiratory infection surveillance tool to maintain a list of symptomatic residents: <https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf>