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 **Infection Control COVID-19**

**Policy Statement**

[facility name’s] Infection Control Program (ICP), includes policies and procedures to assist in preventing transmission of COVID-19 into the [facility name] campus. In the event a transmission occurs, prompt detection and effective triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among additional residents, employees, and visitors. [facility name] recognizes its high-risk population and, as such, the actions listed below will be implemented, and [facility name] will further coordinate the ICP and Emergency Preparedness (EP) plans to address COVID-19. These policies and practices are based on Infection Prevention and Control recommendations from the Centers for Disease Control (CDC), Tennessee Department of Health (TDOH) and the World Health Organization (WHO) and is based on the currently limited information available about coronavirus disease 2019 (COVID-19) related to disease severity, transmission efficiency, and shedding duration. According to the CDC, their guidance is applicable to all U.S. healthcare settings and subject to change as more information becomes available. [facility name] will monitor the CDC website routinely and update this policy as needed.

**Background**

Coronavirus disease 2019 (COVID-19) is a respiratory disease first detected in China. Early on, many of the patients in the epicenter of the outbreak in Wuhan, Hubei Province, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside of Hubei and in countries outside China, including the United States (US). To date, imported, person-to-person, and community spread cases have been identified in the US. **Community spread** means some people have been infected and it is not known how or where they became exposed. The virus that causes COVID-19 seems to be spreading easily and sustainably in the community (“community spread”). Current symptoms reported for patients with COVID-19 have included mild to severe respiratory illness with fever, cough, and difficulty breathing. It has also been determined older adults and individuals with severe chronic medical conditions, such as heart, lung or kidney disease, are higher risk for more serious COVID-19 (Control, 2020).

Early reports suggest person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission **is currently uncertain**. However, airborne transmission from person-to-person over long distances is unlikely.

Some spread might be possible before people show symptoms; there have been reports of this occurring with this new coronavirus, but this is not thought to be the main way the virus spreads. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. The virus that causes COVID-19 seems to be spreading easily and sustainably in the community (“community spread”) in some affected [geographic areas](https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html).

**Definitions**

**Airborne precautions refer to actions taken to prevent or minimize the transmission of infections agents/organisms that remain infections over long distances when suspended in the air. These particles can remain suspended in the air for prolonged periods of time and can be carried on normal air currents in a room or beyond, to adjacent spaces or areas receiving exhaust air.**

**Close contact** for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the resident; or sitting within 6 feet of the resident in a healthcare common area or room); or b) having unprotected direct contact with infectious secretions or excretions of the resident (e.g., being coughed on, touching used tissues with a bare hand).

**Cohorting** is the practice of grouping residents infected with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. During outbreaks, healthcare staff may be assigned to a specific cohort of residents to further limit opportunities for transmission.

**Droplet precautions** refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.

**Healthcare Personnel (HCP)**: For the purposes of this document HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to residents or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

**Isolation**means the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease.

**Personal protective equipment (PPE**) are protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. This includes but is not limited to gloves, gowns, goggles, facemasks, or respirators.

**Standard precautions** are infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infections agents.

**Transmission based precautions** are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission.

**Defining HCP Exposure Risk Categories and Appropriate PPE**

While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit, and urine, might put HCP at risk of COVID-19.

According to CDC guidance,  ***high-risk*** exposures refer to HCP who performed or were present in the room for treatments or procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, nebulizer therapy, sputum induction) on residents with COVID-19 when the healthcare providers’ eyes, nose, or mouth were not protected. When high-risk treatments or procedures are completed by a [facility name] staff member, the following PPE will be required: gloves, gown, goggles and respirator. While a respirator is preferred in high-risk exposure situations, and respirators should be prioritized for high-risk treatments and procedures that are likely to generate respiratory aerosols, a facemask is an acceptable alternative and may be used in the event respirator supply is unavailable.

***Medium-risk*** exposures generally include HCP who had prolonged close contact with residents with COVID-19 where HCP mucous membranes were exposed to material potentially infectious with the virus causing COVID-19. These scenarios involve interactions with symptomatic residents who were not wearing a facemask for source control. Because these exposures do not involve treatments or procedures that generate aerosols, they pose less than that described under *high-risk*. When a [facility name] staff member is involved in medium-risk exposure situations, the following PPE will be required: gloves, gown, goggles and respirator. While a respirator is preferred in medium-risk exposure situations, if a respirator is not available, a facemask may be used.

***Low-risk*** exposures generally refer to brief interactions with residents with COVID-19 or prolonged close contact with residents who were wearing a facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure. When a [facility name] staff member is involved in low-risk exposure situations, the following PPE will be required: gloves, gown, goggles and facemask.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with residents infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures HCP should still perform self-monitoring with delegated supervision.

HCP with no direct resident contact and no entry into active resident management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have *no identifiable risk*.)

**Preventing the Introduction of COVID-19 into our Campus**

1. The primary goal of [facility name] is to prevent COVID-19 from being introduced within our campus. Prevention efforts include:
	1. Following **Standard Precautions**, which are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where health care is delivered. These practices are designed to both protect HCP; and prevent HCP from spreading infections among residents. Standard Precautions include —
		1. Hand hygiene - washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand rub that contains at least 60% alcohol before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves.
			* Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
			* If hands are visibly soiled, staff will use soap and water before returning to alcohol-based hand rub.
		2. Use of personal protective equipment (e.g., gloves, gowns, masks, eyewear) when there is an expectation of possible exposure to infectious material.
		3. Respiratory hygiene/cough etiquette principles.
		4. Properly handle and properly clean and disinfect patient care equipment and instruments/devices.
		5. Clean and disinfect the environment appropriately; and in accordance with [facility name’s] environmental services policy.
		6. Handle textiles and laundry carefully; and in accordance with [facility name’s] linen handling policy.
	2. Providing training and education for staff, residents, and visitors on COVID-19 to include prevalence, signs and symptoms, standard precautions, and the [facility name] Infection Control and Emergency Preparedness plans. Additionally, on:
		1. Avoiding touching eyes, nose, and mouth with unwashed hands.
		2. Avoiding close contact with people who are sick; and
		3. Maintaining social distances, when possible, of 6 feet or greater.
	3. Reminding employees to stay home if they are experiencing fever and respiratory symptoms.
	4. Ongoing communication with residents, employees, and resident representatives/families.
	5. Monitoring residents (current and new admissions) and employees for fever or respiratory symptoms, such as, cough, or shortness of breath.
		1. If symptoms are identified, move to action steps to prevent the spread of respiratory germs within the [facility name] campus to include restricting residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask, if tolerated.

**Preventing the Spread of COVID-19 Within our Campus**

1. In the event COVID-19 is introduced within the [facility name] campus, our efforts will transition to preventing the COVID-19 from spreading. Prevention efforts will include:
	1. Following **Standard Precautions for all residents**, which are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where health care is delivered. These practices are designed to both protect HCP and prevent HCP from spreading infections among residents. Standard Precautions include —
		1. Hand hygiene - washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand rub that contains at least 60% alcohol before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves.
			* Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
			* If hands are visibly soiled, staff will use soap and water before returning to alcohol-based hand rub.
		2. Use of personal protective equipment (e.g., gloves, gowns, masks, eyewear) when there is an expectation of possible exposure to infectious material.
		3. Respiratory hygiene/cough etiquette principles.
		4. Properly handle and properly clean and disinfect patient care equipment and instruments/devices.
		5. Clean and disinfect the environment appropriately; and in accordance with [facility name’s] environmental services policy.
		6. Handle textiles and laundry carefully; and in accordance with [facility name’s] linen handling policy.

**AND**

* 1. Following **Transmission Based Precautions**, which are the second tier of basic infection control and are to be used in addition to Standard Precautions for **residents who are suspected or confirmed to have COVID-19**, for which additional precautions are needed to prevent infection transmission. There are three types of transmission-based precautions--contact, droplet, and airborne. The CDC is documenting the COVID-19 as droplet, however, the contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission **is currently uncertain**. Therefore, [facility name] will implement all three types of Transmission Based Precautions with resident’s who are suspected or confirmed with COVID-19. Specifically, respirators will be used when available and resident room doors will be closed as able. Transmission Based Precautions include -
		1. **[facility name] will ensure appropriate resident placement (isolation)**in a single resident space/private room if available. If private rooms are unavailable, the IDT will make room placement decisions balancing risks to other residents; and by cohorting impacted residents.
			+ Until information is available regarding viral shedding after clinical improvement, discontinuation of isolation precautions should be determined on a case-by-case basis, in conjunction with the Infection Preventionist and the TDOH.
				1. Factors that should be considered include presence of symptoms related to COVID-19 infection, date symptoms resolved, other conditions that would require specific precautions (e.g., MRSA, Clostridioides difficile), other laboratory information reflecting clinical status.
		2. **[facility name] will use personal protective equipment (PPE) appropriately.** Donning PPE upon room entry and properly discarding before exiting the resident room is done to contain pathogens. PPE use will include:
			+ Donning clean, non-sterile gloves upon entry into the resident room or care area.
			+ Changing gloves if they become torn or heavily contaminated.
			+ Removing and discarding gloves when leaving the resident room or care area, and immediately performing hand hygiene.
			+ Donning a clean isolation gown upon entry into the resident room or care area.
			+ Changing the gown if it becomes soiled.
			+ Removing and discarding the gown in a dedicated container for waste or linen before leaving the resident room or care area.
			+ Disposable gowns will be discarded after use.
			+ If there are shortages of gowns, they will be prioritized for:
				1. aerosol-generating procedures
				2. care activities where splashes and sprays are anticipated
				3. high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:

dressing

bathing/showering

transferring

providing hygiene

changing linens

changing briefs or assisting with toileting

device care or use

wound care

* + - * Donning a respirator or facemask (if a respirator is not available) before entry into the patient room or care area.
				1. N95 respirators or respirators that offer a higher level of protection will be used instead of a facemask when performing or present for an aerosol-generating/high-risk procedure.
			* Disposable respirators and facemasks will be removed and discarded after exiting the resident’s room or care area.
			* Resident doors will be closed unless there are safety considerations (the IDT will determine safety exclusions to closing the resident’s door).
			* Performing hand hygiene after discarding the respirator or facemask.
			* If reusable respirators (e.g., powered air purifying respirator/PAPR) are used, they will be cleaned and disinfected according to manufacturer’s reprocessing instructions prior to re-use.
			* [facility name] will refer to the following guidance on extended use of respirators: [Strategies to Optimize the Current Supply of N95 Respirators](https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html).
			* Donning eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the resident room or care area.
				1. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
			* Removing eye protection before leaving the resident room or care area.
			* Reusable eye protection (e.g., goggles) will be cleaned and disinfected according to manufacturer’s reprocessing instructions prior to re-use.
			* Disposable eye protection will be discarded after use.
		1. **[facility name] will limit the transport and movement of residents who are suspected or confirmed with COVID-19** outside of their room to medically necessary purposes.  When transport or movement is necessary, the following steps will occur:
			- The resident will use a facemask (as tolerated). If the resident cannot tolerate a facemask, they should use tissues to cover their mouth and nose.
			- Staff will remove and dispose of contaminated PPE and perform hand hygiene prior to transporting residents on Transmission Based Precautions.
			- Staff will don clean PPE to handle the resident at the transport location.
			- In the event a resident requires transfer to the hospital, the EMS and Hospital ED will be notified of the resident’s COVID-19 status.
		2. **[facility name] will use disposable or dedicated resident-care equipment** (e.g., blood pressure cuffs). If common use of equipment for multiple residents is unavoidable, the equipment will be cleaned and disinfected before use on another resident.
		3. **[facility name] will prioritize cleaning and disinfection of the rooms** of residents on Transmission Based Precautions ensuring rooms are frequently cleaned and disinfected (e.g., at least daily focusing on frequently touched surfaces and equipment in the immediate vicinity of the resident).
		4. **[facility name] will ensure only essential personnel should enter the room** and will implement staffing policies to minimize the number of HCP who enter the room (dedicated staff assignments).
		5. **[facility name] will keep a log** of all persons who care for or enter the rooms or care areas of impacted residents.

**Postmortem Care**

1. In the event a resident with suspected or confirmed COVID-19 expires while at [facility name],
	1. The [facility name] Administrator, Infection Preventionist or designee will notify the resident’s physician and the TDOH.
		1. All recommendations from the TDOH will be implemented.
	2. The following PPE will be worn during post-mortem care.
		1. Gloves, gown, facemask, and goggles
			* The goal is to protect the face, eyes, nose, and mouth from splashes of potentially infectious body fluids. Additionally, if the staff member has cuts or wounds on their hands, double gloving is recommended.
		2. Upon receiving the order to transfer the resident’s body to the mortuary, [facility name] staff will inform the mortuary of the resident’s suspected or confirmed COVID-19 status and provide the mortuary with the TDOH number to allow the mortuary to seek guidance.
		3. The staff will greet the mortuary at the [facility name] entrance to screen the mortuary staff for potential COVID-19 and to ensure they perform hand hygiene and to provide them with necessary PPE.