

Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings

2022



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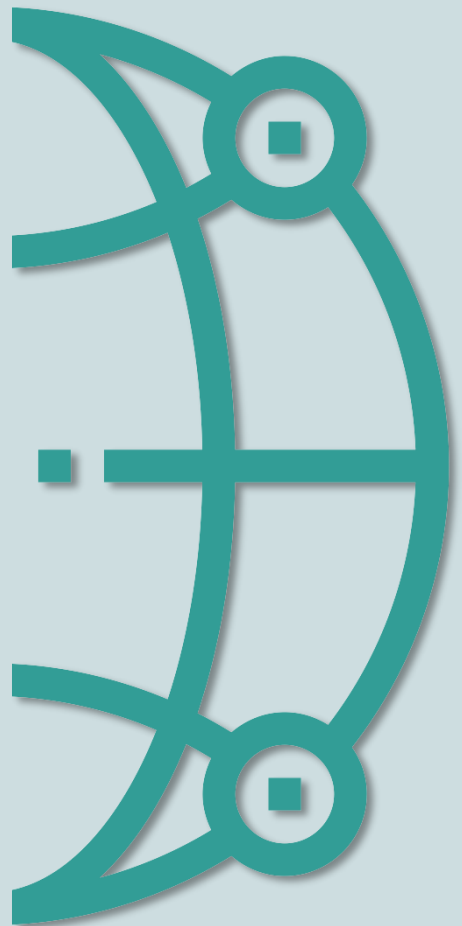


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Background and Purpose

This document includes Washington State Department of Health (DOH) recommendations to prevent transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease 2019 (COVID-19) in healthcare settings. Healthcare settings should use these recommendations to create flexible policies specific to their facility based on their individual risk assessment reflecting [CDC's community levels of transmission](#).

In general, healthcare settings should follow Centers for Disease Control and Prevention (CDC) guidance to prevent transmission of SARS-CoV-2:

- [Interim Infection Prevention and Control Recommendations for Healthcare Personnel \(HCP\) During the COVID-19 Pandemic](#)
- [Overview of Testing for SARS-CoV-2, the virus that causes COVID-19](#)
- [Interim Guidance for Managing HCP with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#)
- [Strategies to Mitigate HCP Staffing Shortages](#)
- [Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes](#)
- [Summary for Healthcare Facilities: Strategies for Optimizing the Supply of Personal Protective Equipment \(PPE\) during Shortages](#)

The guidance in this document is not regulatory in nature except when required by a regulatory agency such as Washington State Labor & Industries (L&I), Washington State Department of Social and Health Services (DSHS), DOH-Health Systems Quality Assurance (HSQA), and Centers for Medicaid and Medicare Services (CMS). When creating policy and procedures, healthcare settings should ensure they are meeting regulatory requirements.

The guidance in this document is interim in nature and, as such, will be updated with changes in national and state guidance and most recent evidence and data. Changes will be summarized in the [change log](#).

Key Information

[DOH COVID-19 public health reporting and surveillance guidelines](#) provide useful key information about COVID-19 including information on incubation period, mode of transmission, and period of communicability.

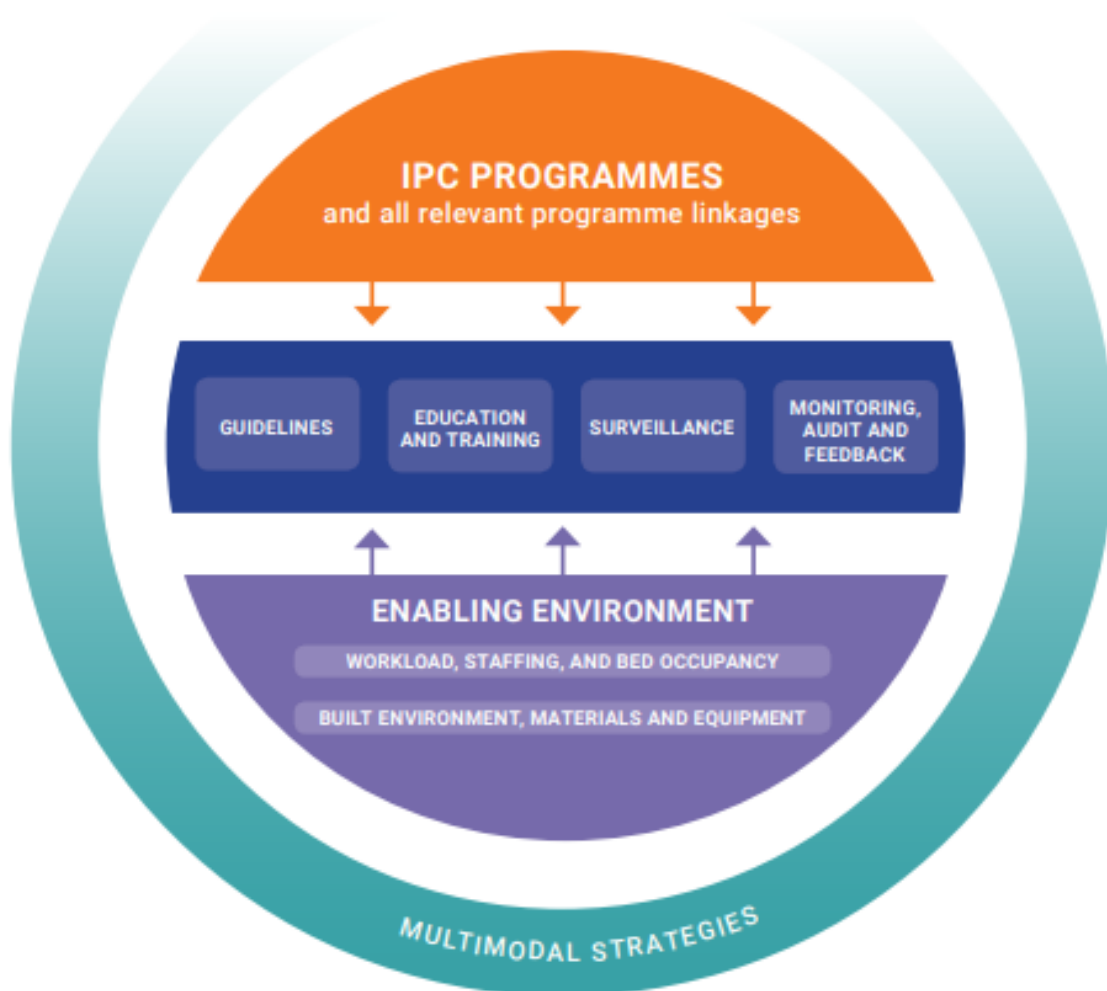
For updated case counts:

- Washington: <https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard>
- US: https://covid.cdc.gov/covid-data-tracker/#cases_casesinlast7days
- Global: <https://covid19.who.int/>

Infection Prevention and Control Program and Plan

Healthcare facilities should have a person dedicated to infection prevention and control and a plan to mitigate risk of infection transmission. Some healthcare settings have specific regulatory requirements for infection prevention and control. Please refer to regulatory agencies' (L&I, DSHS, HSQA, and CMS) requirements for regulatory requirements. An infection prevention and control program should at minimum include:

- 1) Guidelines, policies, and procedures
- 2) Education and training
- 3) Surveillance
- 4) Monitoring, audit, and feedback



From: [WHO's core components of infection prevention and control program](#)

Elements of COVID-19 Prevention in all Healthcare Settings

Screening

Follow [CDC recommendations](#) to establish a process to identify anyone entering the facility, regardless of their vaccination status, who meets any of the following three criteria so that they can be properly managed:

- A positive viral test for SARS-CoV-2, or
- [Symptoms of COVID-19](#), or
- Close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a [higher-risk exposure \(for HCP\)](#).

Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.

DOH has [visitor screening](#) and [healthcare worker screening](#) tools available for adaptation.

Visitors who are not moderately to severely immunocompromised and have recently had mild to moderate SARS-CoV-2 infection should not visit until:

- Symptoms improve with no fever in the last 24 hours and no fever reducing medication
- AND**
- 10 days from onset of symptoms or positive test if asymptomatic
- OR**
- 7 days from onset of symptoms with a negative SARS-CoV-2 antigen test collected within 48 hours

Visitors who are [not up to date with COVID-19 vaccines](#) and have had close contact (defined as within 6 feet for 15 cumulative minutes in 24 hours) should not visit until:

- 10 days from last date of close contact
- OR**
- 7 days from last date of close contact with a negative SARS-CoV-2 antigen or nucleic acid amplification test (NAAT) test, such as a polymerase chain reaction (PCR) test, collected within 48 hours

Healthcare facilities do not need to verify visitor vaccination status, test status, severity of disease, or immunological status.

Exclude HCP according to recommendations for CDC's [HCP Exposure and Exclusion from Work](#) and DOH [Mitigating Healthcare Worker Staffing Shortage](#).

Hand Hygiene

Follow [CDC recommendations for hand hygiene](#). HCP should use an alcohol-based hand rub containing at least 60 percent alcohol or wash with soap and water for the following clinical indications:

- Immediately before touching a patient
- Before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices
- Before moving from work on a soiled body site to a clean body site on the same patient
- After touching a patient or the patient's immediate environment
- After contact with blood, body fluids, or contaminated surfaces
- Immediately after glove removal

Handwashing with soap and water should be done after using the restroom and when hands are visibly soiled. At other times, an alcohol-based hand rub is preferred over soap and water due to evidence of better compliance compared to soap and water.

Physical Distancing

Follow [CDC recommendations](#) for physical distancing in healthcare settings. Physical distancing (when physical distancing is feasible and will not interfere with provision of care) is recommended for **everyone in a healthcare setting**. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with [substantial to high community transmission](#) or who:

- Are not [up to date](#) with all recommended COVID-19 vaccine doses; or
- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (for example, those with runny nose, cough, sneeze); or
- Had [close contact](#) (patients and visitors) or a [higher-risk exposure](#) (HCP) with someone with SARS-CoV-2 infection for 10 days after their exposure, including those residing or working in areas of a healthcare facility experiencing SARS-CoV-2 transmission; or
- Have [moderate to severe immunocompromise](#); or
- Have otherwise had [source control](#) and physical distancing recommended by public health authorities.

Environmental Infection Control - Cleaning and Disinfection

Follow CDC recommendations for environmental cleaning and disinfection found in their [Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#) and [Guidelines for Environmental Infection Control in Health-Care Facilities](#).

Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.

All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.

Routine cleaning and disinfection procedures (for example, using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which [aerosol generating procedures](#) (AGPs) are performed.

Refer to [List N](#) on the United States Environmental Protection Agency (EPA) website for EPA-registered disinfectants that kill SARS-CoV-2.

Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.

Once the patient who had or was suspected of having COVID-19 has been discharged or transferred, HCP, including environmental services personnel (EVS), should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. Refer to CDC's [clearance rates under differing ventilation conditions](#) including important footnotes. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

Ventilation

Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals (for example, physical barriers at reception/triage locations and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas).

Explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in all shared spaces.

- Guidance on ensuring that ventilation systems are operating properly are available in the following resources:
 - CDC's [Guidelines for Environmental Infection Control in Health-Care Facilities](#)
 - [American Society of Heating, Refrigerating and Air-Conditioning Engineers \(ASHRAE\) resources for healthcare facilities](#), which also provides [COVID-19 technical resources for healthcare facilities](#)
 - CDC's [Ventilation in Buildings](#), which includes options for non-clinical spaces in healthcare facilities

DOH provides additional information on improving ventilation:

- [Ventilation and Air Quality for Reducing Transmission of COVID-19](#)
- [Creating Safer Air Movement for Cooling with Consideration of COVID-19](#)

Personal Protective Equipment (PPE) and Transmission-based Precautions (TBP)

HCP should adhere to [Standard Precautions](#) and the follow PPE requirements according to [Transmission-based Precautions \(TBP\)](#). When caring for patients in TBP for confirmed or suspected COVID-19, HCP must wear appropriate PPE including:

- [National Institute of Occupational Health and Safety \(NIOSH\) approved respirator](#)
- Gloves
- Gown
- Eye protection (for example, goggles or a face shield that covers the front and sides of the face)

This section provides tools to quickly determine what PPE is appropriate in different circumstances. These tools provide general guidance and do not cover all possible scenarios. Use Table 1 to determine what PPE to wear, and Table 2 for guidance on how to use the PPE.

[Table 1 – PPE Residents, HCPs, and Visitors Should Wear in Resident Care Settings](#)

[Table 2 – HCPs: How to Use PPE](#)

For more information about PPE use and source control please refer to:

- [Division of Occupational Safety and Health \(DOSH\) Directive 11.80](#)
- [Chapter 296-842 WAC Safety Standards for Respirators](#)
- [CDC Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#)
- [CDC Optimizing Supply of PPE and Other Equipment during Shortages](#)
- [DOH recommendations for Cohorting](#)
- [DOH SARS-CoV-2 Source Control in Healthcare Settings](#)
- [Washington State Secretary of Health Order Statewide Face Coverings](#)

Use conventional PPE strategies unless experiencing shortages. If experiencing shortages, implement [contingency strategies](#) only after all conventional strategies have been implemented.

Table 1: PPE Patients, HCPs, and Visitors Should Wear in Healthcare Settings

What to Wear...	Source Control			PPE				Comments
	Well-fitting cloth face covering	Procedure mask (medical-grade facemask)	Respirator (N95, and others)	Respirators* (Fit tested N95, and others)	Eye Protection**	Gown	Gloves	
Patients								
Presumed or confirmed COVID+	✓ --OR--	✓ --OR--	✓					Stay in room as much as possible. Wear mask if need to leave room or when within 6 feet of others, if possible. If shortages, facemasks should be prioritized for HCP.
Presumed healthy	✓ --OR--	✓ --OR--	✓					Wear mask when out of room or when others (excluding roommate) are in their room
HEALTHCARE PERSONNEL (employed or contracted)								
Close contact with patients presumed or confirmed COVID+, or in observation/quarantine				✓	✓	✓	✓	Practice single use disposable PPE (one per resident per encounter). Discard disposable PPE after each use, and when soiled. Disinfect reusable PPE See Table 2 for recommendations for use in COVID+ unit/cohort.
Aerosol Generating Procedures (AGPs)**				✓	✓	✓	✓	Wear all PPE during AGPs*** and up to 3 hours after the procedure. Practice single use disposable PPE (one per resident per encounter) for AGPs*** ; discard after each use, and when soiled.
Close contact with patients presumed healthy		✓ --OR--	✓		✓			Discard disposable eye protection after each use, and when soiled.
No contact with residents		✓ --OR--	✓					Wear N95 (or other respirator) as voluntary use or facility policy.
VISITORS and ESSENTIAL SUPPORT PERSONS (ESP)								
Visiting patients in isolation or quarantine for COVID+		✓ --OR--	✓		✓	✓	✓	Remote visit preferred. Follow CDC guidelines and additional facility procedures. Avoid being present during AGPs*** .
Visiting patients presumed healthy	✓ --OR--	✓ --OR--	✓					Plus Standard Precautions and any posted TBP

*If respirator is unavailable, contact your local health jurisdiction (LHJ) and follow [CDC's optimization strategies](#). Document attempts to procure additional respirators. In shortages, respirators should be prioritized for care of residents with known or suspected COVID-19 or [AGPs](#).

**Wear eye protection for all patient encounters if facility is in an area with [substantial to high transmission](#).

**See DOH guidance on [Infection Control for AGP](#)

Table 2: HCPs: How to Use PPE

	Source Control or Universal Use	COVID-19+ (single resident), or AGP, or Quarantine	COVID-19+ unit/ Cohort*	Other instructions
N95 Respirator	N95 voluntary. If used for universal source control , and not PPE for TBP or AGP , may be worn until moist, soiled or damaged, then discard. Contact your supervisor for where to get more N95s.	Fit-tested N95 or higher respirator required. Use one for one patient encounter, then discard. Don new N95 for next patient. Discard N95 when soiled, wet, damaged.	Fit-tested N95 or higher respirator required. For multiple patients with same COVID+ status, extend N95 use. Discard after leaving area/unit, when N95 becomes wet, soiled or damaged, and after leaving the space in which <u>any</u> AGPs are performed.	For disposable respirator, single use, then discard when N95 is required. If used as source control only (not PPE), N95 fit test is not required. See note below for reusable respirators.
Facemask (surgical mask)	May be worn until moist, soiled, or damaged, then discard. Dispose of facemask when removed. Do not re-use.	Do not use surgical mask for COVID+ resident or AGPs .	Do not use surgical mask for COVID+ resident or AGPs .	For patient care, single use, then discard. Cloth masks are not surgical masks and should not be used by HCP at worksite.
Eye Protection	Extend use of eye protection: <u>Disposable</u> : Wear during multiple resident encounters without removing it between residents. Remove it when leaving the care area. Discard. <u>Re-usable</u> : Same as disposable, but do not discard, instead disinfect**; store for next use.	<u>Disposable</u> : Single use, then discard. <u>Re-usable</u> : Use for one patient encounter, then disinfect**. Store for next use.	Throughout the unit, extend use of eye protection. Use same eye protection for multiple residents with same COVID-19 status. Doff and disinfect** reusable eye protection when leaving area. Store re-usable eye protection for next use.	Your facility provides the proper disinfectant for the organism. Do not use damaged equipment. <u>For re-usable eye protection</u> : After all AGPs , doff and disinfect** between resident encounters.
Gown	No gowns needed for source control . Use according to standard and TBP.	Single use, one per patient, then discard (or launder if cloth).	Single use, one per resident, then discard (or launder if cloth).	Change gown when visibly soiled. Use according to standard and TBP.
Gloves	No gloves needed for source control . Use according to standard and TBP.	Single use, one pair per patient per care encounter or until contaminated.	Single use, one pair per resident per care encounter or until contaminated.	Single use, one pair per resident per care encounter or until contaminated. Always discard when moving from 'dirty' tasks to 'clean' tasks, and after each resident encounter.

*[Recommendations for Cohorting](#)

**Put on clean gloves when disinfecting eye protection.

Reusable respirators (for example, elastomeric, powered air-purifying respirators, etc.): For COVID+ resident, quarantined resident, or [AGPs](#): A fit tested elastomeric respirator is required. No fit test needed for loose-fitting powered air-purifying respirator. Disinfect** after each resident encounter, and when wet or soiled. Allow to dry, then store. Don again for next resident encounter requiring respirator use. If elastomeric or powered air purifying respirators are used in clinical circumstances where a sterile field must be maintained, use respirators that have no exhalation valve, filter the expired air, or otherwise adequately maintain [source control](#).

Source Control

There is overlap of devices used for source control and PPE. Fitted respirators (such as N95s) and well-fitting medical facemasks when worn as PPE also act as source control. There are times in healthcare settings, however, when PPE is not indicated, and source control is still required.

This section:

- Provides guidance on when source control should be worn in healthcare settings and what is considered appropriate source control for HCP, patients, and visitors;
- Describes source control and differentiates between source control and PPE, considering that some devices under certain circumstances may function as both;
- Provides guidance on how to improve the fit of source control in healthcare settings, which is different than community settings.

The guidance in this section is not comprehensive with respect to PPE and should not be used to determine whether a device worn for source control meets or exceeds requirements for PPE. For information on when PPE should be used refer to:

- [CDC Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic;](#)
- [L&I publication F414-168-000 \(Which Mask for Which Task\)](#)

Source Control Versus PPE

Source control refers to the use of well-fitting [cloth face coverings](#), facemasks, or respirators to cover a person's mouth and nose to prevent spread of potentially infectious respiratory secretions when they are breathing, talking, sneezing, or coughing. Some devices used for source control may not protect the wearer from infection with SARS-CoV-2. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. Healthcare facilities should follow the CDC's [Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#).

Source control should be used in addition to other interventions used to control the spread of SARS-CoV-2 (the virus that causes COVID-19), including maintaining a distance of least six feet (when physical distancing is feasible and will not interfere with provision of care) and hand hygiene.

PPE is worn to minimize exposure to hazards that cause serious workplace injuries and illnesses, see the [Occupational Safety and Health Administration \(OSHA\) page on Personal Protective Equipment](#).

Ensuring a proper fit is important to optimize the function of both source control and PPE. Transmission from asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection can occur in healthcare settings.

The following table reviews equipment used for source control, or as PPE, but is not a comprehensive summary for PPE.

Table 3: Source Control and PPE Protection

	Source Control protects others		PPE protects the wearer	
	Source Control for HCP	Source Control for visitors and patients	PPE for care of patients with COVID-19 or AGPs*	PPE for care of patients on Droplet Precautions
NIOSH approved, fit tested respirator	YES	N/A	YES	AGPs*
Non-NIOSH approved or not fit-tested respirator	YES	May be used, should be prioritized for HCP	Only in crisis PPE optimization strategies	AGPs* only in crisis PPE optimization strategies
FDA approved facemask	YES	May be used, should be prioritized for HCP	Only in crisis PPE optimization strategies	YES (except for AGPs*)
Non-FDA approved facemask	Only in non-patient care settings	YES	DO NOT USE	DO NOT USE
Cloth mask/face covering	Only in non-patient care settings	YES	DO NOT USE	DO NOT USE

**Procedures likely to generate high concentrations of potentially infectious respiratory aerosols that could create uncontrolled respiratory secretions according to DOH [Preventing Transmission of SARS-CoV-2 During Aerosol Generating and Other Procedures](#)*

NOTES:

- Contact LHI if experiencing shortages of PPE and document efforts to procure PPE and fit testing.
- Refer to [DOH PPE guidance](#) and [CDC Strategies for Optimizing the Supply of N95 Respirators](#) for additional information of respirator prioritization.

Source Control for Patients and Visitors

Patients and visitors should wear their own well-fitting form of source control upon arrival to and throughout their stay in the facility. CDC has recommended several ways to [improve the fit and filtration](#) of masks for the general public. If they do not bring their own, patients should be offered an option that is equivalent to what is recommended for people in the community. Some healthcare facilities may have requirements that exceed the recommendations in this document (for example, facility provided mask).

- Patients may remove their source control when alone in their rooms but should put it back on when around others (for example, when visitors enter their room) or leaving their room.
- Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for **everyone in a healthcare setting**. Visitors and patients should wear a mask/source control according to [Secretary of Health Order](#) and [CDC Guidance](#).
- Cloth face coverings, facemasks and respirators should not be placed on:
 - Young children under age 2, **OR**
 - Anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing a mask safely, **OR**
 - Anyone who is unconscious, incapacitated or otherwise unable to remove their cloth face covering, facemask or respirator without assistance.
 - Facilities should offer reasonable accommodations to visitors who are not able to wear a face covering or mask as source control, such as alternatives to on-site visits (for example, telephone or internet communication).
 - Educate patients, visitors, and HCP about the importance of performing hand hygiene, including immediately before and after any contact with their cloth face covering, facemask, or respirator.

Source Control for Healthcare Personnel

One of the following should be worn by HCP for source control while in the facility:

- A NIOSH-approved N95 or equivalent or better respirator, **OR**
- A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators, **OR**
- A well-fitting facemask (for example, selection of a facemask with a nose wire to help the facemask conform to the face; selection of a facemask with ties rather than ear loops; [tying the facemask's ear loops and tucking in the side pleats; fastening the facemask's ear loops behind the wearer's head](#).
 - HCP should always wear well-fitting source control while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers.

- To reduce the number of times HCP must touch their face and potential risk for self-contamination, when used for **source control** only and not as **PPE** under TBP, HCP should consider continuing to wear the same respirator or well-fitting facemask (extended use) throughout their entire work shift. If the respirator or well-fitting face mask is removed, (for example, eating, drinking), then it should be discarded and replaced. Re-use (removing and redonning the face mask, including for breaks or eating/drinking) should only be practiced if operating under crisis capacity strategies.
- Once put on, HCP should not touch their medical facemask. If they touch or adjust their medical facemask, they must perform hand hygiene before and after contact.
- HCP should remove their respirator or facemask, perform hand hygiene, and put on their community source control when leaving the facility at the end of their shift.

Facemask Use in Healthcare Settings

In healthcare settings, medical facemasks are used by HCP for two general purposes:

- As **PPE** to protect a HCP's nose and mouth from exposure to inhalation, splashes, sprays, splatter, and respiratory secretions, such as when treating patients on Droplet Precautions. For guidance on appropriate use of PPE in the context of the COVID-19 pandemic, see:
 - [CDC Interim Infection Prevention and Control Recommendations for HCP the COVID-19 Pandemic](#); and
 - [L&I publication F414-168-000 \(Which Mask for Which Task\)](#).
- When worn as PPE to protect HCP's nose and mouth from exposure to inhalation, splashes, sprays, splatter, and respiratory secretions (for example, for patients on droplet precautions), facemasks should be removed and discarded after each patient encounter.
 - For **source control** to cover HCP's nose and mouth to prevent spread of respiratory secretions from HCP to other people.
 - When used for **source control only**, and PPE is not indicated, medical facemasks may be used for the duration of a shift unless they become soiled, damaged, or hard to breathe through; medical facemasks, used for **source control only** should be removed and discarded at least after each shift. If the respirator or well-fitting face mask is removed, (for example, eating, drinking), then it should be discarded and replaced. Re-use (removing and redonning the face mask, including for breaks or eating/drinking) should only be practiced if operating under crisis capacity strategies.
 - Wear and disposal practices are different if facemasks are used as **PPE**: see [Table 2](#) and [CDC's Strategies for Optimizing the Supply of Facemasks](#).

Improving the Fit of Masks in Healthcare Settings

The fit of the device used to cover the wearer's mouth and nose is a critical factor in the level of source control (preventing exposure of others) and the level of the wearer's exposure to infectious particles. Fit-tested respirators offer the highest level of both source control and protection against inhalation of infectious particles in the air. Facemasks that conform to the wearer's face so that more air moves through the material of the facemask rather than through gaps at the edges are more effective for source control than facemasks with gaps and can also reduce the wearer's exposure to particles in the air. Improving how a facemask fits can increase the facemask's effectiveness for decreasing particles emitted from the wearer and to which the wearer is exposed.

CDC has recommended several ways to [improve the fit and filtration](#) of masks, including covering a medical facemask with a cloth face covering. However, if a good fit is achieved using a single medical facemask using techniques such as [knotting and tucking](#), other approaches to improving fit such as adding layers or using framed mask "fitters" might not be necessary. CDC indicates that layering masks requires special care in healthcare settings. WA DOH and WA L&I do not recommend using a non-disposable device, such as cloth face coverings or framed mask "fitters" to improve the fit of medical masks due to the complexity of implementing CDC's special care recommendations safely. Certain types of facial hair, like beards, can make mask fitting difficult. To improve fit, HCP with beards can shave their beards or trim their beards close to the face.

*****Cloth face coverings/masks are not PPE and should not be used to protect against splashes and sprays, such as when used while treating patients on Droplet Precautions*****

Precautions During and Following Aerosol Generating and Other Procedures

Some procedures performed on patients are more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing.

These [AGPs](#) potentially put HCP and others at an increased risk for pathogen exposure and infection. These aerosols may remain suspended in the air for hours following the procedure. This document provides guidance on preventing transmission of SARS-CoV-2, the virus that causes COVID-19, during and following [AGPs](#) and other procedures when potentially infectious particles remain suspended in the air or when there is a risk of uncontrolled respiratory secretions for all patients, when there is [substantial to high community transmission](#).

AGP When performing procedures on a patient with COVID-19, facilities should follow [CDC guidance](#).

HCP and healthcare facilities and settings should follow:

- [CDC's Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#)

Healthcare facilities and settings should use engineering and work practice controls to reduce worker exposure to generated aerosols to the extent feasible. If a healthcare facility or setting can demonstrate that the generated aerosol is effectively captured or disinfected to prevent exposures or residual contamination of the patient care area, additional mitigation measures may not be necessary to prevent potential transmission.

Aerosol-generating Procedures and Procedures that Create Uncontrolled Respiratory Secretions

Aerosol-generating procedures (AGPs)

Development of a comprehensive list of AGPs for healthcare settings has not been possible due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining if reported transmissions during AGPs are due to aerosols or other exposures. Facilities should evaluate what procedures are commonly performed in their setting, including all surgical procedures that might pose higher risk for transmission if the patient were to have COVID-19 (for example, that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract), to determine if they have the potential to generate aerosols and include those procedures in their respiratory protection plan and facility risk assessment. Commonly performed medical procedures that are often considered AGPs include, but are not limited to:

- Endotracheal intubation and extubation
- Manual ventilation
- Mechanical ventilation (unless using a closed system where expired air is filtered)
- Open suctioning of airways (including open tracheostomy suctioning)
- Cardiopulmonary resuscitation
- Bronchoscopy (unless carried out through a closed-circuit ventilation system)
- Surgery and post-mortem procedures in which high-speed devices, such as oscillating bone saws are used
- Dental procedures employing the use of ultrasonic scalers; high-speed dental handpieces; air/water syringes; air polishing; and air abrasion
- Non-invasive ventilation (NIV) (for example, bi level positive airway pressure ventilation (BiPAP) and continuous positive airway pressure (C-PAP))
- Induction of sputum
- Pulmonary function testing, including spirometry
- Maternal labor, stage 2

Procedures that Create Uncontrolled Respiratory Secretions

The following are additional procedures that could create uncontrolled respiratory secretions and are therefore a potential risk for SARS-CoV-2 transmission. Facilities should evaluate what

procedures are commonly performed in their setting to determine if they have the potential to create uncontrolled respiratory secretions and include those procedures in their respiratory protection plan and facility risk assessment. Some additional procedures that could generate uncontrolled respiratory secretions include but are not limited to:

- Collecting or handling specimens from known or suspected COVID-19 patients including nasopharyngeal specimen collection, other nasal specimen collection, oropharyngeal or other respiratory tract specimen collection
- (Nasogastric) NG tube placement and/or manipulation
- Transesophageal echocardiogram (TEE)
- Upper endoscopy

Infection Prevention During Aerosol Generating Procedures and Procedures that Create Uncontrolled Respiratory Secretions

To protect the health and safety of healthcare workers, if an AGP or procedure that creates uncontrolled respiratory secretions is performed on a patient in a facility with [substantial to high community transmission](#), regardless of COVID-19 status, the following should occur:

- HCP in the room (or patient care area) should wear a NIOSH approved N95 or equivalent or higher-level respirator, eye protection, gloves, and a gown.
- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support (for example, parents/caregivers for emotional or physical support). Visitors should not be present for the procedure, if possible.
- [AGPs](#) should take place in an airborne infection isolation room (AIIR), if possible. If an AIIR is not available, the door to the room should remain closed during the procedure and for the lengths of time indicated in the next sections following the [AGP](#).
- If respirators are in short supply, facilities should implement [CDC's Strategies for Optimizing the Supply of N95 Respirators](#).

Infection Prevention Following the Aerosol Generating Procedure

Because potentially infectious aerosols may remain suspended in the air following an [AGP](#), facilities should take additional measures to reduce the risk of transmission following the [AGP](#). These additional measures are not necessary following a procedure that only creates uncontrolled respiratory secretions.

- HCP entering the room or patient care area following the procedure must wear a NIOSH approved N95 or equivalent or higher-level respirator.
- The door to the room where the [AGP](#) was performed should remain closed unless exemption criteria as detailed below are met.
 - If a facility knows the ventilation and filtration rate of the room, the facility may use CDC's [clearance rates under differing ventilation conditions](#) to determine the time the door to the room should stay closed following the procedure.

- One hour is sufficient in clinical space constructed under DOH clinical facility requirements (6 air changes per hour).
 - 15 minutes is sufficient in an AIIR.
- If the air changes per hour are unknown, the door to the room should stay closed and anyone entering the room must wear a NIOSH approved N95 or equivalent or higher-level respirator for a minimum of 3 hours following the procedure.
- Non-HCP (patients, residents, visitor, etc.) should not enter following the [AGP](#) until the clearance time per above has passed, if possible.
- Clean and disinfect procedure room surfaces promptly using a disinfectant from [EPA's List N](#).

Healthcare Personnel Exemptions to Respirator Use Following an Aerosol-generating Procedure

Healthcare facilities and settings can implement specific risk mitigation measures that would exempt HCP from the requirement to wear a NIOSH-approved N95 or other respirator in the area following the [AGP](#) if:

- The patient on whom the [AGP](#) is performed is not known or suspected of having COVID-19, **AND**
- The patient on whom the [AGP](#) is performed has not had any known exposure to COVID-19 in the 14 calendar days before the procedure, **AND**
- The HCP are [up to date with COVID-19 vaccines](#) and have not disclosed that they are immunocompromised. **AND EITHER**
 - The patient on whom the [AGP](#) is performed has been tested with either a NAAT/PCR or antigen test for SARS-CoV-2 as close to the procedure as possible, the testing has not been performed greater than 24 hours before the procedure, and before initiation of the [AGP](#) the test results are known to be negative by the HCP where the [AGP](#) is performed,
- OR**
 - If before initiating the procedure, the patient on whom the [AGP](#) is performed is known by the HCP to be [up to date with COVID-19](#) vaccines.
- If a neonate must undergo a procedure after delivery, AGP precautions do not need to be implemented until 2 days after delivery.

Patient, Resident, and Visitor Exemptions Following an Aerosol Generating Procedures

Ideally, visitors and other patients/residents would not be present during or following an [AGP](#) until the clearance time has passed. Healthcare facilities and settings should implement policies and procedures to address how to protect other patients/residents and visitors who request to be present during and following [AGPs](#) including consideration for:

- Informing other patients/residents or visitors who must be present during or following the procedure of the risk associated with being present, especially if they are not vaccinated, and ways they can mitigate risk.
 - Healthcare facilities and settings should provide patients/resident and visitors with PPE and should provide basic instruction on its use.
- Vaccination status of the person on whom the procedure is being done.
- COVID-19 status of the person on whom the procedure is being done including:
 - Ensuring the person on whom the procedure has a recent (for example, within 24 hours) negative COVID-19 test can increase certainty of COVID-19 status and decrease risk.
- Additional engineering controls (for example, HEPA filters on medical devices or in the room).

Infection Prevention Following a Procedure that Creates Uncontrolled Respiratory Secretions

For procedures that only have risk of creating uncontrolled respiratory secretions and do not pose a risk of generating higher concentrations of infectious aerosols, healthcare facilities and settings can implement specific risk mitigation measures that would exempt HCP from the need as otherwise described in this document to wear a NIOSH approved N95 or other respirator in the area following procedures that creates uncontrolled respiratory secretions.

Patient Isolation and Quarantine

Follow [CDC recommendations](#) for TBP including quarantine and isolation.

Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. Also refer to [cohorting recommendations](#). The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom.

Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shifts. Only patients with the same respiratory pathogen should be housed in the same room.

Limit transport and movement of the patient outside of the room to medically essential purposes.

Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (for example, radiology) and to other healthcare facilities.

Isolation Versus Quarantine

QUARANTINE: The TBP used to keep someone who might have been exposed to COVID-19, away from all others to prevent potential transmission of COVID-19.

ISOLATION: The TBP used to keep someone who has confirmed COVID-19, away from others to prevent transmission to others.

Table 4: Summary of SARS-CoV-2 Isolation and Quarantine		
	Quarantine	Isolation
Days	<p>10 Day Quarantine or 7-day Quarantine with a negative test with a specimen collection date within 48 hours for:</p> <ul style="list-style-type: none"> Asymptomatic patients who are NOT up to date with COVID-19 vaccines and have had exposure to someone with COVID-19 Skilled nursing facility (SNF) resident who is newly admitted resident or has left the facility >24 hours and is NOT up to date with COVID-19 vaccines Residents who are up to date with COVID-19 vaccines do not need to quarantine 	<p>Isolation ends for patients who are not severely immunocompromised when:</p> <ul style="list-style-type: none"> At least 10 days have passed since symptoms first appeared <p>AND</p> <ul style="list-style-type: none"> At least 24 hours have passed since last fever without the use of fever reducing medications <p>AND</p> <ul style="list-style-type: none"> Symptoms (for example cough, shortness of breath) have improved
Reason for TBP	<p>The incubation period for COVID-19 is thought to extend to 14 days, with a median of 4-5 days from exposure to symptom onset. Most people with COVID-19 who have symptoms will do so within about 11 days of SARS-CoV-2 infection.</p> <p>Patients who are up to date on vaccinations are at lower risk of acquiring and transmitting COVID-19. Patients who are up to date on vaccine do not need to quarantine. If exposed to COVID-19, perform post-exposure testing.</p>	<p>It takes about 10 days for someone to stop being infectious after they become ill with COVID-19, which is why it is recommended that someone who tests positive for COVID-19 isolates for 10 days.</p>

Cohorting

Cohorting is an infection prevention and control measure that groups together patients with the same infectious condition and no other infection.

Benefits of cohorting patients with known or suspected COVID-19:

- Limits the risk of spreading COVID-19 by using dedicated staff to care for only COVID-19 positive patients.
- Allows for conservation of PPE resources and extended use of PPE such as respirators, face masks and eye protection when supplies are limited.

While intended for long-term care facilities, [additional strategies for cohorting](#) may be adapted for many inpatient healthcare settings.

Healthcare Personnel Exposure and Exclusion from Work

Follow [CDC recommendations](#) for managing HCP with SARS-CoV-2 infection or exposure.

Mitigating Healthcare Worker Staffing Shortage

In times of COVID-19 surge, healthcare facilities may experience HCP shortages due to employee illness, exclusion from work due to higher-risk exposure, the need to care for ill family members, fear of illness, and burnout. Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. This guidance is for COVID-19 contingency capacity staffing and crisis capacity staffing, which are defined as:

Contingency Capacity Staffing: When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem.

Crisis Capacity Staffing: When staffing shortages occur, healthcare facilities and employers, in collaboration with human resources and occupational health services, may need to implement crisis capacity staffing strategies to continue to provide patient care when there threatens to be insufficient staff to provide safe patient care.

These strategies are independent of “contingency standards of care” and “[crisis standards of care](#)” based on the framework developed by the National Academies of Medicine.

Unlike implementation of crisis standards of care, which in Washington requires a formal statewide declaration, healthcare facilities and employers may choose to implement contingency capacity staffing and crisis capacity staffing independently.

Strategies to Mitigate Healthcare Personnel Staffing Shortages

During HCP staffing shortages facilities should follow guidance from CDC:

- [Interim Guidance for Managing HCP with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#)
- [Strategies to Mitigate HCP Staffing Shortages](#)

CDC’s [Strategies to Mitigate HCP Staffing Shortages](#) offer a continuum of options for addressing staffing shortages. Contingency and then crisis capacity staffing strategies augment conventional strategies and should be considered and implemented sequentially. If experiencing staff shortage, facilities should reach out to their local health jurisdiction and local emergency management as well as their [regional health care coalition](#).

Healthcare facilities should understand that shortening the duration of work restriction might result in additional transmission risks to HCP and patients. Healthcare facilities, in collaboration with risk management, should inform patients and HCP when the facility is operating under contingency capacity staffing or crisis capacity staffing standards, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are requested to work to fulfill critical staffing needs.

Healthcare facilities may consider allowing **willing** HCP who are infected with SARS-CoV-2 and are not moderately to severely immunocompromised to return to work earlier than conventional timeframes if implementing contingency or crisis staffing mitigation measures. Prior to agreeing to return to work, **willing** HCP should assess personal symptoms, current health status, and determine their personal readiness to safely return to work. Mitigation measures should be implemented sequentially (that is, implementing contingency before crisis).

When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem including adjusting staff schedules, hiring additional HCP, rotating HCP to positions that support patient care activities:

- Cancel all non-essential procedures and visits
- Attempt to address social factors that might prevent HCP from reporting to work.
- Identify additional HCP to work in the facility
- As appropriate, ask HCP to postpone elective time off with consideration for the mental health benefits of time off

Preventing illness among HCP is a key component of mitigating staffing shortages. With the SARS-CoV-2 omicron variant, booster doses are necessary to provide the best protection against infection and severe disease. All HCP are strongly encouraged to get a booster dose of vaccine and for healthcare employers to make access to booster doses of vaccine available onsite for their employees. HCP should also get a yearly influenza vaccination.

Table 5: Summary of CDC’s recommendations for HCP exclusion from work according to staffing mitigation strategy

Work Exclusion for HCP	Vaccination Status	Mitigation Strategy		
		Conventional Capacity Staffing	Contingency Capacity Staffing	Crisis Capacity Staffing
Tested positive with SARS-CoV-2 Infection	<ul style="list-style-type: none"> Up to date and not up to date 	If asymptomatic or mildly symptomatic with improving symptoms and fever free for 24 hrs. without fever-reducing medications, exclude from work for: <ul style="list-style-type: none"> 10 days OR 7 days with negative test** within 48 hours before returning to work 	If asymptomatic or mildly symptomatic with improving symptoms and fever free for 24 hrs. without fever-reducing medications exclude from work* for at least 5 days since symptoms first appeared (day 0) with or without negative test**	No work restriction with prioritization considerations (for example, asymptomatic should be prioritized for early return to work)*
Asymptomatic with high risk exposure	<ul style="list-style-type: none"> Up to date 	No work restriction with negative test** on post exposures day 2 and at least 5 days following exposure	No work restrictions	No work restrictions
	<ul style="list-style-type: none"> Not up to date 	Exclude from work for: <ul style="list-style-type: none"> 10 days OR 7 days with negative test** on post exposure day 2 and at least 5 days following exposure 	No work restriction with negative tests** on post exposure days 1, 2, 3, & at least 5 days following exposure; If testing supplies are limited, testing should be prioritized for 1-2 days after the exposure and, if negative, at least 5 days following exposure	No work restrictions. Test** if possible.

*Healthcare facilities may consider allowing **willing** HCP who are infected with SARS-CoV-2 and are not immunocompromised to return to work earlier than conventional timeframes if implementing contingency or crisis staffing mitigation measures. Prior to agreeing to return to work, **willing** HCP should assess personal symptoms, current health status, and determine their personal readiness to safely return to work. Mitigation measures should be implemented sequentially (that is, implementing contingency before crisis)

** Either an antigen test or NAAT can be used when referenced in the criteria above. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

Considerations for Shortened Exclusion from Work for Healthcare Personnel After a High-Risk Exposure to SARS-CoV-2

If all other [conventional and contingency capacity staffing strategies](#) have failed, facilities may consider allowing [asymptomatic HCP with high-risk exposures](#) who have not received all recommended doses COVID-19 vaccine, including a booster, to return to work before the end of their indicated [exclusion from work](#). HCP who have received all recommended COVID-19 vaccine doses and a booster would not generally be excluded from work and have no work restrictions. All HCP with higher-risk exposures, regardless of exclusion from work and regardless of vaccination status, should have at minimum post-exposure testing immediately (on post-exposure day 1 or 2) and at least 5 days following exposure. See [CDC's Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#) and [DOH's Testing in Long-Term Care Facilities](#).

If allowed to return before the end of their indicated exclusion from work, any HCP who is either not [up to date](#) with all recommended COVID-19 vaccine doses should:

- Continue to be screened for symptoms before each shift and should either not report to work or stop working and notify their supervisor or occupational health services prior to leaving work if they develop even mild symptoms. These HCP should be prioritized for SARS-CoV-2 testing.
- Have expanded post-exposure testing when testing supplies allow on each of the first three post-exposure days and at least 5 days following exposure (for example, days 1,2,3, and 5), and be tested immediately if symptoms develop.
- Consider use of a respirator or, if not available, a well-fitting facemask at all times in the facility.
- If they test positive for SARS-CoV-2, immediately be excluded from work until they meet all [return-to-work criteria](#) and according to the staffing shortage mitigation strategy in place. The facility should begin identifying and notifying patients, staff, and visitors who may have been exposed. The HCP should wear a respirator or, if not available, a well-fitting facemask at all times in the facility.

Considerations for Shortened Exclusion from Work for Healthcare Personnel with SARS-CoV-2 Infection

Facilities may consider allowing asymptomatic or mildly symptomatic HCP who are **willing** to return to work before the end of their indicated [isolation period](#) in contingency staffing shortage mitigation strategies if:

- At least 5 days have passed since symptoms first appeared or, if asymptomatic, the day of their positive test (day 0), **and**
- At least 24 hours have passed since last fever without the use of fever-reducing medications, **and**
- Symptoms (for example, cough, shortness of breath) have improved.

If allowed to return before the end of their isolation period in contingency or crisis staffing shortage mitigation strategies, the HCP should:

- Be prioritized for assignment to care for patients with suspected or confirmed COVID-19, preferably in a cohort setting such as a COVID-19 Unit.
- Self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.
- Wear a respirator or, if not available, a well-fitting facemask at all times while in the facility, even when they are in non-patient care areas such as breakrooms.
- To the extent possible, they should practice physical distancing from others.
- Separate themselves from others if they must remove their respirator or well-fitting facemask, for example, in order to eat or drink.

Facilities should consider providing NIOSH approved respirators for other HCPs working in the same physical areas as any HCP returning to work before the end of their indicated isolation period. Refer to [L&I Respirator Use to Prevent COVID-19 During Healthcare Staff Shortages](#).

Transferring Between Facilities

While intended for long-term care facilities (LTCFs), [DOH guidance for transferring between facilities may](#) be adapted for other healthcare settings and provides recommendations for healthcare facilities receiving patients from LTCFs and other healthcare facilities discharging patients to LTCFs.

Testing

A robust testing program can identify cases earlier, allowing early isolation, identification of people exposed and early quarantine when indicated.

- HCP and patients should be tested immediately if symptomatic, regardless of vaccination status.
- HCP and patients should be tested immediately, but not within 24 hours, and at least 5 days following [higher risk close contact](#) with a person with confirmed SARS-CoV-2 infection, regardless of vaccination status.
- Asymptomatic HCP and patients who have been exposed and have recovered from SARS-CoV-2 infection in the prior 90 days should be tested using an antigen test rather than NAAT or PCR test.
- Performance of pre-procedure or pre-admission viral testing is at the discretion of the facility. The yield of this testing for identifying asymptomatic infection is likely low when performed on vaccinated individuals or those in counties with low or moderate transmission. However, these results might continue to be useful in some situations (for example, when performing higher risk procedures on people who are not [up to date](#) with all recommended COVID-19 vaccine doses) to inform the type of infection control precautions used (for example, room assignment/cohorting, or PPE used).
- For routine testing of HCP in LTCFs (SNFs, ASL, AFHs, SL) refer to [LTCF recommendations for routine testing of HCP](#).
- For testing HCP to return to work following SARS-CoV-2 infection or exposure refer to recommendations for [mitigating healthcare worker staffing shortage](#).

Testing Prioritization

During times of COVID-19 surge, testing supplies may be inadequate to meet demand. This guidance provides a framework for prioritizing testing supplies in healthcare facilities to maximize patient and HCP worker safety. Facilities should adapt this framework to meet the facilities' individual needs. General principles to consider when prioritizing testing supplies may include:

- Testing symptomatic staff and patients
- Testing those who are not [up to date](#) with vaccination
- Testing those who have a known exposure
- Testing those who have not had a COVID-19 infection in the past 90 days
- Testing HCP who are responsible for patient care
- Outbreak testing should take priority for all LTC facilities. For SNFs, consideration should be given to required testing per [CMS QSO 20-38](#). Work with your local health jurisdiction (LHJ) to prioritize outbreak testing
- Testing resources to facilitate implementation of contingency and crisis staffing shortage mitigation measures

For guidance on staffing shortage mitigation including information about contingency and crisis staffing mitigation and return to work refer to [DOH Mitigating Healthcare Worker Staffing Shortage During the COVID-19 Pandemic](#).

Example of LTCF Prioritization from Highest (1) to Lowest (3)

Table 6 is an example of a testing supply prioritization from highest priority to lowest priority and should be adapted a healthcare facility’s resources and needs and may be useful to healthcare settings beyond LTCFs. The prioritization categories below are intended to be implemented sequentially (for example, if able to implement all testing in priority 1 and have adequate supply, priority 2 testing should be implemented in addition to priority 1 testing). Facilities should implement as much of the recommended testing as supply allows. In this example, testing within the prioritization categories is not further ranked.

Table 6: Testing Supply Prioritization

Resident Testing	Healthcare Personnel
Priority 1 - High	
Post-exposure testing at least 5 days following exposure	
Symptomatic residents	Vaccination exemption per facility policy and granted accommodations
	Symptomatic staff with no known exposure and no access to other testing resources
Outbreak investigation testing in residents and HCP	
Priority 2 - Medium	
Asymptomatic resident post-exposure on day 1-2 in addition to at least 5 days following exposure	In conventional staffing, testing at least 5 days following exposure for an early return to work on day 7 after COVID-19 infection
	In conventional staffing, post-exposure testing on day 1-2 in addition at least 5 days following exposure
	In contingency staffing, post-exposure testing on days 1,2,3 in addition to at least 5 days following exposure
	Twice a week testing for HCP who are up to date with COVID-19 vaccines
Priority 3 - Low	
	In contingency staffing, testing on day 3-5 for early return to work on day 5
Essential support persons and compassionate care and other visitors.	In crisis staffing, any recommended testing for post exposure or early return to work

Determining Exposure

Refer to [CDC's Interim Guidance for Managing HCP with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#) for risk assessment to determine if exposure is higher risk.

Anyone who had prolonged close contact (within 6 feet for at least 15 minutes) should be considered potentially exposed. The use of a facemask for [source control](#) and adherence to other recommended infection prevention and control (IPC) measures (for example, hand hygiene) by the HCP help to reduce the risk of transmission.

The following should be considered when determining which patients are at higher risk for transmission and might be prioritized for evaluation and testing:

- Facemask use by the patient – Mirroring the [risk assessment guidance for HCP](#), patients not wearing a facemask would likely be at higher risk for infection compared to those that were wearing a facemask.
- Type of interaction that occurred between the patient and infected HCP – An interaction involving manipulation or prolonged close contact with the patient's eyes, nose, or mouth (for example, dental cleaning) likely poses higher risk of transmission to the patient compared to other interactions (for example, blood pressure check).
- PPE used by infected HCP – HCP wearing a well-fitting respirator might have had better [source control](#) than wearing only a facemask.
- Current status of patient – Is the patient currently admitted to a hospital or LCTF? These individuals, if infected, can be at higher risk for severe illness and have the potential to expose large numbers of individuals at risk for severe disease.

Contact tracing should be carried out in a way that protects the confidentiality of affected individuals to the extent possible and is consistent with applicable laws and regulations. HCP and patients who are currently admitted to the facility or were transferred to another healthcare facility should be prioritized for notification. These groups, if infected, have the potential to expose a large number of individuals at higher risk for severe disease, or in the situation of admitted patients, be at higher risk for severe illness themselves.

Consider using a unit-wide or facility-wide approach to exposure management based on facility resources.

Guidance for Specific Settings

In general, [CDC's infection prevention and control guidance](#) and DOH guidance for [all healthcare settings](#) applies to all settings where healthcare is delivered. However, facilities may adapt recommendations to their setting, ensuring that HCP and patient safety are maintained and regulatory requirements are adhered to. This section provides COVID-19 prevention recommendations with consideration to specific healthcare settings.

Long-term Care Facilities

All LTCFs should follow [CDC's Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#), and [DSHS COVID-19 Response Plans](#) appropriate for their setting.

SNFs should also follow:

- [CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes](#)
- [CMS QSO 20-39 NH – Nursing Home Visitation – COVID-29](#)
- [CMS QSO 20-38 NH - Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to LTCF Testing Requirements](#)

While intended for SNFs, the above guidance may be useful to other LTCF settings, particularly memory care.

Transferring Between Facilities

Residents in LTCF are more susceptible to COVID-19 infection acquisition and, subsequently, more severe outcomes of the disease, leading to increased transfers to other healthcare settings. When transferring LTCF residents between healthcare facilities, safe processes and bidirectional communication are critical. Efficient and safe transfers between facilities are essential to maintain capacity in acute care hospitals and other healthcare facilities. Facilities should follow CDC's [Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#) and DOH [PPE recommendations](#).

Transferring from a LTCF to another Healthcare Setting

Responsibilities of the Transferring LTCF

- The transferring facility should inform transporting personnel and the accepting facility:
 - Of the COVID-19 status and vaccination status of the resident being transferred, whether it is known, unknown, or suspected (that is, [presence of signs and symptoms](#) that increase the index of suspicion for COVID-19), including if any test results are pending and from which lab.
 - If any COVID-19 cases are in their infectious period at the LTCF, via both verbally and written communication in transfer documents.

- When sending LTCF residents for evaluation in a clinic, dialysis facility, emergency department, or other outpatient setting, the LTCF should expect and plan to have the resident return to their facility regardless of SARS-CoV-2 testing status, as long as the facility is able to provide the appropriate level of care under the appropriate TBP.

Responsibilities of the Receiving Healthcare Facility

- Screen patients for [symptoms consistent with COVID-19](#) when receiving them in transfer from LTCFs.
- If a patient transferred from a LTCF has [symptoms of COVID-19](#) or the transferring LTCF has known cases of COVID-19 in their infectious period, implement TBP until testing is complete and results reported.
- Outpatient facilities should consider offering telehealth visits for LTCF residents, if possible and clinically appropriate.
- Patients with known or suspected COVID-19 should remain in TBP until they meet criteria according to [CDC's discontinuation of TBP of patients with COVID-19 in healthcare settings](#).
- Provide LTCF residents' SARS-CoV-2 test results to their LTCF verbally and by sending a hard copy of the test results to the LTCF (for example, via mail, fax, or electronically).

Hospital Admission

For LTCF residents not already known to have COVID-19 infection and who have not been tested for SARS-CoV-2 in the past 72 hours, consider testing on admission to the hospital. If there is suspicion for COVID-19 or if the transferring facility has known cases of COVID-19 in their infectious period, consider placing all LTCF admissions on presumptive [TBP](#) while waiting for SARS-CoV-2 test results.

Transferring from a Hospital or other Healthcare Setting to LTCF

Responsibilities of the Discharging Hospital or other Healthcare Setting

- For patients whose COVID-19 status is unknown, prior to hospital discharge, consider testing the patient to facilitate appropriate placement and implementation of precautions in the LTCF.
 - Testing might help direct placement of asymptomatic SARS-CoV-2-infected residents into a COVID-19 care unit, however, **testing should not be required prior to transfer of a resident to a LTCF.**
 - A single negative test upon LTCF admission does not mean that the resident was not exposed or will not become infected in the future.
 - When testing solely for LTCF placement purposes, TBP at the hospital are not necessary while waiting for SARS-CoV-2 test results unless the patient is symptomatic or there is another indication for additional precautions [for example, Multidrug-Resistant Organism (MDRO), etc.].
- Hospitals should offer vaccination and encourage patients who are not up to date with COVID-19 vaccines..

Responsibilities of the Admitting LTCF

- **Testing should not be required prior to accepting transfer of a resident from an acute-care facility to a LTCF.**
 - LTCFs should accept residents back from all healthcare settings, regardless of SARS-CoV-2 testing status, as long as the LTCF is able to provide the appropriate level of care under the appropriate TBP.
 - If testing supplies allow, best practice is that newly-admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-COV-2 infection; immediately and, if negative, again at least 5days after their admission or return to the facility.
- SNFs should create a plan for [managing new admissions and readmissions](#). Refer to [DOH guidance on isolation and quarantine](#).
 - Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19 for 10 days, or 7 days with a negative test with a specimen collection date within 48 hours.
 - Residents who are being admitted to a post-acute care facility if they are [up to date on vaccine](#) or have recovered from COVID-19 in the past 90 days do not need to quarantine.

Admitting to a LTCF During a LTCF COVID-19 Outbreak Investigation

The ability to admit residents from hospitals to LTCF must be maintained to ensure adequate hospital capacity and continuity of care for residents. A pause in admissions was previously recommended if a case of COVID-19 is detected in the facility; a pause is no longer recommended as long as the LTCF is safely able to provide the appropriate level of care. Facilities should notify the resident to be admitted (or guardian/POA) of the COVID-19 status in the facility.

Cohorting Strategies for Long-term Care Facilities

Cohorting positive residents in a single area allows dedicated HCP to work with only with resident with known COVID-19. This decreases the risk of spreading the virus from infected to uninfected residents. Facilities should prepare their COVID-19 dedicated unit following DOH's [Preparing your LTCF COVID-19 Unit](#).

Table 7: Recommended Cohorting Strategy

Unit/Wing/ Zone/Area	Resident criteria	Cohort	Staffing	PPE required
COVID-19 positive unit (isolation)	<ul style="list-style-type: none"> Confirmed COVID-19 	<ul style="list-style-type: none"> Acceptable if no other reasons for isolation precautions, (for example, multi-drug resistant organisms (MDROs), <i>C. diff</i>, influenza, etc.) 	<ul style="list-style-type: none"> Dedicated staff Reduce number of staff interacting with resident environment Dedicated EVS staff, if possible If dedicated staff is not possible, EVS should start in Standard Unit and move to COVID-19 unit 	<ul style="list-style-type: none"> Respirator and eye protection always anywhere on the unit source control for residents leaving their room or within 6 feet of others Gowns and gloves when entering resident rooms Must change gowns and gloves between residents
Observation unit (quarantine)	<p>Asymptomatic</p> <ul style="list-style-type: none"> NOT up to date with COVID-19 vaccine <ul style="list-style-type: none"> Newly admitted SNF residents SNF residents who have left the facility for >24 hours Residents with known exposure 	<ul style="list-style-type: none"> Single rooms with private bath, if possible If cohorting is necessary, consider risk of exposure and vulnerability of roommate 	<ul style="list-style-type: none"> Dedicated staff, if possible 	<ul style="list-style-type: none"> Respirator and eye protection anywhere on the unit Cloth face coverings on residents upon leaving their room or within 6 feet of others Gowns and gloves when entering resident rooms Must change gowns and gloves between residents Prioritize gowns for hands on care if there is a shortage of gowns

Notes:

- N95s and other tight-fitting respirators must be fit-tested. Follow [CDC Strategies for Optimizing the Supply of N95 Respirators](#) if supplies are limited. N95 and other respirators should be prioritized for HCP caring for residents with known or suspected COVID-19 and HCP directly involved in [AGPs](#).
- Eye protection should be worn for all resident encounters in facilities located in areas of [substantial to high transmission](#).
- Facilities should follow [DOH recommendation to mitigate HCP staffing shortages](#) if experiencing staff shortages

Placement of Residents in Quarantine

- The resident should remain or be placed in a single-person room when possible.
 - Depending on the facility layout, a separate observation area may mean a dedicated wing or unit, or a designated block of rooms set aside for this purpose.
 - In a community-based setting, an observation area may include a private apartment/room.
 - If the resident becomes ill or exhibits symptoms of COVID-19 at any point during the quarantine, they should immediately be tested and placed in a single-person room.
- Residents can be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for duration of their quarantine period.
- If the resident is NOT [up to date](#) with COVID-19 vaccine:
 - At the time of admission and is newly admitted to a SNF, **or**
 - Leaves the SNF for >24 hours, **or**
 - Has had an identified exposurePerform testing according to DOH Testing in Long-Term Care Facilities and place the resident in transmission-based precautions in a separate observation area (ideally, in a single-person room) 10 days or 7 days with negative test with a specimen collected within 48 hours.
- If the resident is [up to date](#) with COVID-19 vaccines and has had a known exposure, perform testing according to [DOH Testing in LTCFs](#). If one roommate has confirmed COVID-19, the other roommate should be considered exposed and should not share rooms with other residents until they have completed post-exposure testing according to [DOH Testing in LTCFs](#)
 - Leave the exposed resident in the room if their roommate is moved to the COVID-19 unit.
 - Clean and disinfect the room with a product on [EPA list N, Disinfectants for COVID-19](#).
 - Exposed residents may be permitted to share a room with other exposed residents as a last resort if space is not available for them to remain in a single room.
- Staff should be dedicated to observation/quarantine unit if staffing resources allow.

Observation/Quarantine Best Practices when Single-person Room is Unavailable

This section outlines considerations for deciding when and how to place newly admitted, re-admitted, or exposed residents together in a shared room when single-person rooms are not an option.

- Symptomatic residents and those exposed or potentially exposed to SARS-CoV-2 infection should be prioritized for placement in a single-person room.
- Placing residents in a shared room during their quarantine period increases the risk of exposure to SARS-CoV-2 and should be considered only on a limited, case-by-case basis.

- When making resident management decisions, the person responsible for infection control measures should review the **following list of considerations** (*Note: this list is not exhaustive*):

Table 8: Considerations for Cohorting When a Single Room is not Available	
Patient Status	<ul style="list-style-type: none"> • Appropriate roommate for quarantined resident: <ul style="list-style-type: none"> • Recovered from COVID-19 within previous 90 days • Released from TBP • No longer symptomatic • Avoid pairing residents at higher risk of severe illness
Community Status	<ul style="list-style-type: none"> • Rate of COVID-19 in surrounding community • Risk level of previous setting of cohorting residents • Partner with local facilities for single room placement
Facility Layout and Capacity	<ul style="list-style-type: none"> • Dedicate space for observation/quarantine that separates residents (can be a wing, unit or block of rooms) • Provide at least 6 feet between residents • Assess engineering/ventilation improvements

Testing

- Follow [CDC’s Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes](#) and [DOH’s Testing in LTCFs](#).
- A negative SARS-CoV-2 test is not required for discontinuation of the 10-day quarantine but is required for discontinuation at 7 days with a specimen collection date within 48 hours by testing.

PPE

- Follow PPE recommendations in CDC’s [Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#) and DOH [PPE recommendations](#).
- Staff should change gloves and gown when moving between residents and perform hand hygiene after glove removal.

Source Control

- As part of universal source control measures, all residents should wear a well-fitting cloth face covering or facemask (if tolerated) whenever they leave their room or when staff are within 6 feet. See [CDC’s Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#) and [DOH SARS-CoV-2 Source Control in Healthcare Settings](#).

Considerations for Memory Care Units

Residents and staff of LTCF are disproportionately affected by COVID-19, with more outbreaks, cases, and deaths compared to acute care facilities. Memory care poses unique challenges for infection prevention best practices.

This section contains suggested best practices based on memory care-facility specific experiences during the COVID-19 pandemic and includes some recommendations which may not be regulatory requirements. For questions about regulatory requirements, contact your [DSHS Field Manager](#). Some recommendations may not apply to all circumstances or all facility types. Please contact your [LHJ](#) if you have questions about implementing any of these recommendations.

- Residents in memory care facilities/units may have difficulty understanding or remembering the need to wear masks, maintain physical distance (when physical distancing is feasible and will not interfere with provision of care), remain in their rooms, or avoid communal spaces.
- Residents in memory care may gather closely, touch surfaces, staff, and/or each other frequently, and may become distressed with changes in routine and process made in response to COVID-19. Potentially upsetting changes include fewer visits, relocation within the facility or unit, change in schedule, and cancelation of group activities.

Proactive Cohorting

- Facilities should be familiar with their building design. Separate buildings or cottages can be utilized as units to house residents with confirmed or suspected COVID-19. If separate buildings are not available, separate wings or hallways could be utilized.
- If possible, keep a set of adjacent rooms open to facilitate immediate quarantine and isolation in the event of an exposure or new case.

Outbreak Mitigation

- In consultation with DSHS, fire safety officials, and your LHJ, consider closing fire doors to create physically separate spaces for units.
- In consultation with DSHS and your LHJ, consider converting non-licensed rooms (common rooms, etc.) into resident rooms to facilitate cohorting.
- Consider using the facility lay-out map to identify residents who may wander and create a cohorting plan that provides safe routes to wander.
- Use temporary barriers, like visqueen or plywood to create physically separate units in consultation with the LHJ and your building maintenance staff. Ensure barriers are placed where they will not interfere with intended ventilation, fire code, or life safety requirements.
- Consider introducing activities or using TVs and other distractions away from the boundaries between units to discourage residents from attempting to leave their unit.
- Increase staffing during outbreak periods to have extra help monitoring residents and keep them in their assigned units; consider using agency staff if necessary.

- Consider using sitters to keep residents calm and comfortable in their unit. Refer to [DSHS COVID-19 Response Plan](#) on use of essential support persons.
- Transfer personal comfort items with residents to help them acclimate to new rooms if room moves occur.
- Have a dedicated person to conduct screening for all staff and visitors; avoid self-screening or attestation. Make sure the screener feels empowered to turn away anyone with symptoms.

Symptoms in Memory Care Residents

COVID-19 may present differently among those with dementia due to their inability to describe symptoms. Common symptoms in the dementia population to look out for include:

- Changes in behavior, such as:
 - Increased agitation
 - Increased confusion
- Sudden sadness
- Coughing
- Difficulty breathing
- Fever
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell

PPE considerations

[PPE guidance](#) is the same for memory care units as it is for other healthcare facility types. While healthcare workers may express concern about the potential for contact with residents in common areas (hallways, common rooms, dining rooms), there are no data to show that universal use of gowns and gloves in common spaces provides additional protection to healthcare workers when PPE is not indicated by TBP. Rather, it may increase the risk of transmission among residents and staff as loose gowns may drape over and touch contaminated surfaces, and constant use of PPE can give staff a false sense of security leading to less frequent hand hygiene.

If residents are struggling with communication problems related to PPE, staff may consider other PPE options that meet the same level of protection (that is, safety glasses instead of face shields, and/or transparent masks approved for use in healthcare settings).

Testing in Long Term Care Facilities

Nursing home and other LTCF residents are at high risk for infection, serious illness, and death from COVID-19. Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens detects current infections (referred to here as [viral testing](#)) among residents in LTCFs. Viral testing of residents in LTCFs is an important addition to other IPC recommendations aimed at preventing SARS-CoV-2 from entering LTCFs, detecting cases quickly, and stopping transmission.

Table 9: Routine testing for all LTCF Staff

Routine Testing for ALL STAFF			
Facility Type	Required/recommended	CDC Level of Community Transmission **	Minimum Frequency*
SNF	Required by CMS QSO-20-38-NH ***	Low transmission	Not recommended
		Moderate transmission	Once a week
		Substantial and high transmission	Twice a week
All other licensed LTCFs	Follow LHJ direction, otherwise, optional based on resources available	Low transmission	Not recommended
		Moderate transmission	Once a week
		Substantial and high transmission	Twice a week

*This frequency presumes availability of Point of Care testing on-site at the LTCF or where off-site testing turnaround time is <48 hours.

**Testing frequency should be based on [CDC's levels of community transmission](#).

*** DOH continues to recommend that all HCP be included in routine testing, regardless of vaccination status. Those who have recovered from COVID-19 in the past 90 days should be tested with new onset of symptoms or exposure. If testing resources are limited, [prioritize testing](#) unvaccinated staff, staff who have not recovered from COVID-19 in the past 90 days, and staff who are not [up to date](#) with COVID-19 vaccines

Outbreak Investigation Testing

On identification of a HCP or other non-resident case, or identification of a facility or agency-acquired resident COVID-19 case, LTCFs should implement outbreak investigation testing, including unit-wide testing, on all units where a person identified as having COVID-19 was present for greater than or equal to 15 cumulative minutes in a 24-hour period beginning two days before their [signs or symptoms](#) develop, or two days before a positive SARS-CoV-2 test if asymptomatic. If resources allow, LHJs may assist LTCFs in contract tracing as an alternative to unit wide testing.

- LTCF and agency-acquired COVID-19 infection in a resident is defined as a positive (NAAT/PCR or antigen) case diagnosis 14 days or more after admission for a non-COVID-19 condition, without an exposure during the previous 14 days to another setting where an outbreak was known or suspected to be occurring. It does not refer to the following:
 - Residents or patients who were known to have COVID-19 on admission to the facility and were placed into appropriate TBP to prevent transmission to others in the facility.

- Residents or patients who were placed into TBP on admission, had no other more likely facility-source of exposure, and developed COVID-19 infection within 14 days after admission.
- For the purposes of this guidance a unit is a geographically separated area of the facility, or an area that can be easily separated with physical barriers. A unit must be accessible without having to pass through unaffected areas of the facility. If the affected area/unit cannot be separated, consider expanding testing to include a larger area or the entire floor.
- Test all residents and all staff, regardless of vaccination status, present on the identified unit(s) for greater than or equal to 15 cumulative minutes in 24 hours on the days according to [post exposure testing](#).
 - Twice weekly routine testing of HCP meets requirement for post-exposure testing.
 - If exposure is identified on post-exposure day 5-14, a second round of testing is not necessary.

Follow CDC's [Interim U.S. Guidance for Managing HCP with SARS-CoV-2 infection or Exposure to SARS-CoV-2](#) to determine work exclusions for HCP who are [up to date](#) with all recommended COVID-19 vaccine doses.

Follow CDC's [Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes](#) and [DOH Recommendations for Cohorting in LTCFs](#) for residents who are not [up to date](#) with all recommended COVID-19 vaccine doses.

If additional cases are identified through testing, LTCFs should repeat the process of [unit-wide testing](#) beginning with the additional case(s) and continue unit-wide testing of all who tested negative every 3-7 days until no positives are identified for 14 days.

Testing for Visitors and Essential Support Persons (ESP)

- Regardless of testing performed or the facility's COVID-19 status, the facility should continue to [screen](#) all persons entering the facility, including visitors, for [signs and symptoms](#) of COVID-19.
 - Visitors/ESP who have positive SARS-CoV-2 results should not be allowed to visit according to the [screening recommendations](#).
- Facilities may offer testing to visitors and ESP, if feasible and resources allow.
 - Facilities may encourage visitors to be tested on their own prior to coming to the facility within 48 hours of the visit.
 - Facilities that test visitors using point-of-care tests must [report results to DOH](#), either directly to DOH or through CDC's National Healthcare Safety Network (NHSN).

Obtaining a CLIA Waiver and Reporting

CMS requires SNFs to have a CLIA waiver to meet testing requirements according to [QSO memo 20-38](#). For more information on CLIA and Medical Test Site Waivers refer to [DOH Laboratory Quality Assurance](#) and Medical Test Site Waiver information from [DOH Over the Counter Testing guidance](#).

Point of care test results must be reported through CDC's National Healthcare Safety Network (NHSN) by LTCF participating in NHSN reporting, or directly to DOH according to [DOH's Reporting COVID-19 Results for Point-of-Care Testing](#).

Visiting in Long-term Care Facilities

All LTCFs should follow [DOH screening and visitor exclusion guidance, DSHS COVID-19 Response Plan](#) and SNFs should also follow visiting guidance in [CMS QSO 20-39](#).

Visitors who are not moderately to severely immunocompromised and have recently had mild to moderate SARS-CoV-2 infection should not visit until:

- Symptoms improve with no fever in the last 24 hours and no fever reducing medication
- AND**
- 10 days from onset of symptoms or positive test if asymptomatic
- OR**
- 7 days from onset of symptoms with a negative SARS-CoV-2 antigen test collected within 48 hours

Visitors who are [not up to date with COVID-19 vaccines](#) and have had close contact (defined as within 6 feet for 15 cumulative minutes in 24 hours) should not visit until:

- 10 days from last date of close contact
- OR**
- 7 days from last date of close contact with a negative SARS-CoV-2 antigen or nucleic acid amplification test (NAAT) test, such as a polymerase chain reaction (PCR) test, collected within 48 hours

Healthcare facilities do not need to verify visitor vaccination status, test status, severity of disease, or immunological status.

- Visitors/ESP tested by the facility with a positive SARS-CoV-2 result who do not enter the facility would not be considered a facility-associated case and should not trigger an outbreak response or testing.
- Visitors who visit the facility while asymptomatic, but during their infectious period (two days before positive test) should not trigger an [outbreak investigation testing](#):
 - The visitor(s) went directly to the resident's room, and
 - The entire visit occurred in the resident room, and
 - The visitor wore [source control](#) the entire time present in the facility outside of the resident's room.

- If a visitor visits the facility during their infectious period the facility should assess for possible higher-risk exposures, including the resident visited, and test according to [post-exposure test recommendations](#).
- If a visitor visits the facility during their infectious period and the above criteria are not met, the facility should conduct [outbreak investigation testing](#).

Behavioral Health

In general, [CDC's infection prevention and control guidance](#) and DOH guidance for [all healthcare settings](#) applies to all settings where healthcare is delivered, including behavioral health. However, facilities may adapt recommendations to their setting, ensuring that HCP and patient safety are maintained. For example, inpatient psychiatric care includes communal experiences and group activities that may need to continue. If so, these activities might need to be adapted to align with [physical distancing](#) recommendations. Other recommended infection control measures (for example, ensuring access to alcohol-based hand sanitizer, cohorting patients with COVID-19 and assigning dedicated staff, or implementing universal [source control](#) measures) might not be safe or appropriate to implement in all locations or for all patients due to security and behavioral concerns.

Cohorting

Inpatient behavioral health should adapt DOH guidance for [isolation, quarantine, and cohorting](#). To prevent transmission, it is generally recommended that patients with SARS-CoV-2 infection be transferred to a separate area of the facility where they can be cared for by dedicated HCP. Because of security concerns or specialized care needs, it might not be possible to cohort certain patients together or change HCP assigned to their care. When cohorting is not possible, implement measures to maintain physical distancing (at least 6 feet) between patients with SARS-CoV-2 infection and others on the unit. Ideally, this would include a separate bathroom for patients with SARS-CoV-2 infection. Ensure HCP wear [all recommended personal PPE](#) when caring for patients with suspected or confirmed SARS-CoV-2 infection.

Group Therapy Sessions, Dining, and Smoking

Inpatient behavioral health facilities should adapt [DOH guidance for physical distancing and maintain physical distancing of at least 6 feet](#), when physical distancing is feasible and will not interfere with provision of care.

Group counseling, therapy, and discussion sessions are critical components of psychiatric treatment and care plans, but the traditional set-up for these activities is not compatible with physical distancing recommendations. When possible, use virtual methods, or decrease group size so physical distancing can be maintained. Consider using a room with [good ventilation](#) to decrease risk. In the event that SARS-CoV-2 is transmitted in the facility, sessions should stop or move to a video discussion forum until additional infection prevention measures are in place to stop the spread.

As part of physical distancing, communal dining is generally not recommended. However, eating needs to remain supervised due to the potential for self-harm with eating utensils and because commonly used psychiatric medications may cause side effects (for example, tardive dyskinesia, dysphagia, hypo- and hypersalivation) that increase choking risk for patients. One option is to position staff in patients' rooms to monitor their dining. Another option is to allow communal dining in shifts so that staff can monitor patients while ensuring they remain at least 6 feet apart. A third option is to have patients sit in appropriately spaced chairs in the hallway outside their rooms so they can be monitored while they eat.

A higher proportion of psychiatric patients smoke cigarettes compared to the general population. Patients might congregate in outdoor smoking spaces without practicing appropriate physical distancing. Limit the number of patients allowed to access smoking spaces at the same time, and position staff to observe and ensure patients are practicing appropriate physical distancing.

Source Control

Inpatient behavioral health facilities should adapt [DOH guidance for source control](#). For some patients, the use of [well-fitting source control](#) (respirators, facemasks or cloth masks) might cause distress or pose an additional danger to themselves or others. Some patients may be unable or unwilling to use them as intended. Elastic and cloth straps can be used for strangling oneself or others, and metal nasal bridges can be used for self-harm or as a weapon. Consider allowing patients at low risk for misuse to wear facemasks or cloth masks, with a preference for those with short ear-loops rather than longer ties. Consider use of facemasks or cloth masks during supervised group activities. In areas of [substantial to high community transmission](#), ensure that HCP interacting with patients (who are not suspected or confirmed to have SARS-CoV-2 infection) are still wearing eye protection in addition to well-fitting source control. HCP should always wear [PPE](#) when caring for patients with suspected or confirmed SARS-CoV-2 infection.

Alcohol-based Hand Sanitizer

While alcohol-based hand sanitizer (ABHS) containing 60-95% alcohol is an important tool to increase adherence to [hand hygiene](#) recommendations, ABHS must be used carefully in psychiatric facilities to ensure it is not ingested by patients. Consider not placing ABHS in patients' rooms in psychiatric facilities, nor in locations where the patients have unsupervised access. Encourage frequent hand washing with soap and water for patients and HCP. Consider providing personal, pocket-sized ABHS dispensers for HCP. Currently, the CDC only recommends alcohol-based hand sanitizer. There is no recommendation regarding the routine use of non-alcohol-based hand rubs for hand hygiene in healthcare settings.

Transfers

While intended for LTCFs, [DOH guidance for transferring between facilities may](#) be adapted for inpatient behavioral health setting.

Visitation

While intended for hospitals and outpatient settings, [DOH guidance for hospital and outpatient visits](#) be adapted for behavioral health settings.

Acute Care

Visitor Guidance for Inpatient Hospitals and Outpatient Settings

Visitation is appropriate for essential patient well-being and care, and resumption of visitors to inpatient hospitals (acute and psychiatric) and outpatient settings should be considered even while we continue to experience COVID-19 activity in Washington state.

Visitor access may fluctuate depending on the [CDC's levels of COVID-19 transmission in the area where](#) the facility is located and the facility's capacity to implement infection prevention measures associated with allowing visitors.

Visitor Protocol

A facility's policies and procedures to manage visitors in their facility should include:

- Screening visitors for signs and symptoms of COVID-19.
- Ensuring visitors wear appropriate [source control](#) (for example, well-fitting facemasks).
- Establishing expectations for physical distancing of at least 6 feet (when physical distancing is feasible and will not interfere with provision of care).
- Any additional expectations as determined by the facility to manage visitor flow to allow for distancing and other infection prevention practices (for example, specific entry or exit, routes through the facility, specified hours for visiting, etc.).
- Educating visitors and prospective visitors on expectations of infection prevention.
- Denying entry to any person with a positive screen, or who is unable or unwilling to adhere to infection prevention measures described in this document and the facilities policy and procedure.
- A process to respond to exposures involving visitors, healthcare workers, or patients.
- Post signage that strongly encourages staff, visitors, and patients to practice frequent hand hygiene with soap and water or hand sanitizer, avoid touching their face, and practice cough etiquette.
- Follow all requirements related to visitors addressed in Governor Inslee's Proclamation on [Requirements for Non-Urgent Medical and Dental Procedures](#).

All recommendations in this section apply to both [up to date with COVID-19 vaccines](#) and unvaccinated status of patients, HCP, and visitors , unless recommendations are otherwise specified in the document.

Visitor Education

A facility's process to educate visitors and prospective visitors on core infection prevention practices should include:

- The need to be screened before each visit.
- Performing hand hygiene before and after their visit.
- Wearing [source control](#) (for example, facemask) at all times while in the facility.

- Maintaining physical distance of at least 6 feet (when physical distancing is feasible and will not interfere with provision of care), including patients, HCP, and other visitors.
- Not being present in the patient room during [AGPs](#) and other procedures.
- If visiting a patient when PPE is indicated, how to properly wear PPE.
- The risks associated with visitation should be explained to patients and their visitors so they can make an informed decision about participation.
- Nonadherence to any of the infection principles outlined in the facility's policy will result in denial of visitation.

DOH provides examples of a [visitor screening tool](#), a [visitor log](#), and [educational letter for visitors](#).

Screening

Refer to [DOH screening guidance](#).

Universal Source Control (for example, facemasks) Measures

As required under [Proclamation 20-25.14](#), including any subsequent amendments, require visitors to wear face coverings in compliance with the [Secretary of Health's order \(20-03.4\)](#), including the exceptions and exemptions therein. Also refer to [DOH source control guidance](#).

Physical Distancing

Refer to [DOH physical distancing guidance](#).

Exposure Response Process

Facilities should have a process for notifying the health department about suspected or confirmed cases of SARS-CoV-2 infection, and establish a plan, in consultation with local public health authorities, for how exposures in a healthcare facility will be investigated and managed and how [contact tracing](#) will be performed. The plan should address the following:

- The person responsible for identifying contacts (for example, HCP, patients, visitors) and notifying potentially exposed individuals.
- The process for notifications.
- Actions and follow-up to be taken for those who were exposed (for example, testing, etc.).

Visitors of Patients without Suspected COVID-19

- Facilities [screen](#) all visitors before entering the facility.
- Facilities provide instruction, before visitors enter patients' rooms, on hand hygiene, and use of PPE according to current facility policy while in the patient's room.
- Facilities provide instruction on the need to wear [source control](#) at all times while in the facility.
- Facilities provide instruction for visitors to maintain [physical distancing](#) (when physical distancing is feasible and will not interfere with provision of care) of at least 6 feet from others.
- Visitors are not to be present during [AGPs](#) or other procedures, unless necessary as part of patient care.

Visitors of Patients with Suspected or Confirmed COVID-19

- Limit visitors to the facility to only those essential for the patient's physical or emotional well-being and care (for example, care partner, parent).
- Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.
- If visitation to patients with SARS-CoV-2 infection occurs, visits should be scheduled and controlled to allow for the following:
 - Facilities evaluate risk to the health of the visitor (for example., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions.
 - Facilities provide instruction, before visitors enter patients' rooms, on hand hygiene, and use of PPE according to current facility policy while in the patient's room.
 - Visitors are not present during [AGPs](#) or other procedures, unless necessary as part of patient care.
 - Visitors are instructed to only visit the patient's room. They should not go to other locations in the facility.

Additional Resources

Outbreak Definition in Healthcare Settings

Refer to [Interim COVID-19 Outbreak Definition for Healthcare Settings](#).

Outbreak and Preparedness Checklists

Long-term Care Checklist

What to do if you identify a COVID-19 case in your Long-term Care Facility

This checklist provides a framework for responding to COVID-19 in a LTCF and may be used to guide response actions. Consult with your LHJ when managing outbreaks.

Contain and prepare

- COVID-19 positive resident: Place in aerosol contact precautions and post [precautions sign](#) on door.
- COVID-19 positive HCP: Exclude from work (see CDC [Return to Work Criteria](#)). Notify LHJ and follow LHJ direction.
LHJ Contact _____
Phone # _____
- Prepare to open a [COVID-19 unit and quarantine unit](#) (if not already open):
 - Deploy physical barriers as necessary to create separate COVID-19 unit.
 - Dedicate separate staff (staff that does not care for residents outside of the COVID-19 unit during their shift) to care of residents with COVID-19.
 - Refer to CDC guidance for mitigating [staffing shortages](#) and [PPE optimizing strategies](#) if needed. Contact LHJ if experiencing PPE shortages. Access [DSHS Rapid Response Team](#) staffing resources as needed.
 - Ensure adequate specimen collection supplies for point-of-care or laboratory NAAT/PCR tests. Identify where additional supplies may be obtained.
- Consider placing a hold on admissions to the facility until the extent of transmission can be clarified and interventions can be implemented. Follow the [DOH Guidance for Transferring Residents Between LTCFs and Other Healthcare Settings](#) and guidance from your LHJ.
- Limit outside-contracted staff entering the building to acutely necessary medical treatments and therapies, and critical building and infrastructure maintenance or repair.
- Notify all HCP, residents, and families of the outbreak. Reinforce basic infection control practices.

Identify additional cases

- Prepare to conduct [unit-wide testing](#).
- Identify staff who can assist with specimen collection.
- Designate a point person to receive and track results.
- Obtain orders for testing from a licensed provider or use [DOH standing order](#) for screening.
- With assistance from your LHJ, begin [unit-wide testing](#), including all residents and staff present in the facility two days prior to onset of the identified case.
 - Aim for the shortest turnaround time for tests as possible, ideally within 2 days.
 - If using point-of-care antigen tests, refer to [CDC's SARS-CoV-2 Antigen Testing in Long Term Care Facilities](#) for recommendations regarding confirmatory NAAT/PCR testing.
- Report all positive cases to your LHJ.
- Continue testing all residents and staff on affected unit who previously tested negative every 3-7 days for a minimum of 14 days from most recent positive result, or according to LHJ direction.

Identify potential exposures

- With assistance from your LHJ, identify HCP, residents, and visitors who may have been [exposed to COVID-19](#).
- Place any resident identified as potentially exposed in [quarantine](#).
 - If possible, place in private rooms.
 - If private rooms are unavailable, avoid placing residents with high probability of exposure with residents at high risk for severe disease).
- HCP who are [up to date](#) with COVID-19 vaccines and [higher-risk exposures](#) who are asymptomatic do not need to be restricted from work for following their exposure per CDC [guidance](#).

Managing additional cases

- Place all residents who test positive in the COVID-19 unit. Provide care using dedicated staff using [aerosol contact precautions](#).
- Exclude all staff from work who test positive according to [CDC guidance](#).
- Maintain adherence to [cohorting guidelines](#), frequent testing, and [proper PPE](#) use to minimize your outbreak.

Returning to normal operations

- Follow the [CDC's time and symptom-based strategy](#) for returning recovered residents to the general unit. Note that immunocompromised residents may require a prolonged recovery time.
- Work with your LHJ on resuming normal operations in line with state and national guidance.

Hospital Checklist

What to do if you identify a COVID-19 case in your Hospital

This checklist provides a suggested framework for responding to COVID-19 in a hospital and may be used to guide response actions. Consult with your LHJ when managing outbreaks in healthcare settings.

Contain and prepare

- COVID-19 positive patient: place in [appropriate precautions](#), in a negative airflow room, if available. Hospitals are encouraged to use WSHA's [precautions sign](#).
- COVID-19 positive HCP: Exclude from work if the newly identified case is a HCP (see CDC [Return to Work Criteria](#)). Notify and follow LHJ direction.
LHJ Contact _____
Phone # _____
- Prepare to open your COVID-19 unit (if unable to isolate or have dedicated COVID-19 staff spaces on regular unit):
 - Deploy physical barriers as necessary to create separate COVID-19 unit.
 - Ensure adequate staffing to dedicate to care of COVID-19 patients.
 - Prepare for potential staff shortages and identify resources for additional staff. Refer to DOH guidance for mitigating [staffing shortages](#).
 - Ensure adequate PPE, identifying resources if additional PPE is needed. Refer to CDC [PPE optimizing strategies](#) if needed.
 - Ensure adequate specimen collection supplies and identify where additional supplies may be obtained.
 - Limit visitation on the unit where positive case is identified, following [DOH Visitor Guidance](#).
 - Notify family or designated power of attorney as appropriate.

Identify potential exposures and additional cases

- In coordination with your LHJ and following [CDC guidance for Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic](#) begin expanded testing of identified possible exposures (may be a staff department such as IT, a specific hallway where a positive patient resides, or an entire unit).
- Exposed staff who are not [up to date](#) with COVID-19 vaccines should be excluded from work according to CDC [HCP with Potential Exposure to SARS-CoV-2](#) guidance.
- Exposed patients should be placed in quarantine, using the same precautions used for patients who have COVID-19. Patients in quarantine and patients known to have COVID-19 should not be roomed together.
- HCP [up to date](#) with COVID-19 vaccines and [higher-risk exposures](#) who are asymptomatic do not need to be restricted from work for 10 days or 7 day with a negative test following their exposure.
- Place any patient identified as potentially exposed in [quarantine](#).
 - If possible, place in private rooms.

- If private rooms are unavailable, consider the probability of exposure and risk to the roommate (for example, avoid placing patients with high probability of exposure with patients at high risk for severe disease).
- Aim for the shortest turnaround time for tests as possible.
- Report all results to the hospital infection prevention/control and to the LHJ.
- Complete [post-exposure testing](#) for those with identified exposures.

Managing additional cases

- Place all patients who test positive in the COVID-19 unit (or isolation room on regular unit) and care for using [aerosol contact precautions](#) using dedicated staff (staff cares for only COVID-19 positive patients or only general patients during their shift).
- Exclude from work all staff who test positive according to [CDC guidance](#).
- Maintain strict adherence to cohorting guidelines, frequent testing, and proper PPE use to minimize your outbreak.
- Refer to DOH guidance for mitigating [staffing shortages](#) if needed.
- Refer to CDC's [PPE optimizing strategies](#) if needed.

Returning to normal operations

- Follow the [CDC's time and symptom-based strategy](#) for returning recovered patients to the general unit. Note that immunocompromised patients may require a prolonged recovery time.
- Work with your LHJ on resuming normal operations in line with state and national guidance.

Preparing your LTCF for COVID-19

The following checklist of activities is intended to help LTCFs ensure they are prepared to manage residents with COVID-19 while maintaining staff, resident, and visitor safety. This checklist may be adapted to meet LTCFs specific needs.

Work with your LHJ to identify and implement appropriate local regulations.

Identify key contacts

The facility should maintain a current list of key external contacts who can assist with COVID-19 response.

Local Health Jurisdiction (LHJ) contact:

Name:

Phone:

Email:

Department of Social and Health Services (DSHS) contact:

Name:

Phone:

Email:

Department of Health (DOH) contact:

Name:

Phone:

Email:

Healthcare coalition contact:

Name:

Phone:

Email:

LTCF Association contact:

Name:

Phone:

Email:

LTCF personnel assigned for communications with public health agencies:

Name:

Phone:

Email:

Structure, education, and training

To ensure implementation of COVID-19 protocol, the facility should have structure in place that supports emergency response, infection prevention, HCP training, and identifies key internal stakeholder responsibilities.

- COVID-19 has been incorporated into emergency management planning for the facility.
- A multidisciplinary planning committee or team has been created to specifically address COVID-19 preparedness planning. The existing emergency or disaster preparedness team may be assigned this responsibility. Members of the planning committee should include representatives for each role **(please identify)**:
 - Facility administration:**
 - Medical Director:**
 - Director of Nursing:**
 - Infection control:**
 - Occupational health:**
 - Staff training and orientation:**
 - Engineering/maintenance services:**
 - Environmental (housekeeping) services:**
 - Dietary (food) services:**
 - Pharmacy services:**
 - Occupational/rehabilitation/physical therapy services:**
 - Transportation services:**
 - Purchasing agent:**
 - Facility staff representative:**
 - Other member(s) as appropriate (for example, clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff including consultant services, union representatives):**
- The facility has designated one or more individuals with specialized training in infection prevention and control as the Infection Preventionist (IP). This individual works at least part-time in the facility.
Designated facility IP (please identify):
- The facility has written infection prevention and control policies and procedures which are based on current nationally recognized evidence-based guidelines (for example, CDC/HICPAC), regulations or standards for its Infection Prevention and Control Program (IPCP).
- The facility has evidence of mandatory personnel infection prevention and control training which includes the IPCP written standards, policies, and procedures.

- The facility has documentation of a facility infection control risk assessment conducted according to infection control professional organizations (for example, APIC, SHEA) guidelines.
- The facility has documentation of an annual review of the IPCP using a risk assessment with both facility and community risks and updates the IPCP risk assessment annually and as necessary.
- The facility has processes to provide education and training to HCP, residents, and family members of residents to help them understand the implications of, and basic prevention and control measures for, COVID-19.
- A person has been designated with responsibility for coordinating education and training on COVID-19 (for example, identifies and facilitates access to available programs, maintains a record of personnel attendance).

Person coordinating education (please identify):

- The facility should have building heating, ventilation, and air conditioning (HVAC) and ventilation systems maintained on a routine basis.
- If the COVID-19 unit is not in a standalone building, an air barrier (for example, a physical barrier) the facility should separate the COVID-19 treatment area from other areas where care is provided to patients without a COVID-19 positive diagnosis if feasible given facility factors (for example, physical layout, census, etc.). If facility is using a barrier between COVID-19 unit and other units, ensure the barrier is sealed. Ideally, the barrier should suck in towards the COVID-19 unit and not ballooning out away from the COVID-19 unit.
- The facility should follow DOH's guidance [Ventilation and Air Quality for Reducing Transmission of COVID-19](#) and CDC's [Ventilation in Buildings](#) guidance. The facility should consult with an HVAC specialist to optimize ventilation.

Develop a written COVID-19 plan

The facility should have a written COVID-19 plan available at the facility and accessible to staff.

The COVID-19 plan should include the following:

- A person assigned responsibility for monitoring public health advisories (local, state, and federal) and updating the COVID-19 response coordinator and members of the COVID-19 planning committee of changes to community status and changes in federal and state guidance.

Person monitoring advisories (please identify):

- The facility has a process for inter-facility transfers that includes notifying transport personnel and receiving facilities about a resident's suspected or confirmed diagnosis (for example, presence of respiratory symptoms or known COVID-19) prior to transfer; see [DOH Transferring between LTCFs and other Healthcare Settings](#).

- SNFs have a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
- The facility has infection control policies that outline the recommended TBP that should be used when caring for residents with respiratory infection; see: [Infection Control Guidance for Healthcare Professionals about Coronavirus \(COVID-19\)](#)
- A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of COVID-19 in the facility.
Person assigned to communicate COVID-19 status (please identify):
- The facility has communication plans on how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (for example, consultants, sales and delivery people) about the status of COVID-19 in the facility.
- Contact information for family members or guardians of facility residents is up to date.
- A list of other healthcare entities and their points of contact (for example, other long-term care and residential facilities, local hospitals and hospital emergency medical services, relevant community organizations—including those involved with disaster preparedness) with whom it will be necessary to maintain communication. **Attach a copy of contact list.**

Identification of ill residents and ensuring adequate testing

The facility should have policies and procedures in place to quickly identify potentially infectious staff, residents, and others entering the facility.

- The facility [screens](#) HCP and any others entering the facility for signs, symptoms, and potential exposure to COVID-19.
- The facility has a process to identify and manage residents with symptoms of COVID-19 upon admission and daily screening for symptoms, which include implementation of appropriate TBP.
- The facility has developed plans on how to immediately notify the LHJ of clusters of respiratory infections, severe respiratory infections, or suspected and confirmed COVID-19 in staff and residents.
- The facility has supplies, resources, processes and protocols in place for routine and targeted COVID-19 testing including:

- Testing all staff at frequency according to [CMS requirements](#) and [DOH recommendations](#).
- If a single staff or single healthcare-onset case is identified in the facility, begin outbreak investigation including testing all staff and residents immediately and at least 5 days following exposure. If additional cases are identified continue testing every 3-7 days until no positives have been identified for 14 days.
- A process that allows for COVID-19 results to be reported to the facility within 48 hours, when possible.

Implementing transmission-based precautions and ensuring adequate PPE

The facility should ensure adequate supplies to implement COVID-19 response plan and ensure HCP and resident safety.

- Alcohol-based hand sanitizer for hand hygiene is available in every resident room (ideally both inside and outside of the room) and other resident care and common areas (for example, outside dining hall, in therapy gym).
- Sinks are well-stocked with soap and paper towels for hand washing.
- Facility ensures HCP have access to [EPA-registered hospital-grade disinfectants](#) to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
- Signs are posted immediately outside of resident rooms in TBP indicating appropriate IPC precautions and PPE.
- The facility provides facemasks for anyone entering the facility and no-touch receptacles for disposal.
- The facility has supplies of necessary PPE, provides necessary PPE (including N95s or other respirators, gowns, gloves, and eye protection) for HCP use and PPE it is available immediately outside of the resident room and in other areas where resident care is provided.
- The facility has a [written respiratory protection plan](#) that includes identification of HCP at risk, medical evaluation, fit testing, employees training to including donning, doffing, and when to use.
- The facility has assigned a person to be responsible for coordinating respiratory protection plan, medical evaluation, respirators inventory control, and respirator fit testing.
Person assigned to coordinate respiratory protection plan and fit testing (please identify):
- The facility provides fit testing for HCP working in the COVID-19 care unit if N95s are used.

- A process is in place to track and report available quantities of consumable medical supplies including PPE.
- The facility has a contingency plan, that includes engaging their LHJ and healthcare coalition when they experience (or anticipate experiencing) supply shortages and aligns with CDC's [Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages](#).

Plan for cohorting

The facility has criteria and a protocol for limiting symptomatic and exposed residents to their room and implementing [TBP](#). The facility should determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit. Facilities should follow CDC's [DOH Recommendations for Cohorting](#) for cohorting guidance.

Dedicated COVID-19 Unit (for residents with confirmed COVID-19)

- Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19.
- The COVID-19 unit has signage to indicate the entrance of COVID-19 unit and appropriate entry and exit procedures (for example, PPE, close door behind you) and instructs HCP to wear eye protection and a fit-tested respirator at all times while on the unit. Gowns and gloves should be added when entering resident rooms.
- A process is in place for staff to enter and leave COVID-19 unit without contaminating the rest of the facility (consider screening, time clock in and out, and lighting for entrances/exits)
- HCP and other staff (for example, EVS) should be dedicated to work only on the COVID-19 care unit if staffing levels allow. To the extent possible, restrict access of ancillary personnel (for example, dietary) to the unit, consider telemedicine, schedule dedicated days for the COVID-19 unit, and/or have providers go to COVID-19 unit at the end of the day
- The facility provides HCP working on the COVID-19 care unit with a respirator defined as NIOSH approved and fit-tested N95 or equivalent or higher respirators.
- The facility provides HCP working on the COVID-19 unit with eye protection defined as goggles or a disposable face shield that covers the front and sides of the face.
- Plan for discharge from the COVID-19 unit prior to admittance when possible. If residents come to the end of their isolation period and there is not space for discharge in the other areas in the facility, consider keeping residents on the COVID-19 unit.

- Dedicate equipment to the COVID-19 unit. Providers should not bring equipment that cannot be disinfected (for example, laptops and similar electronics) in and out of resident rooms.
- The facility should consider management of other equipment and supplies to avoid cross contamination as appropriate, including medication cart, crash cart, EVS cart, vitals equipment, stethoscopes, Hoyer lifts and slings, therapy equipment, time clock.
- The facility should dedicate a breakroom and bathroom for COVID-19 unit staff

Observation/Quarantine Area (for new admits and potentially exposed)

- Ideally should be a separate area but could be a private room.
- All [recommended COVID-19 personal protection equipment \(PPE\)](#) should be worn during care of residents under observation, which includes use of a fit-tested respirator eye protection, gloves, and gown.
- Residents [who are not up to date with COVID-19 vaccines](#) should quarantine for 10 days or 7 days with completion and negative results of from [post exposure testing](#) if:
 - Exposed; and
 - In SNFs and memory care, if newly admitted or have left the facility for >24 hours.

Once residents have completed the 7 days of quarantine, no additional precautions or restrictions are indicated, for example, the residents may participate in group activities, leave the unit. Additional PPE is not indicated for healthcare workers.

Visitation in COVID-19 unit or quarantine unit

- Consideration for how visitors will enter and leave facility without contaminating the rest of the facility (screening, education, and obtaining PPE).
- Provide materials to visitors to educate on the risk of visiting a COVID-19 unit, offer them [PPE](#), and provide basic instruction on use. Ensure visitors adhere to [core principles of infection control](#), including masking and maintaining 6 feet of physical distance, when physical distancing is feasible and will not interfere with provision of care.
- Consideration for flexing unit larger or smaller to accommodate cohorting.

All others

- Staff should care for residents using standard precautions and [universal source control](#) and [universal eye protection](#).

Staff screening and ensuring adequate staffing

- The facility instructs HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of respiratory infection, as a part of routine practice.
- The facility has a process to screen HCP for fever and symptoms when they report to work.
- The facility has a process to manage HCP with fever and [symptoms of COVID-19](#) and other respiratory infections.
- The facility has sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill HCP to stay home.
- The facility has a plan for monitoring and assigning work restrictions for ill and exposed HCP; See: CDC's [Interim U.S. Guidance for Risk Assessment and Work Restrictions for HCP with Potential Exposure to COVID-19](#).
- A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations; see DOH [Interim Recommendations to Mitigate Healthcare Worker Staffing Shortage During the COVID-19 Pandemic](#). and [Continuum of Care Decisions for Critical Staffing Management in Long-Term Care Settings Guide](#)

The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.

Visitor Screening Tool

1. *Are you experiencing any of the following symptoms of COVID-19 (please check for yes)?*

- 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

If you have answered “yes” to any of the above, consider being assessed for COVID-19 and tested as appropriate. Please do not visit until you are well.

2. *In the past 10 days, have you had close contact (within six feet for 15 minutes or more in a 24-hour period) with anyone with COVID-19?*

- Yes
- No

If you have answered “yes” to the above, please do not visit for at least 10 days since the last close contact with a person with COVID-19, or 7 days with a negative test within 48 hours.

3. *Have you had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting results of a COVID-19 test?*

- Yes
- No

If you answered “yes” to the above, please do not visit until you have received the results of your COVID-19 test and wait at least 10 days since your symptoms first appeared AND 24 hours with no fever without fever-reducing medication AND symptoms of COVID-19 are improving.

4. *Within the past 10 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?*

- Yes
- No

If you answered “yes” to the above, please do not visit until your 10-day self-monitor, self-isolate, or self-quarantine has ended.

Visitor Log

VISITOR'S LOG								
Date	Time In	First & Last Name	Email	Phone	Room number and/or Resident's Initials	Time Out	Symptom Screening Neg	Received Education on Visitation



Letter to Visitors

Dear Residents, Clients, Families, and Friends:

We are committed to keeping our residents and clients safe and we need your help. The virus causing Coronavirus Disease 2019 (abbreviated COVID-19) can cause outbreaks in long-term care facilities and residential homes. Many of our residents and clients are in the high-risk group for COVID-19 and may have medical conditions putting them at a very high risk of becoming sick, or even severely ill, with COVID-19. While the risk of COVID-19 is significantly decreased for both residents and visitors if up to date with COVID-19 vaccines, the risk is not eliminated. For the safety of your loved one and our community, visitors must adhere to core infection prevention while inside the facility. Visiting outdoors is safer and preferred to indoor visitation.

Core Infection Prevention

- Visitors must be screened for:
 - Symptoms of COVID-19
 - Positive SARS-CoV-2 viral test within the past 10 days
 - Close contact with someone with COVID-19 within the past 10 days.
- Visitors and residents must use alcohol-based hand rub or wash hands with soap and water before and after each visit.
- Residents/clients and visitor(s) must wear a well-fitting face mask or respirator as source control according to [Secretary of Health Order](#) and [CDC Guidance](#). See [Cloth Face Covering and Mask FAQ](#).
- Visitors should go directly to the visiting area and directly out of the facility when the visit has ended.

During times of increased visitation, such as holidays, and when there is a large outbreak, facilities may have procedures in place to manage visitation and visitor flow so these core infection prevention principles are maintained. This may include limiting the number of visitors per resident at one time or limiting the total number of visitors in the facility at one time.

Thank you for helping us keep our community and residents safe.

Signs and Other Tools

WSHA Aerosol Contact Precaution Sign

Available at: [http://www.wsha.org/wp-content/uploads/Aerosol Contact Precautions 2022.02.18.pdf](http://www.wsha.org/wp-content/uploads/Aerosol>Contact%20Precautions%202022.02.18.pdf)

Aerosol Generating Procedure Sign

Available at: <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/420-374-AerosolGeneratingProcedure.pdf>

Quarantine Sign

Available at: <https://doh.wa.gov/sites/default/files/2022-03/420-314-QuarantineSign.pdf>

COVID-19 Announcement for Visitors

Available at:

<https://doh.wa.gov/sites/default/files/legacy/Documents/1600/coronavirus//COVID-19-CoronavirusAnnouncementforVisitors.pdf>

Additional languages: [Chinese Simplified](#) | [Chinese Traditional](#) | [Korean](#) | [Russian](#) | [Spanish](#) | [Tagalog](#) | [Ukrainian](#) | [Vietnamese](#)

Employee Callout Log

Available at:

- PDF - <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/Employeeecalloutlog.pdf>
- Excel - <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/Employeeecalloutlog.xlsx>

Breakroom Safety Sign

Available at: <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/420-317-LongTermCareBreakroomSafetySign.pdf>

Maximum Occupancy Sign

Available at: <https://doh.wa.gov/sites/default/files/legacy/Documents/1600/coronavirus//420-315-MaximumOccupancySign.docx>

Definitions

Aerosol Generating Procedures (AGPs): Aerosol-generating procedure. See [COVID-19 Infection Control: Aerosol-Generating Procedures](#). AGPs require the use of a fit-tested N95 or other respirator such as a powered air-purifying respirator.

Burn rate: The average consumption rate of each type of PPE. The burn rate helps determine how quickly a facility goes through its PPE supply. Factors in calculating PPE burn rate include the number of full boxes of each type of PPE in stock, and the total number of patients at your facility. Use the [CDC's Burn Rate Calculator](#).

Cloth face covering/mask: Textile (cloth) covers that are intended primarily for source control in the community. **They are not personal protective equipment (PPE) appropriate for use by HCP as the degree to which cloth face covering protect the wearer might vary.** Guidance on design, use, and maintenance of cloth face covering is [available](#).

Cohorting: Creating distinct roommates or small groups of COVID-19 positive residents that stay together to ensure minimal or no interaction with residents who do not have COVID-19. This practice can help prevent the spread of COVID-19 by preventing transmission between residents and HCP.

COVID-19 unit: Several rooms or a dedicated area for cohorting a number of COVID-19 positive residents during a COVID-19 outbreak.

Encounter: Encounters are in-person, interactions between staff and residents and there is less than 6 feet between the staff and resident for any period of time. These may involve medical procedures, caregiving activities/activities of daily living, medication administration, transportation, etc. Passing by a resident in a common area would not be considered a resident encounter.

Exposure: Within 6 feet and 15 or more cumulative minutes in 24-hour period of someone with COVID-19. Refer to [CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for HCP with Potential Exposure to SARS-CoV-2](#).

Extended use: The practice of wearing the same PPE continuously between encounters with multiple residents with the same illness, without changing PPE between resident encounters. PPE is doffed and discarded, and new PPE is donned for the next set of encounters. Extended use is well-suited to situations when multiple residents with the same infectious disease diagnosis are cohorted. Staff should change PPE and perform hand hygiene between caring for residents with COVID-19 and without COVID-19. Under extended use, tight-fitting respirators or facemasks should be discarded immediately after being removed. If removed for a meal break, the respirator or facemask should be discarded, and a new respirator or facemask put on after the break.

Eye protection: Eye protection provides a barrier to infectious materials entering the eye and is often used in conjunction with other PPE such as gloves, gowns, masks, or respirators. Eye protection includes goggles that fit snugly, particularly from the corners of the eyes across the

brow, or face shields that have crown to chin protection and wrap around the face to the point of the ear.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Fitter: Devices worn over a face mask to improve fit; often with a frame-like design. Not recommended by WA DOH and WA L&I.



Fully vaccinated: People are considered fully vaccinated:

- 2 weeks after their second dose in a 2-dose series, like the Pfizer or Moderna vaccines, or
- 2 weeks after a single-dose vaccine, like Johnson & Johnson's Janssen vaccine.

COVID-19 vaccines must be authorized for emergency use, licensed, or otherwise approved by the FDA or listed for emergency use or otherwise approved by the World Health Organization. If it has been less than 2 weeks since your final dose, or if you still need to get your second dose, you are NOT fully protected. Keep taking all prevention measures until you are fully vaccinated.

Healthcare facility/setting: places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, residential LTCF, home healthcare, vehicles where healthcare is delivered (for example, mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental, behavioral health and others

Healthcare personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (for example, blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home HCP, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the

healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (for example, clerical, dietary, EVS, laundry, security, engineering and facilities management, administrative, billing, dental personnel, and volunteer personnel).

Isolation: Physically separating someone who has COVID-19 away from those who do not have it. Isolation prevents spreading COVID-19 to others. See [Recommendations for Cohorting in LTCF During a COVID-19 Outbreak](#).

Long-term care facility: Skilled nursing facilities (nursing homes), assisted living facilities, enhanced services facilities, adult family homes, intermediate care facilities for individuals with intellectual disabilities, certified community residential service and support

Mitigation strategies for staffing shortage:

Conventional strategy for staffing shortage: Strategies used to maintain staffing levels and staff retention when staffing shortages are not anticipated.

Contingency capacity staffing: When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem.

Crisis capacity staffing: When staffing shortages occur, healthcare facilities and employers, in collaboration with human resources and occupational health services, may need to implement crisis capacity staffing strategies to continue to provide patient care when there threatens to be insufficient staff to provide safe patient care.

Medical facemask: Medical facemasks are PPE and are often referred to as surgical masks or procedure masks. Use medical facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Non-healthcare personnel: Anyone in the healthcare setting who is not healthcare personnel, including visitors.

Optimization strategies for PPE: A continuum of options for use when PPE supplies are stressed, running low, or exhausted. Contingency and then crisis capacity measures augment conventional capacity measures and are meant to be considered and implemented sequentially. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices. See [CDC's Optimizing PPE Supplies](#).

Conventional strategy for PPE: Measures consisting of engineering, administrative, and PPE controls that should already be implemented in general infection prevention and control plans in healthcare settings. Generally, this is single use PPE (one per resident encounter), then discard or launder/disinfect for PPE that is intended to be multiuse.

Contingency strategy for PPE: Measures that may be used temporarily during periods of expected supply shortages (examples include extending PPE use and prioritizing PPE for [AGPs](#)).

Crisis strategy for PPE: Strategies that are not commensurate with U.S. standards of care but may need to be considered during periods of known shortages of PPE (this includes strategies such as using PPE beyond manufacturer's expiration date, re-using PPE between resident care activities, etc.). 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.

Patient refers to anyone receiving care for medical reasons or assistance with activities of daily living, including clients and residents.

Personal Protective Equipment (PPE): equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. See [OSHA's page on PPE](#).

Quarantine: Physically separating someone who might have been exposed to COVID-19 away from all others to prevent potential transmission of COVID-19 to others. This may be done by placing a patient who has been identified as having been potentially exposed in a single-person room or in a separate observation area and implementing TBP while monitoring the patient for signs and symptoms of COVID-19. Quarantine helps prevent spread of disease that can occur before a person knows they are sick or if they are infected with the virus without feeling symptoms. If possible, possible should remain in their room except for medical necessity. Quarantine lasts as long as the incubation period of the disease. See [Recommendations for Cohorting in LTCF During a COVID-19 Outbreak](#).

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

Respiratory hazards: Respiratory hazards can be chemical vapors, gases, mists, fumes, biologic particles (such as viruses, bacteria, etc.), certain dusts, low oxygen environments, etc., that when breathed in can cause or contribute to medical conditions/diseases and death. Respiratory hazards must be identified, and steps must be taken to reduce or eliminate the hazard. Steps may include engineering controls, administrative controls, use PPE, substitution, or a combination of control measures.

Re-use (Limited re-use): The practice of using the same filtering facepiece respirator (for example, N95) or facemask by one HCP for multiple encounters with different residents but removing it (doffing) after each encounter. **Store the N95 and use the same one again** for the next encounters. **Note: Re-use is ONLY for crisis strategies when implementing the CDC optimizing strategies after all conventional and contingency strategies have been implemented.** Do not use more than five times in a shift, then discard. See CDC guidelines: [Strategies for Optimizing the Supply of N95 Respirators: COVID-19 | CDC](#)



Source control: Use of well-fitting cloth face covering, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control prevents spreading potentially infectious agents to others. See [DOH SARS-CoV-2 Source Control in Healthcare Settings](#).

Standard precautions: Wearing PPE as appropriate for contact with blood or body fluids. For more information see [Standard Precautions for All Patient Care](#).

Transmission-based precautions (TBP). 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. Examples of TBP include contact, droplet, and airborne related transmission. For more information see [CDC's Transmission-based Precautions](#).

Up to date: Having had received all recommended doses in the primary series and booster(s) when eligible per CDC's Stay Up to Date with Your COVID-19 Vaccines.

Abbreviations

ABHS: alcohol-based hand sanitizer

ACH: air changes per hour

AGP: aerosol generating procedure

AIIR: airborne infection isolation room

ASHRAE: American Society of Heating, Refrigerating and Air-Conditioning Engineers

CDC: [United States] Centers for Disease Control and Prevention

CMS: [United States] Centers for Medicare and Medicaid Services

COVID-19: coronavirus disease 2019

DOH: [Washington State] Department of Health

DOSH: [Washington State Labor & Industries] Division of Occupational Safety and Health

DSHS: [Washington State] Department of Social and Health Services

EPA: [United States] Environmental Protection Agency

EVS: environmental services

HCP: healthcare personnel

HSQA: [Washington State Department of Health] Health Systems Quality Assurance

LHJ: local health jurisdiction

LTCF: long-term care facility

L&I: [Washington State Department of] Labor and Industries

NAAT: nucleic acid amplification test

NIOSH: National Institute of Occupational Health and Safety

PCR: polymerase chain reaction

PPE: personal protective equipment

OSHA: [United States] Occupational Safety and Health Administration

TBP: transmission-based precautions

SARS-CoV-2: severe acute respiratory syndrome coronavirus 2

SNF: skilled nursing facility (nursing home)

WHO: World Health Organization

Change Log

April xx, 2022 – Initial posting

More COVID-19 Information and Resources

Stay up-to-date on the [current COVID-19 situation in Washington](#), [Governor Inslee's proclamations](#), [symptoms](#), [how it spreads](#), and [how and when people should get tested](#). See our [Frequently Asked Questions](#) for more information.

A person's race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data are revealing that communities of color are being disproportionately impacted by COVID-19. This is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer opportunities to protect themselves and their communities. [Stigma will not help to fight the illness](#). Share only accurate information to keep rumors and misinformation from spreading.

- [WA State Department of Health 2019 Novel Coronavirus Outbreak \(COVID-19\)](#)
- [WA State Coronavirus Response \(COVID-19\)](#)
- [Find Your Local Health Department or District](#)
- [CDC Coronavirus \(COVID-19\)](#)
- [Stigma Reduction Resources](#)

Have more questions? Call our COVID-19 Information hotline: **1-800-525-0127**

Monday – 6 a.m. to 10 p.m., Tuesday – Sunday and [observed state holidays](#), 6 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language**. For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.