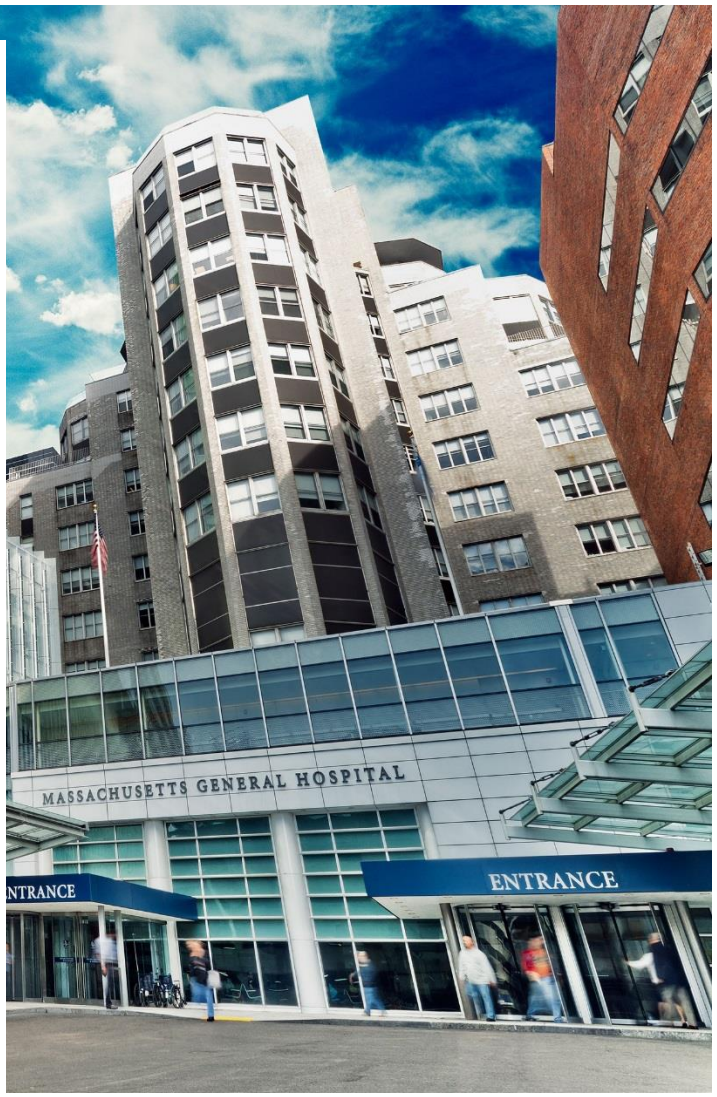
SARS-CoV-2 (COVID-19) Toolkit



FEBRUARY 28, **2020**

Planning documents for patients requiring Airborne Isolation + Contact Isolation + Eye Protection

MASSACHUSETTS GENERAL HOSPITAL
CENTER FOR DISASTER MEDICINE

Resource Guide

How to use this document:

This document is a compilation of resources to support your organization's planning for high consequence infectious diseases (HCIDs) requiring airborne isolation + contact isolation + eye protection for healthcare workers and other staff who encounter the patient. Pathogens that fall in to this category include Middle East Respiratory Syndrome (MERS), Severe Acute Respiratory Syndrome (SARS), and the 2019 novel coronavirus.

"Easy to use resources and templates to enhance your organization's ability to follow the CDC's Identify, Isolate, and Inform algorithm."

Guidance from the Centers for Disease Control and Prevention and your state and local Departments of Public Health supersede the information in these documents. The information included is meant to serve as a template and facilitate planning and preparedness activities.

When developing plans, policies, and procedures for your organization we suggest including representatives from the following groups: clinicians (all levels), infection control, infectious disease, supply chain/materials management, emergency preparedness, laboratory, environmental services, occupational health, and key organizational leadership positions.

Planning Documents:

- *Identify, Isolate, and Inform Algorithm (page 6)*
    - This document guides healthcare workers in screening for recent travel history at portals of entry to your facility (e.g. Emergency Department, OB triage). This can be done by clinicians or others depending on decisions made at your institution. The goal is to establish an epidemiological risk (exposure to the pathogen) and couple that information with symptoms.
        - Additionally, this concept can be adapted for use in telephonic screening prior to ambulatory visits and other areas of your facility.
        - In this version of the toolkit we have included several examples of workflow processes for identification and isolation of patients presenting to the main information desk, ambulatory areas staffed by physicians or nurses, and ancillary areas that are not staffed by physicians or nurses.
    - The *Inform* component of the algorithm should include both internal notification as well as notification to your state/local public health authority. Early contact with public health can facilitate determining which patients do or do not meet person under investigation (PUI) criteria.
        - Identifying subject matter expertise within your organization is beneficial in this process, providing a consistent and appropriate resource for clinicians and staff to access when they have identified a patient is crucial.

- *Current Infectious Disease Outbreaks of Concern (page 13)*
    - This document should be maintained by an Infection Control Practitioner or an Infectious Disease Provider with specialty knowledge of HCIDs. It supports the information gathered in the travel history during screening.

- *Cough Etiquette and Travel History Signage (page 14)*
    - Having highly visible documents at portals of entry to the facility help patients and visitors with respiratory symptoms to self-isolate by applying a mask and washing their hands-- it is ideal to co-locate signage with access to masks and alcohol-based hand rub (ABHR). Additionally, asking patients to notify staff if they have traveled recently assists in the identification of possible cases.
    - Signs should be translated into common languages spoken by your patient population. Care should be taken when copying translated materials as formatting changes often disrupt readability. This sign includes English, Spanish, Arabic, and simplified Chinese.

- *Screening Tool (page 15)*
    - This tool is an example that can be used to guide/support clinician evaluation

and captures information helpful when discussing the case with internal resources and public health authority to determine if further consideration/evaluation as a person under investigation (PUI) is warranted.

- *2019 Novel Coronavirus First Steps Guide (page 16)*
    - This document provides clinicians with easy access to CDC guidance (need to ensure it is updated as appropriate) with information on internal and external resources and references.
    - Creating First Steps Guides for other HCIDs is also a good idea

- *Policy for Managing Patients with HCIDs Requiring Airborne Isolation + Contact Isolation + Eye Protection (page 18)*
    - This policy template provides language for sections of a policy or procedure on managing confirmed or suspected cases and establishes a topical outline of sections that should be considered for inclusion in a policy.
    - This policy can be used to direct care in the Emergency Department and inpatient areas as well, should the patient require admission.

- *Evaluation and Management of High Consequence Infectious Diseases (page 23)*
    - This guide builds on the policy detailed above to provide detailed information on patient placement within your facility, management of multiple patients requiring admission, and proactive thinking with regards to surge planning, patient decompensation requiring immediate interventions, training, operational support, employee tracking and symptom monitoring, and demobilization.

- *Visitor Screening Tool (page 29)*
    - Management of visitors in persons with suspected or confirmed HCIDs should involve collaboration with your public health authority. Additionally, interdisciplinary perspectives should be included. However, screening of visitors facilitates the safety of staff and other patients and visitors. This is one example of a visitor screening tool.

- *PPE Doffing Checklists for Airborne Isolation + Contact Isolation + Eye Protection using N95 respirators and using Powered Air Purifying Respirators (page 30)*

- Doffing is the most important part of safely utilizing personal protective equipment (PPE) in these patients. These checklists demonstrate the appropriate doffing sequence when using either an N95 Respiratory or a Powered Air Purifying Respiratory (PAPR). Adaptation will need to be made based on your organization's PPE. Here we demonstrate single-use disposable gowns designed to break away.
- The PAPR set-up shown utilizes two HEPA filters, providing wearers with equivalent protection to that offered by an N95 respirator.
- Guidance from the CDC, OSHA, NIOSH, and the product manufacturer should be reviewed when developing your policies and procedures for the use of PPE, including reprocessing and cleaning for reuse. These checklists are designed for single patient, single encounter use of PPE, including respiratory protection. Many components of the respiratory protection depicted in these documents (N95, PAPR) are reusable and able to be cleaned and disinfected if appropriate guidelines are developed and followed.
    - We always recommend collaborating with clinicians, infection control practitioners, emergency preparedness, and your supply chain management to develop your policies and procedures on the safe and effective use of PPE.
- Training of clinicians can be supported with videos—here are links to example videos using the included checklists.
    - PPE Donning: https://www.youtube.com/watch?v=52NqOvWygMY&list=PL0A-NKHLVrNEGCeEhTTTXsY7PHfWH7gxJ&index=2
    - PPE Doffing: https://www.youtube.com/watch?v=5orqrFCP3ss&list=PL0A-NKHLVrNEGCeEhTTTXsY7PHfWH7gxJ&index=3

- *Testing Procedure (page 32)*
    - This document is used to guide clinicians in the procurement of specimens for testing for COVID-19. Collection of specimens that will need to be transported and tested at an external facility (state lab, CDC) is often an unfamiliar process for staff. Having clear directions (with pictures) and prepackaged swabs and collection tubes is beneficial in facilitating this process.
    - Here is the link to a video demonstrating the collection process for nasopharyngeal and oropharyngeal swabs and labeling and packaging of the specimens at the bedside. Specimens should first be transported to your facility's laboratory for initial processing and further packaging for shipment.
        - NP & OP Specimen Collection video: https://youtu.be/tSASmeAYZs4.

High Consequence Infectious Disease (HCID): Emergency Department (ED)

Identify - Isolate - Inform Algorithm

To be completed at initial patient contact

How to use this document

This document is designed to serve as a template to be edited/updated with your institutional-specific policies and plans. You can also link to internal and external resources to give your staff quick access to additional information. Consider adding pager numbers or other contact information to the diagram to make it easy for staff to identify and contact the predesignated person/group quickly.

Legend

- **Nurse In Charge** is the designated nurse leader, position is staffed/available 24/7.
- **ED/Clinic Administrator** is the designated administrator with vested institutional authority to activate Hospital Incident Command System
- **Personal Protective Equipment (PPE)** are gowns, gloves, respiratory protection (surgical mask, N95, PAPRs), other protective devices as selected and detailed by your institution
- **Surgical Mask** refers to a simple or procedural mask that does not require respiratory clearance or fit testing to be worn
- **N95** is a respiratory protection device that, if properly fitted, blocks 95% of 0.3 micron particles
- **PAPR** or a Powered Air Purifying Respirator uses a blower to move air through purifying filters; the filters selected determine the protection conferred

Identify

1. Travel outside of US in past 30 days?
   If yes, check your hospital's resource to identify areas of travel and current outbreaks of concern (insert link if applicable)
2. Positive Symptom Screen?
   (i.e. fever, rash, cough, vomiting, diarrhea)

HCID IS POSSIBLE

NO CONCERN → **Usual Triage Protocol**

Isolate

- Instruct patient to don surgical mask
- Isolate patient 6 feet from staff, other patients, and visitors

Inform

Contact the Nurse in Charge

Nurse in Charge:

- Notify Attending physician & appropriate clinicians
- Contact ED/Clinic Administrator or appropriate individual
- Secure an Airborne Infection Isolation (negative pressure) room for the patient

ED/Clinic Administrator:

- Notify appropriate departmental leadership (examples to consider in your planning are Infectious Disease Attending Physician, Hospital Epidemiologist)

Airborne Infection Isolation available within 15 min?

- Patient can remain in place with surgical mask on and 6 ft from other visitors until being moved
- Escort patient to a closed-door room to wait for AII room availability
- Notify attending physician and nurse to don appropriate PPE and begin patient interview and evaluation per institutional protocol

When Airborne Infection Isolation Room is available:

- Ensure negative pressure (i.e. visual indicator or tissue test)
- Ensure all staff entering the room wear appropriate PPE and have been trained in donning/doffing
- Escort patient to AII room, keeping staff and visitors 6 feet away
- Place appropriate institutional signage on the door

! **Isolation Precautions Needed:**

Viral Hemorrhagic Fever or Small Pox PPE precautions detailed on page 2.

If protocols/procedures exist for specific HCIDs, refer to those here

Refer/link to CDC or appropriate institutional policies for guidance on level/type of isolation precautions to implement

Ebola Virus Disease or other Viral Hemorrhagic Fevers *(Page 2)*

Identify

The patient has been identified as a Person Under Investigation (PUI) or confirmed with Viral Hemorrhagic Fever

Isolate

- The patient has been masked
- Staff not in PPE must remain >6ft from patient
- Transport to private room with bathroom or commode; Airborne Infection Isolation (AII) room preferred & required for aerosol generating procedures
- Only staff trained in PPE will enter room
- Discuss with identified institutional representative (may be an assigned attending physician, or local or state public health) for guidance on determination of level of PPE required and plan for patient

Inform

UNPLANNED ARRIVAL OF PATIENT

AMBULANCE EMS/REFERRAL/AMBULATORY WALK-IN ARRIVAL

• The **nurse in charge** will assign roles to ED/clinic staff as soon as patient identified:
  • Retrieve the institutional EVD protocol including prepared checklist for plan and assign Site Manager
  • Page a nursing supervisor or other designated individual to coordinate the initial response
  • An appointed Site Manager receives appointment from the nurse in charge; obtains the hospital outlined EVD protocol and Site Manager checklist/toolkit

Job Action Sheets/Checklists should include:
• **Attending physician** to contact appropriate institutional leadership
• Notify **Hospital Security** to secure perimeter of the ED/Clinic and specified area of treatment.
• Ensure **ED/clinic staff** are ready to safety receive the patient in a designated negative pressure room.
• **Trained Observer:** Oversee PPE donning/doffing for ED staff
• **Doffing Buddy i**n doffing area in appropriate to assist with doffing
• **ED/Clinic Administrator** notifies necessary departments of the EVD Patient Arrival

PLANNED ARRIVAL OF PATIENT

AMBULANCE ARRIVAL/TRANSFER

Job Action Sheets/Checklists should include:
• **Attending physician** to contact appropriate institutional leadership
• A **Site Manager** is assigned per the hospital EVD protocol and retrieves Site Manager checklist/toolkit
• Notify **Hospital Security** to secure the perimeter of the ED/clinic and the specified area of patient treatment
• Notify the appropriate institutional and departmental **leadership**.
• Activate appropriate **personnel** to support management of patient.

MGH Information Desks
2019 Novel Coronavirus Screening Process

1.	Ask: How may I help you today					
PATIENT ANSWER	I'm here for an appointment		I'm here to visit		I'm here for medical care (no appointment)	
2.	Ask: Have you traveled from or through Italy, Iran, Japan, South Korea or China (including Hong Kong) in last 30 Days?					
PATIENT ANSWER	YES	NO	YES	NO	YES	NO
3.	A. Provide a mask, ask them to wear it. B. Ask Question 4	Ask Question 4	A. Provide a mask, ask them to wear it. B. Ask Question 4	Ask Question 4	A. Provide a mask, ask them to wear it. B. Ask question 4	Ask Question 4
4.	Ask: Do you have a fever or cough?		Ask: Do you have a fever or cough?		Ask: Do you have a fever or cough?	
PATIENT ANSWER	YES	NO	YES	NO	YES or NO	YES / NO
5.	A. Provide a mask (if they don't have one), ask them to wear it. B. Ask them to tell the practice of travel and/or symptoms when they arrive for their appointment C. Direct them to their destination	Direct them to their appointment.	A. Provide a mask (if they don't have one), ask them to wear it. B. Ask them to defer their visit	Direct them to their destination	A. Direct to ED or MWIU B. Ask them to tell staff of their travel/ symptoms.	A. Provide a mask, ask them to wear it. B. Direct to ED or MWIU / Direct to ED or MWIU

2019 Novel Coronavirus -- IN PERSON
Front Desk Screening Process

Patient Arrives

**Confirm patient's mobile and/or phone number

Ask patient: Have you been to **China (including Hong Kong and Macau), South Korea, Iran, Italy, or Japan** including the last 30 days, Including an airport or flight connection?

No

Ask patient: Do you have a fever or cough?

No

Standard clinic process: If scheduling an urgent visit, use **urgent visit type**. (Urgent, Urgent New, Urgent Follow-Up, Same Day, Walk-In)

Yes

Standard clinic process. Immediately provide patient with **surgical mask**. **Document:** add flu like symptoms to appt. notes. If scheduling an urgent visit, use urgent visit type: (Urgent, Urgent New, Urgent Follow-Up, Same Day, Walk-In)

Yes

Instruct patient to wear **surgical mask** on arrival and throughout visit; any family members accompanying them should also wear surgical masks.

Ask patient: Do you have a fever or cough?

Yes/No

See Clinical Flow

Ask patient and any companions to remain at check-in desk and immediately contact designated clinical staff member

Cadence Documentation Workflow

Does patient have fever or cough?

No

Document: add Returning Traveler from China, Hong Kong, Macau, South Korea, Iran, Italy, or Japan in appt notes.

Yes

Document: add Flu like symptoms and Returning Traveler from China, Hong Kong, Macau, South Korea, Iran, Italy, or Japan to appt notes

Complete standard check-in process.

No

Is this a walk-in visit?

Yes

Use **urgent visit type**: (Urgent, Urgent New, Urgent Follow-Up, Same Day, Walk-In)

2019 Novel Coronavirus – IN PERSON
Designated Clinical Staff Member Process

Flow from front desk

Ensure patient is wearing a mask.

Did patient indicate fever or cough at check-in?

No

Did patient indicate travel to China, Hong Kong, Macau, South Korea, Iran, Italy, or Japan within ≤14 days at check-in?

Yes (travel less than or equal to 14 days)

Is this an essential visit as defined by department?

No

Schedule non-essential patient appointments **14 days** after leaving China, Hong Kong, Macau, South Korea, Iran, Italy, or Japan.

Advise the patient that if they develop symptoms of fever or cough between now and the end of the 14 days, to call the clinic for advice prior to coming to the hospital.

Document: add Returning Traveler from China, Hong Kong, Macau, South Korea, Iran, Italy, or Japan to appt. notes. If cancelling appointment, use institution cancellation code.

Yes

What type of visit is the patient scheduled for?

Office Visit

Instruct patient to wear **surgical mask** throughout visit; any family members accompanying them should also wear surgical masks.

If any questions, contact **Infection Control** for Guidance

Procedure

Does the procedure require post-procedure admission?

Yes

Is the planned procedure aerosol generating (e.g. intubation, bronchoscopy, upper endoscopy, ENT)?

No

Inform: Page **Subject Matter Expert**. Strict isolation protocols apply.

Instruct patient to wear **surgical mask** throughout visit; any family members accompanying them should also wear surgical masks. Contact **Infection Control** for guidance.

No (travel greater than 14 days)

Standard clinic process.

No

Is the planned procedure aerosol generating (e.g. intubation, bronchoscopy, upper endoscopy, ENT)?

Yes

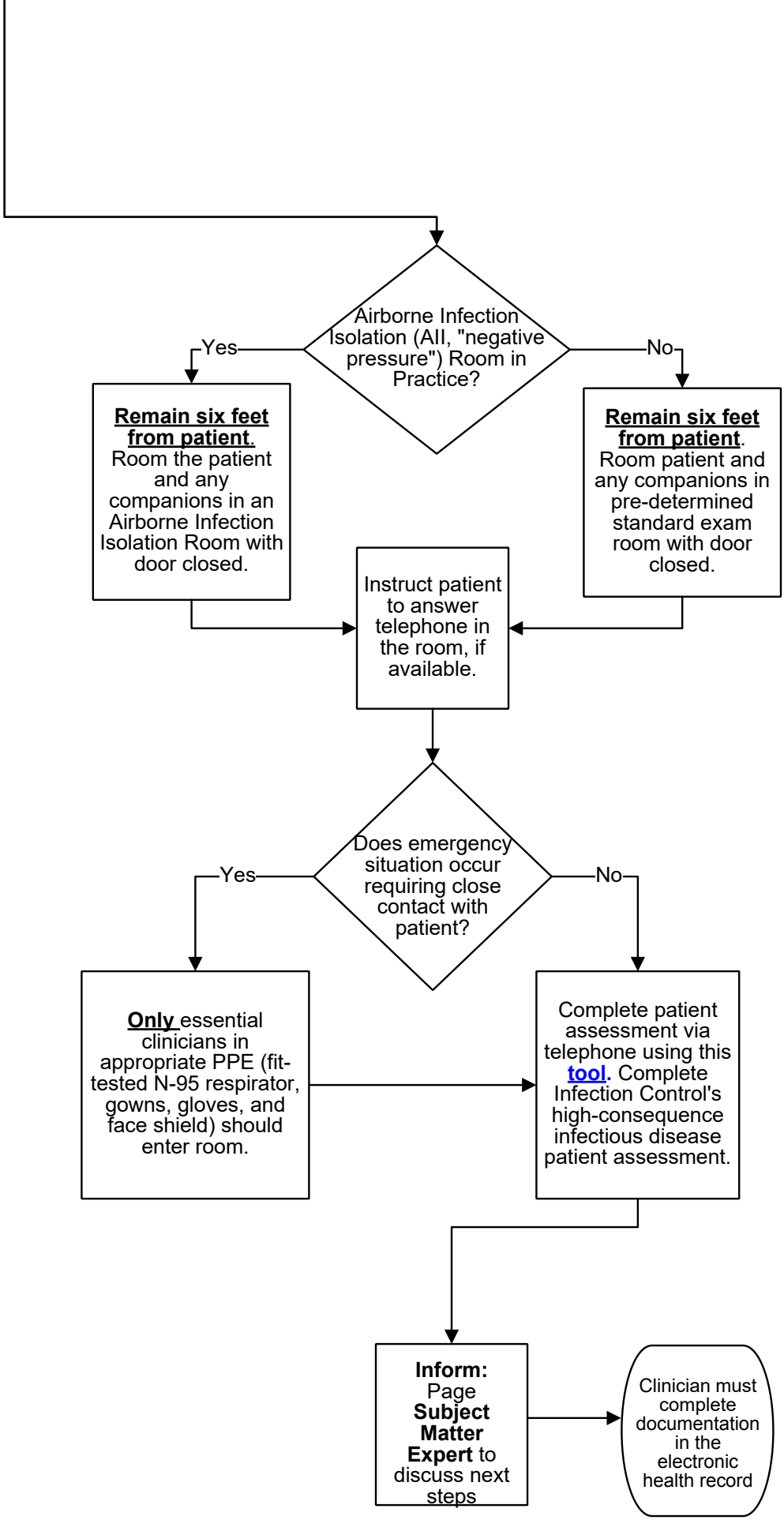
Inform: Page **Subject Matter Expert**. Strict isolation protocols apply.

No

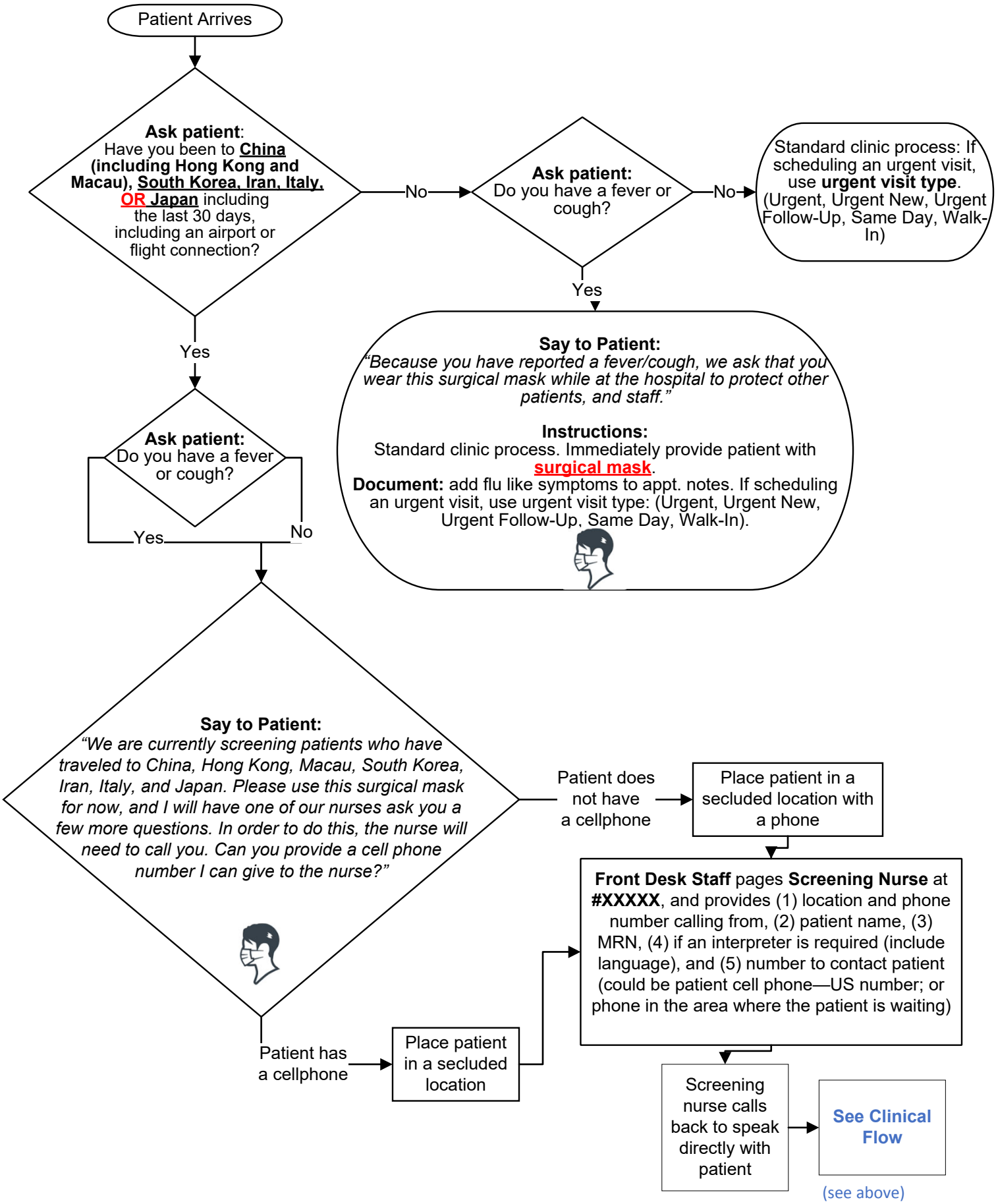
Instruct patient to wear **surgical mask** throughout visit; any family members accompanying them should also wear surgical masks. If any questions, contact **Infection Control** for Guidance

Yes to either

Continued on page 2


Airborne Infection Isolation (AII, "negative pressure") Room in Practice?
Yes
No
Remain six feet from patient. Room the patient and any companions in an Airborne Infection Isolation Room with door closed.
Remain six feet from patient. Room patient and any companions in pre-determined standard exam room with door closed.
Instruct patient to answer telephone in the room, if available.
Does emergency situation occur requiring close contact with patient?
Yes
No
Only essential clinicians in appropriate PPE (fit-tested N-95 respirator, gowns, gloves, and face shield) should enter room.
Complete patient assessment via telephone using this tool. Complete Infection Control's high-consequence infectious disease patient assessment.
Inform: Page Subject Matter Expert to discuss next steps
Clinician must complete documentation in the electronic health record

2019 Novel Coronavirus -- IN PERSON
Screening Process for Ancillary Areas



High Consequence Infectious Disease (HCID): Emergency Department (ED)

Current Infectious Disease Outbreaks of Concern

Last Updated 08/01/2018

How to use this document

This document provides front-line clinicians with the tools to take a targeted travel history for patients who may be at risk for HCIDs. It is not intended to be exhaustive or replace a full travel history, but is focused on HCIDs circulating as of the date above.

For the diseases listed below, clinicians should ask whether the patient has 1) a history of travel to an affected area within the appropriate timeframe **and** 2) symptoms that are possibly consistent with the disease of concern. (Click on the link to the right to see the case definitions to be used for any of the infections listed).

For questions or concerns regarding these diseases

Contact the Biothreats Pager **(institutions SME, I.e. ID on call)** available 24/7 at pager number **XXX**.

For routine (non-HCID) Infection Control guidance

Contact **(phone number)** or visit the IC website at **link to website (links to your institution resources or CDC sites)**.

Country Traveling From	Surveillance Window (max time from US arrival to symptom onset)	Disease(s)	Case Definition and Guidance (note these are hyperlinks to resources)
Bahrain	14 Days	MERS	**IC-MERS** (example document included)
Benin	21 Days	Lassa Fever	CDC Lassa; *note: **EVD Plan** applies
China	10 Days	H7N9; H5N1	CDC-H7N9 and CDC-H5N1
Democratic Republic of Congo (Congo, DRC)	21 Days	Ebola	**EVD Plan**
→	21 Days	Measles	**Airborne Isolation Plan**

Abbreviations. MERS: Middle East Respiratory Syndrome

Content Experts: **XXXXXXXXXX** and **XXXXXXXXXX (Insert Names)**

ATTENTION PATIENTS

If you have any of the following symptoms:
- **Cough**
- **Fever**

Please use hand sanitizer and put on a mask.

Have you traveled outside of the United States in the last 30 days? Please Tell the Nurse.

AVISO A PACIENTES

Si tiene cualquiera de los siguientes síntomas:
- **Tos**
- **Fiebre**

Utilice un desinfectante de manos y póngase una mascarilla.

Avísele a la enfermera si usted viajó fuera de los EE. UU. en los últimos 30 días.

تنبيه للمرضى

إذا كان لديك أي من الأعراض التالية :

- **السعال**
- **الحمى**

يرجى استخدام المطهر اليد ووضع على قناع
هل سافرت خارج الولايات المتحدة في آخر 30 يومًا؟
من فضلك أخبرالممرضة

病人請注意

如果你有任何以下症狀：
- **咳嗽**
- **發燒**

請使用洗手液並戴上口罩
請告訴護士您過去30天有沒有在美國以外旅行？

Assessing Patient Risk of High Consequence Infectious Diseases for Frontline Providers
2/28/2020

These questions can be used during your history-taking for a patient with a suspected high-consequence infectious disease such as 2019 Novel Coronavirus (COVID-19), Avian flu, and Middle East Respiratory Virus (MERS). These details will provide helpful information when discussing the case with the designated Subject Matter Expert and State Epidemiologist, if required. *Gathering this information should not delay isolation of the patient under the recommended isolation precautions(airborne isolation + contact isolation + eye protection) or notification of the Subject Matter Expert.*

Step 1. Timing is KEY. Obtain the following dates.

- ✓ Date arrived in foreign country (i.e., China, S. Korea, Italy, Japan, Iran, etc.)
- ✓ Date departed country ((i.e., China, S. Korea, Italy, Japan, Iran, etc.)
- ✓ Date arrived in US
- ✓ Date of symptom onset

Step 1a. Additional exposure details:

- ✓ Were they in a healthcare setting (patient, visitor, healthcare worker) **YES** or **NO**
- ✓ Are they a healthcare worker **YES** or **NO**
- ✓ Any animal exposures: **YES** or **NO**
  - o if yes, what animal:_____
- ✓ Contact w/ suspected/confirmed case specific infection (i.e., COVID-19 or MERS): **YES** or **NO**

Step 2. Clinical details:

- ✓ Cough or short of breath **YES** or **NO**
- ✓ Fever or feverish **YES** or **NO**
- ✓ Nausea, vomiting, or diarrhea **YES** or **NO**
- ✓ Have they taken any antipyretics? **YES** or **NO**
- ✓ Will they need to be admitted? **YES** or **NO**
- ✓ Is there an alternative diagnosis (i.e, confirmed influenza) **YES** or **NO**

Step 3. Other important details we will often need:

- ✓ Cell phone number so we can call the patient while in the room:_____
- ✓ What they do for a job_____
- ✓ Where they live (town) and with whom _____

Updated **2/28/2020**

COVID-19 (2019 Novel Coronavirus) INFORMATION

The Centers for Disease Control and Prevention (CDC) continues to closely monitor an outbreak of a COVID-19 in Wuhan City, Hubei Province, China that began in December 2019. Coronaviruses are a large family of viruses. Some cause illness in people; numerous other coronaviruses circulate among animals, including camels, cats, and bats. Rarely, animal coronaviruses can evolve and infect people and then spread between people such as has been seen with Middle Eastern Respiratory Syndrome Coronavirus (MERS-CoV) and Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV).

The CDC Person Under Investigation (PUI) criteria is for COVID-19 is here and should be reviewed in case there are updates. The link also includes information on submitting information needed for public health authorities.

COVID-19 Person Under Investigation (PUI). *The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure).*

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

1. Fever may be subjective or confirmed.
2. For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation
3. Close contact is defined as being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met. See CDC's updated Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings as described in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19.
4. Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for patients in other countries.
5. Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. See all COVID-19 Travel Health Notices.
6. Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which COVID-19 is being considered.

COVID-19 Infection Control Guidance

1. Patients with suspected or confirmed COVID-19 are subject to **our policy governing airborne isolation + contact isolation + eye protection**.
2. As soon as COVID-19 is suspected, the patient should be given a surgical mask to put on, and the patient placed in an Airborne Infection Isolation Room. Validate negative airflow (check airflow into the room with tissue or observe ping pong ball indicator if present). If no AII room is immediately available, place the patient (wearing a surgical mask) in a room with the door closed and arrange for movement of the patient to an AII room as soon as possible.
3. Immediately implement the following the Recommended Isolation Precautions:
    a. Airborne + Contact + Eye Projection (goggles or face shield).
    b. Clinicians must wear a respirator (either a fit-tested N95 mask or PAPR), gown, gloves and eye protection (e.g., goggles or a face shield) to enter the room for any suspected or confirmed case of COVID-19.

4. Limit staff in the room for any aerosol-generating procedures.
5. When removing protective equipment; remove in the following order and then perform hand hygiene. Use the doffing checklist provided.
    - Gloves and Gown in a single step
    - Goggles/Face shield
    - N-95 Mask or PAPR (outside of the room)
6. Page the Designated Subject Matter Expert to review the case. Use the Assessing Patient Risk of High Consequence Infectious Diseases for Frontline Providers to gather information that will be needed to make a determination of patient risk.
7. If the patient is not on campus or is being seen in an ambulatory setting:
    - Minimize contact with the patient
    - Provide a mask for the patient to put on
    - Escort the patient to a private room, maintaining a distance of 3-6 feet
    - Page the **Designated Subject Matter Expert** to review the case.

COVID-19 Testing Guidance and Submission Forms

If the patient is determined to meet criteria for testing based on clinical presentation and epidemiological risk factors, **the State Epidemiologist must be contacted** to review the case and obtain approval for testing and recommendations on what samples to obtain. The Designated Subject Matter Expert will contact the Micro Lab Director on Call to should coordinate shipment of the samples to the State Lab. With guidance from public health authorities, various specimens may be requested.

Testing supplies for State Lab testing are available in a kit—once approved the clinical team must pick up the kit. Use the COVID-19 Testing Kit.

COVID-19 LINKS AND FACT SHEETS

- CDC COVID-19

POLICY FOR HIGH CONSQUENCE
INFECTIOUS DISEASES REQUIRING
AIRBORNE + CONTACT + EYE PROTECTION
ISOLATION PRECAUTIONS

I. Policy

This policy directs the isolation and care for patients known or suspected to be infected with highly pathogenic organisms transmitted by both the airborne route and by direct or indirect contact with the patient, with environmental surfaces, or with contaminated patient care equipment. It utilizes a combination of **Airborne Isolation + Contact Isolation + Eye Protection**.

II. Diseases that fall in this category include:

Severe Acute Respiratory Syndrome (SARS)
Middle East Respiratory Syndrome (MERS)
Avian Influenza
Other pathogens, as directed by Infection Control

III. Procedure

When a patient meeting the criteria to be a person under investigation (PUI) for one of these conditions is identified, staff must contact **XXXXX** to activate the appropriate response. **XXXXX** will respond as needed to the location and provide support, review procedures with staff and provide just in time training (JIT).

IV. Hand Hygiene

HAND HYGIENE IS THE SINGLE MOST IMPORTANT MEANS OF PREVENTING THE SPREAD OF INFECTION. Hands must be disinfected with an alcohol-based hand rub before and after providing care that involves touching the patient or the patient's environment. Hands must also be disinfected after removing gloves, gowns, or respiratory protection devices and after touching inanimate objects in the immediate vicinity of the patient, or touching contaminated items or surfaces. If hands are visibly soiled, wash hands with soap and water, dry hands, and apply an alcohol-based hand rub.

V. Patient Placement – Airborne Infection Isolation Room (AII)

Patients must be placed in an Airborne Infection Isolation Room (AII), preferably with an anteroom. Doors into the room must be kept closed at all times to ensure adequate negative pressure. For rooms that require activation of negative pressure airflow, pressure conversion switches must be switched to "negative". **Negative pressure must be validated daily when in use and documented.** Methods of validation include use of a visual indicator e.g. tissue test, or observation of ball-in-tube device. Both ball-in-tube device, and tissue should be pulled into the room when the door(s) are closed. If there is an anteroom, air should flow from the corridor into the anteroom and from the anteroom into the patient room.

VI. Personal Protective Equipment (PPE)

Correct use of PPE is critical to preventing staff exposure. **XXXXX** staff will be deployed to the unit to review correct donning and doffing procedures with

staff when this protocol is initiated and will periodically monitor staff to ensure compliance with donning and doffing protocols. Doffing checklists are available to guide correct doffing sequence.

A. Donning (putting on) PPE:
These requirements apply to all staff entering the room of a patient. The following PPE is required to be donned prior to entry into the patient room. Donning in the following order is recommended.

1. Gown
A clean, nonsterile, disposable, isolation gown must be worn. Ensure that gown is tied in back and provides full coverage.

2. N-95 respirator or Powered Air Purifying Respirator (PAPR)*
    a. All staff must wear approved respiratory protection (N-95 respirator or PAPR).
    b. Before using an N-95 respirator or PAPR, staff must be medically cleared and trained in how to wear/use each device.
    c. For N-95 respirators, staff must have been fit-tested within the past year to ensure proper size and fit.
    d. A "fit-check" (also known as a "seal check") should be performed before each N-95 respirator use.
    e. If staff is unable to be fit-tested for an N-95 respirator, they must wear a PAPR.

3. The N-95 respirator and PAPR hood and hose must be discarded after each use.

4. Goggles/Face shield
All staff must wear goggles or face shield to protect mucous membranes from exposure due to splash or potential for hand contamination of eyes, nose or mouth. Goggles or face shield are not required if using a PAPR as the hood provides face protection.

5. Gloves
All staff must wear clean, nonsterile gloves. Gloves must be pulled over the sleeves/cuffs of gown.

1. For Airborne Infection Isolation (AII) room with anteroom:
Remove all PPE in anteroom. Make sure the door from the anteroom into the patient room is closed and negative airflow into patient room has been confirmed.

2. For AII room without anteroom

Except for respiratory protection, remove and discard PPE (gloves, gown, face shield or goggles) just inside doorway before exiting to hall**. Remove respiratory protection (N-95 or PAPR) after leaving the patient room and closing door**.

3. **Doffing sequence if N-95 respirator is worn - See Doffing Checklist- N-95 Respirator** (**link here)** for removal sequence. Avoid touching face.

4. **Doffing sequence if PAPR is worn - See Doffing Checklist- PAPR (link here)** for removal sequence.
   a. PAPR hood and hose are discarded after use.
   b. The PAPR belt and blower motor must be wiped down with a hospital-approved disinfectant and be stored (plugged into charging cord). Don clean gloves to perform this step, then remove and discard and disinfect hands with an alcohol-based hand rub.

C. Strict Isolation PPE Donning and Doffing Video Link (**Link here**)

VII. Patient Care Equipment/Supplies

A. Equipment (e.g., stethoscope, blood pressure cuff, thermometers) should be single-use or dedicated to use of the patient to avoid sharing with other patients. Reusable patient care equipment must be disinfected with a hospital-approved disinfectant before use for another patient.

B. Supplies in the room of a patient should be kept to a minimum. Disposable items (e.g. adhesive tape, gauze etc.) must be discarded on discharge.

VIII. Patient Transport: Strict Isolation Requirements

A. **Limit patient transported for essential purposes only.** Notify the receiving department that the patient is on **Airborne Isolation + Contact Isolation + Eye Protection**.

1. If transport or movement outside of an AII room is necessary, place a regular surgical mask on the patient for transport.
2. If the patient is intubated, place a bacterial filter on the endotracheal tube or on the expiratory side of the breathing circuit of a ventilator or anesthesia machine.
3. All staff involved should wear appropriate PPE in the isolation room while preparing the patient for transport. PPE should be removed per doffing procedures above when leaving the room.
4. Wounds must be covered, and body fluids contained**.** The patient should wash or disinfect his or her hands before leaving the room if possible. The patient should wear a clean gown or robe or be covered by a clean sheet or drape for transport to another department or area.

5. The patient chart will be transported in a manner that prevents contact with the patient and/or contaminated linen.
6. **PPE should not routinely be worn when transporting the patient.** **Exception –** If patient contact and/or contact with contaminated equipment will occur during transport (e.g., for ICU patients or patient transported in their bed) full PPE must be worn by those having direct contact with the patient and/or the bed or equipment during transport. PPE is removed per doffing procedure when contact with patient and/or contaminated equipment is completed. Every effort will be made not to touch clean surfaces (e.g., elevator buttons) with gloved or contaminated hands by team members in PPE. **There must be a member of the transport team, not wearing PPE, who has clean hands to interact with the environment.**

IX. Specimen Collection (all types)

A. Preparation
1. Collect appropriate tubes/containers, labels, plastic specimen transport bags, a clean chux (do not use one already in the room) and 2 clean emesis basins.
2. Place all items except chux into one of the clean emesis basins.
3. Disinfect hands and don personal protective equipment (PPE) as required.

B. Procedure
1. Bring emesis basin containing equipment and second emesis basin into room. Place chux on a clean, clear horizontal surface; do not place on patient bed. Place emesis basin with supplies and second emesis basin on the clean chux.
2. Follow standard procedures for patient identification and specimen collection.
3. Place specimen containers/tubes in one emesis basin.
4. Label all specimens at patient bedside.
5. Remove gloves and disinfect hands with alcohol-based hand rub, then don clean gloves.
6. With clean gloves, place labeled specimens into the clean specimen transport bag.
7. Wipe outside of bag with hospital-approved disinfectant wipe and place bag into the second clean emesis basin.
8. Carry bagged specimens out of room in the second emesis basin. Emesis basin may be placed on surface in anteroom or surface outside of room.
9. Remove PPE per doffing protocol and disinfect hands.
10. Bagged specimens may be transported to the lab per standard processes**. Note: If specimen is being sent to test for confirmation or rule out of diagnosis (e.g. MERS/SARS or Avian Flu), specimen should be delivered directly to the lab to avoid delays in processing.**

X. Visitors

A. A policy for the management of visitors should be developed. Points to consider include:
1. Screening of visitors for symptoms of illness
2. Limiting number of visitors
3. PPE for visitors
4. Written instructions for patient and visitors

XI. Healthcare Worker Monitoring

A. A list of healthcare workers entering the room of a patient will be maintained.

B. Healthcare workers caring for a patient, and those that perform tasks associated with risk of exposure (e.g. staff involved in room cleaning) will be monitored for fever and other relevant symptoms for the length of the incubation period, specific to the infection, from their last date of potential exposure.

C. They will be provided with a thermometer and written instructions after their first shift caring for the patient. They will be required to measure their temperature twice per day and document relevant symptoms. In the event of a temperature ≥ 100.4 or positive symptom screen, they are required to contact OHS immediately.

D. HCW Exposure
1. HCWs who report an unprotected exposure (i.e., entering the room without appropriate PPE) or possible exposure should be assessed by OHS as to whether exposure has occurred.
2. If it is determined that an exposure did occur; post exposure follow-up will be conducted based on direction from public health authorities.

XII. Room Turnover Time and Discharge Cleaning

A. After a confirmed case patient vacates room or is discharged, the room must remain in negative pressure with the door closed for 30-60 minutes, based on the number of air changes per hour (ACH) for the room, before staff enters the room without PPE or another patient is admitted to the room.

B. Cleaning staff must wear respiratory protection and other PPE required for Strict Isolation when cleaning during this airing time. If cleaning is performed after the required airing time, respiratory protection is not required but gown, gloves and face protection are. Cleaning staff must follow correct doffing sequence when removing PPE.

C. See Airborne Infection Isolation Room List for documentation of Airborne Infection Isolation Room (AII) air changes per hour (ACH).
1. Rooms with ≥6 air changes per hour (ACH) = 60 minutes
2. Rooms with ≥12 ACH = 30 minutes

Evaluation and Management of High Consequence Infectious Diseases Requiring Airborne Isolation + Contact Isolation + Eye Protection

Overview and Background

For the purposes of this document, HCID refers to pathogens such as Middle East Respiratory Virus Syndrome, Severe Acute Respiratory Syndrome, and Avian/Novel Influenza. This document details the response plan for suspect or confirmed patients with HCIDs requiring airborne isolation + contact isolation + eye protection.

Location of Care

The location of care for patients with suspected of confirmed HCIDs depends upon the age of the patient (adult or pediatric), the patient's clinical care needs (i.e., whether they require care in an intensive care unit or general ward), and whether there are special circumstances such as would occur in a pregnant patient.

For adult, non-critically ill, non-pregnant patients, care under airborne isolation + contact isolation + eye protection will be delivered in an Airborne Infection Isolation (AII) room in [a specified location], as well as patients at less than 22 weeks' gestation. AII rooms provide the negative pressure ventilation required to isolate patients with airborne spread infections. AII rooms with ante-rooms may be preferentially considered for the purposes of donning and doffing Personal Protective Equipment (PPE).

Critically-ill adult patients with HCIDs will be cared for in AII rooms in intensive care units, preferably ones with an anterooms. Non-critically ill pediatric patients will be cared for on a pediatric floor with an AII room, critically ill pediatric patients will be cared for in the Pediatric Intensive Care Unit. Pregnant patients greater than 22 weeks gestation will be cared for in an AII room on the Labor and Delivery floor.

Special Pathogens Care Locations

[Consider describing here the patient care areas in further detail that patients with HCIDs could be treated and how these rooms/locations are activated and who may be involved with an activation at the hospital leadership level.]

Activation: Personnel, Staffing, and Leadership

During activation of a special pathogens [room/area/unit], clinical, administrative, and support departments will continue to be unit-based, with additional support provided by [Consider: Emergency Management, Infection Control (IC), Infectious Diseases (ID), and the Incident Management Team (IMT), as needed]. [Define here who will coordinate communications with local, state, and national authorities as needed and required].

The Attending of Record for care of the HCID patient is drawn from the [Hospital Medicine Unit] and the [Clinician Educator Service]. [Consider eliminating trainees from direct care of the HCID patient].

Staff assigned to the care of this patient will include:

- Attending physicians from the Hospital Medicine Unit and Clinician Educator Service
- Patient Care Services including Registered Nurses (RNs), Unit Service Associates (USAs), Respiratory Therapists (RTs), Patient Care Associates (PCAs), and other clinical therapies (i.e., Occupational Therapy), as indicated.

Other care team members, such as Case Management, may consult without direct patient contact.
- Infectious Disease Attending will be drawn from the ID Consult Service general teams
- Staff who are fit-tested for N95 respirators

HCID Patient Admissions and Daily Operations

When non-critical beds are used to deliver care for a patient with suspected or confirmed HCIDs, unit clinical and administrative leadership remains intact. Additional support will be provided from Infection Control and the Emergency Management upon admission of a PUI or confirmed HCID patient requiring airborne isolation + contact isolation + eye protection.

When the Emergency Department, any ambulatory care setting, or inpatient provider identifies a patient or a group of patients for rule-out of an HCID, the patient(s) will be immediately isolated under airborne isolation + contact isolation + eye protection where they are located, and communications regarding the admission will occur as outlined [per established hospital communication chains]. Immediate determination will be made as to whether the patient's clinical status requires ICU-level care.

Adult Inpatient General Care Unit Level Admission to the Special Pathogens Unit

- [An identified infectious disease clinician or delegate] will be contacted by the attending physician treating the patient to determine if the patient meets criteria as a PUI or is confirmed as having an HCID based on current public health guidance.
- If the patient meets PUI criteria or is confirmed to have an HCID, the infectious disease clinician or delegate will initiate a huddle among the treating attending physician and other identified parties to discuss the following:
    - Overview of the patient's presentation
    - Discussion about risks of the potential pathogen
    - Develop a proposed patient care plan and identify care team
    - Determine type of Isolation indicated (i.e. Airborne alone or Airborne + Contact + Eye Protection)
    - Discuss notifying Emergency Management as appropriate
- If the patient is an outpatient, it is expected that the patient will generally require evaluation and care in an Emergency Department prior to admission to the hospital.
- If the patient is in the Emergency Department and the huddled group decides to admit the patient, the ED will place an admission order and a delegated party will page the floor nursing supervisor to notify them of the decision to admit.
- If the patient is already admitted to the hospital outside of the designated admitting area for a patient with an HCID, Infection Control will consider placing a monitor at door of current patient location to provide "just in time" training (JIT) in airborne isolation + contact isolation + eye protection to staff entering the room until patient is moved.
- Once the nursing supervisor has been contacted regarding the HCID patient admission, the following actions will take place:
    - The Nursing Supervisor will call Admitting Services to initiate the bed search, and coordinate placement.
    - Patients fourteen years of age or older may be admitted to an adult general unit bed or adult ICU bed, with support from other services, including pediatric nurses and physicians.
    - When a surge of HCID patients exceeds available ICU capacity, those patients stabilized in ICUs on ventilators may be transferred to designated general beds in AII rooms.

Clinical Decompensation, Rapid Responses and Codes in the SPU

After a patient is admitted to the SPU, it may become clear that their clinical trajectory is worsening. In this case, there should be a low threshold to transfer the patient to a higher level of care before clinical decompensation occurs. Early involvement of the critical care attending and the nursing supervisors can aide in triage decision making, and every effort should be made to transfer a patient to a higher level of care if they are decompensating.
If a Rapid Response is needed, activate the rapid response team through the usual process. If a rapid response is called, the goal is to provide the necessary care with only essential personnel physically in the room. One of the nursing supervisors will be designated at the door to the anteroom to ensure that only essential team members enter the room and to ensure proper doffing when the rapid response is completed. Infection control will provide Just in Time precaution training for essential team members at the time of HCID patient admittance.

A. Essential team members for Rapid Response team in the room:
    a. Medical senior resident on for the house
    b. Attending of record (to provide clinical information and act as back up for the senior resident)
    c. Primary nurse
    d. Nursing supervisor
    e. Respiratory therapy
B. Rapid response team members outside the room:
    a. Pharmacy

C. Special considerations for rapid responses in an HCID patient room:
    a. If a Rapid Response is called, the patient should be transferred to the MICU when stabilized
    b. If the rapid response is due to a respiratory decompensation, consider intubation on the floor prior to transfer to the MICU depending on clinical status and oxygen requirements at the time of transfer.

As above, every effort should be made to identify a patient requiring a higher level of care and transfer early in the clinical course. If a patient is clinically decompensating, goals of care should be addressed daily. If a patient undergoes a sudden cardiac or respiratory arrest, the goal as above should be to provide necessary care with only essential personnel in the room. As above, one of the nursing supervisors will be designated at the door of the anteroom to ensure that only needed personnel enter and that proper donning/doffing procedures are followed.

A. Essential team members for Code Team present in room:
    a. Medical senior resident on for the house
    b. Attending of record (to provide clinical information and act as back up “code whisperer” for the senior resident)
    c. Primary nurse
    d. Nursing supervisor
    e. Respiratory therapy
    f. RICU Attending and RICU resident
    g. Critical care attending
    h. Additional floor RN as needed for chest compressions
B. Code team members outside the room:
    a. Pharmacy
    b. Back up senior resident
C. Special considerations for codes in an HCID patient room:
    a. Interns normally provide chest compressions. To minimize people in the room, other code team members will be expected to rotate to provide chest compressions.

b. Depending on the presumed etiology of the code, consideration should be given to early cessation of resuscitation efforts if the patient does not attain ROSC after 10-15 minutes.

Admission to Hospital Locations Outside of Non-Critical Care AII Rooms

Intensive Care Unit Admission

If the patient's clinical status requires critical care, patients will preferentially be admitted to the MICU. If there is no available capacity to admit the patient to the MICU, additional patients may be admitted to other ICU AII rooms. There are two AII rooms in the Pediatric ICU (PICU).

Table 2. AII rooms with ICU care capabilities			
Dedicated ICU		**Other ICU-level**	
Location	Number of beds	Location	Number of beds

Management of Family and Visitors

Visitors will be limited to 2 designated persons who are necessary for the support of the patient. Visits must be scheduled and controlled to allow for screening for symptoms of acute respiratory illness before entering the unit. See airborne isolation + contact isolation + eye protection policy for detailed procedures for managing visitors. All visitors must report to Nurses Station to ensure that visitors have been screened before entering patient room. Public health authorities may impose restrictions on movement of family and visitors to the patient.

Training in Infection Control Principles and Practice

The purpose of training in Infection Control principles and practice is to ensure that staff can safely care for patients with a suspected or confirmed HCID, including maintaining competency in the donning and doffing of PPE. Training will include both didactic and practical sessions (Table 3).

Table 3. Training Methods and Content	
Type	**Skill**
Didactic	Infection Prevention for Emerging and Re-emerging Infectious Diseases, including Airborne isolation + contact isolation + eye protection Policy
	Occupational Exposure and Symptom Monitoring
	HealthStream on PAPR use and PAPR cleaning (for those staff requiring use of PAPR)
Practical	Donning and Doffing for PPE used for airborne isolation + contact isolation + eye protection observed and verified by Infection Control Unit staff or unit-based trainers

Initial Training
Training will include an overview of infection control principles and airborne isolation + contact isolation + eye protection paired with live demonstration of donning and doffing of required PPE, with return demonstration by all staff. Verification of proficiency will be by either Infection Control Unit staff or Unit-based trainers. Initial training may include a combination of on-line in addition to in-person training and education.

A HealthStream module on PAPR use will be required for healthcare workers (HCWs) unable to be fit-tested. Additional training will be conducted to include PAPR cleaning. Staff will be educated regarding symptom monitoring and reporting to Occupational Health.

Ongoing Training
Staff from the floors where an HCID patient may be admitted may receive ongoing training as needed. Staff may participate in trainings, drills, and exercises, as indicated.

JIT Training
With low frequency, high risk events, periodic training after initial training is necessary to ensure proficiency. Infection Control will deploy and execute JIT training when admitting an HCID patient.

JIT Training will include the following:

- Overview of specific disease
- Review of airborne isolation + contact isolation + eye protection including Visitor Policy, Staff Entry Log and Tracking, and Symptom Monitoring
- Review of Donning and Doffing PPE and demonstration/observation
- Review response to occupational exposure
- Review available resources
- Review infection control aspects in setting of emergent resuscitation
- Confirmation of fit-testing of staff involved in care within the year

Operations
Supply of Personal Protective Equipment
Initial response supplies will be available from unit daily PAR levels. Resupply of PPE will be coordinated by PCS Clinical Support Services as per usual operations, with support from Materials Management, as needed.

Staffing Considerations
Staffing will be at the discretion of local clinical leadership. The PPE required and donning and doffing procedures for airborne isolation + contact isolation + eye protection may impact the patient:nurse ratio.

Use of staff who are able to wear N-95 respirators for patient care may be favored over staff who require PAPRs due to challenges associated with doffing and management of used equipment. Staff who can be fit-tested for an N-95 respirator will be preferentially assigned to patients on airborne isolation + contact isolation + eye protection. If there are HCWs who need to wear a PAPR and there are patients in rooms without an anteroom, those HCWs will be preferentially assigned to rooms with an anteroom.

Surge Capabilities/Considerations

In the event of an outbreak creating a surge of PUI or confirmed HCID patients, there will be an increased requirement for AII rooms beyond the capacity of the pre-identified beds potentially utilizing other ICU beds. Consider spaces where entire units can be converted to negative airflow space as a last resort in a full-scale infectious disease outbreak.

Occupational Health

Public health authorities may require active monitoring of HCWs caring for HCID patients. If HCW symptom monitoring is required, the frequency, duration and follow-up will be the responsibility of Occupational Health Services. If exposure is suspected for any HCWs involved in patient care, Occupational Health will investigate in consultation with the Infectious Diseases Attending MD. Staff interacting with HCID patients will be required to document their daily interaction on a Room Entry Log or other tracking method.

General Approach to Clinical Care

Clinical care for patients with diseases such as MERS, SARS, and Novel Influenza may be, for the most part, supportive therapy. Experimental therapeutics may be considered and internal and external subject matter experts may relay updates with respect to treatment.

Early diagnostics to either confirm or rule out patient with HCID are essential.

Patients should receive standard diagnostics as relevant to their clinical needs. When possible, patient transport should be kept to a minimum, but if needed, should follow the airborne isolation + contact isolation + eye protection policy guidance.

Demobilization

Discontinuation of airborne isolation + contact isolation + eye protection will be determined after consultation with Infectious Diseases, Infection Control, and public health authorities, as required. Demobilization of the unit in settings of multiple admissions and patient discharge will involve the same consultative groups.

VISITOR SCREENING TOOL
Disease: MERS, SARS, novel Coronavirus

Policy:
1. Visitors are limited to 2 designated persons necessary for support of the patient.
2. Patient/family should identify 2 persons who may visit. Patient should give permission to discuss suspected diagnosis with the 2 designated visitors.
3. **Visitors must call the unit on the day of the visit before coming to the hospital to be screened for symptoms that could be consistent with the infection (see header for specific disease).**
4. If visitors arrive without having been screened via phone; a **Face-to-Face Screen** will be completed

Instructions for the nurse caring for the patient on Contact + Airborne + Eye Protection:
1. The 2 designated visitors must be told to call the unit and speak with the patient's nurse BEFORE coming to the facility. The nurse (or designee) completes the **Phone Screen** below for each visitor.
2. The visitors will be told to report directly to the unit Nurses' Station immediately after arriving at the hospital.
3. If visitors arrive without calling in, the patient's nurse (or designee) will complete the **Face to Face Screening screen** below for each visitor before allowing entry into the patient room.
4. Complete a separate form for each visitor and each visit. Keep completed screening tools in patient's chart for the duration of hospitalization.

Part 1: Phone Screen

Today's date_____ Time_____ Visitor Name: _____
1. Have you had a fever during the past 24 hours (e.g., ≥100°F)? Yes___ No____
2. Do you have a new cough or difficulty taking a deep breath? Yes____ No____

If "yes" to either question #1 or #2, tell the visitor that he/she should not visit the hospital. Tell the visitor that they should expect a call from the healthcare facility or Public Health authorities re: instructions for evaluation to determine next steps.

Part 2: Face-to-Face Screen

Today's date_____ Time_____ Visitor Name: _____
1. Have you had a fever during the past 24 hours (e.g., ≥100°F)? Yes____ No____
2. Do you have either a cough or difficulty taking a deep breath? Yes____ No____

If "yes" to either question, instruct the family member to don appropriate PPE and wait in the patient's room. Page the Biothreats Pager MD immediately (#26876) to evaluate visitor.

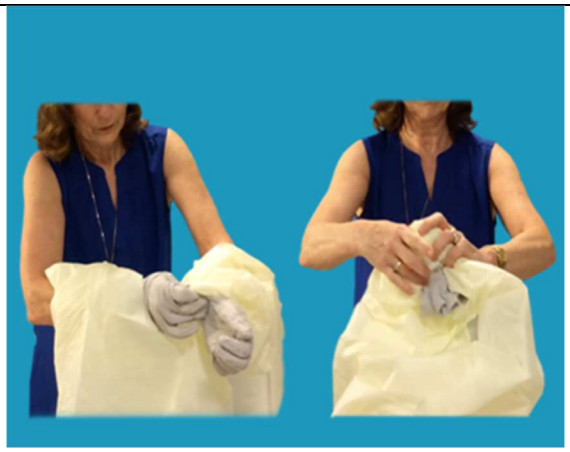
Patient Name/MRN: _____
Nurse: _____

DOFFING CHECKLIST

DISPOSABLE GOWN AND N-95 RESPIRATOR

Except for Respirator, remove PPE at doorway or in anteroom if present.

Remove PPE in the following sequence. Avoid touching face.

#	Step	Location	Detail
1	Remove gown & gloves first - in a single step. Roll gown into itself, peeling off gloves at the same time. Hold gown away from your body and discard*.	Doorway (inside or outside patient room- with door closed) or Anteroom	
2	Remove and discard* face shield or goggles	Doorway (inside or outside patient room- with door closed) or Anteroom	Avoid touching front of face shield. Remove by grasping sides or back of strap then pull forward over head  Avoid touching front of goggles. Remove by grasping sides and pull away from your face 
3	Remove and discard* N-95 Respirator	Outside room	 Do NOT touch front of mask  Pull bottom strap first then top strap over head- without touching respirator  Discard in trash
4	Perform Hand Hygiene	Outside room	Alcohol-based hand rub (ABHR) or wash with soap and water (if indicated), dry, then disinfect with ABHR.

***Discard all PPE in regular waste**

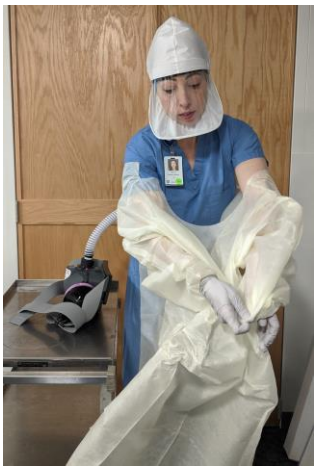
Created: Month/Year
Revised: Month/Year

STRICT ISOLATION – DOFFING CHECKLIST

DISPOSABLE GOWN AND SHORT HOOD PAPR

Except for PAPR, remove PPE at doorway or in anteroom if present.

Remove PPE in the following sequence. Avoid touching face.

#	Step	Location	Detail
1	**Gown and Gloves** To facilitate gown and glove removal, remove belt from waist. Do not turn off blower. Hang blower motor & belt on a hook or place on stable surface.	**Doorway** (inside or outside patient room- with door closed) **OR** in **Anteroom** (with patient room door closed)	 
2	**Gown and Gloves** Once blower motor & belt are secured, remove gown & gloves in a single step. Roll gown into itself, peeling off gloves at the same time. Hold gown away from your body and discard*.	**Doorway** (inside or outside patient room- with door closed) **OR** in **Anteroom** (with patient room door closed)	
3	**PAPR – Outside room or in Anteroom** Perform hand hygiene - don clean gloves. Lean forward, do not touch front of hood. Remove hood by grasping above ears while bending forward. Lift and pull forward away from your face. Disconnect breathing tube from blower unit, shut off blower. Discard hood and hose. Belt and blower unit must be wiped down with hospital-approved disinfectant and stored. Plug blower into charging cord		
4	Remove gloves perform Hand Hygiene	Outside room	Cal Stat or wash with soap and water (if indicated), dry, then disinfect with Cal Stat

If the patient is determined to meet criteria for testing based on clinical presentation and epidemiological risk factors, the State Epidemiologist must be contacted by the Institutional Subject Matter Expert (State Epi Hotline: XXX-XXX-XXXX. If testing is approved request the COVID-19 Testing Kit to be delivered to the primary team.

Testing for COVID-19 be processed at the State Lab **must be collected using the contents of this kit.** DO NOT USE ANY OTHER SUPPLIES FOR TESTING FOR THIS PURPOSE. All *other* laboratory testing will proceed using standard testing supplies.

Follow these instructions.

1. Specimen collection and decontamination guidance for clinical staff are described in the policy detailing the care of patients on Airborne Isolation + Contact Isolation + Eye Protection and should be reviewed by clinical staff prior to beginning collection. Ensure that you have patient labels in the room. Watch this video, demonstrating proper specimen collection technique.
2. Determine which specimens will be collected upon recommendation of the designated subject matter expert and the state epidemiologist.
3. Use the table below to collect the appropriate specimen in the correct collection devices.
4. **It is critically important to label each specimen, specifically the NP and OP swabs need to be labeled as such.**
5. The State Lab submission form should be filled out by the Responding Clinician with the information required. This form is required prior to sending out the specimen. An example form is provided here

Sample	Collection device	Instructions	Notes
Expectorated sputum ***Additional respiratory specimens that may be collected are:*** **BAL, NP aspirate or washing.**		*For Expectorated sputum*: Have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Click **here** for NP aspirate or washing collection instructions.	If patient cannot produce, we will not send this sample. I.e. we will not induce sputum collection.
NP swab		Insert a swab into the nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions. Swab both nasopharyngeal areas with the same swab. Insert swab into the 3 mL UTM tube and break swab off at the scored mark.	Label UTM tube with epic label and hand write NP swab on the specimen container
OP swab		Swab the posterior pharynx, avoiding the tongue. Insert swab into the 3 mL UTM tube and break swab off at the scored mark.	Label UTM tube with epic label and hand write OP swab on the specimen container