Lincoln Park Health Care

DEPARTMENT: Administrative	
EFFECTIVE DATE: 03/2020	**REVISED DATE: March 7, 2020**
SUBJECT: Coronavirus COVID-19 Pandemic Plan	

Policy Statement

A pandemic Coronavirus disaster plan has been incorporated into this facility's overall disaster preparedness plan.

Policy Interpretation and Implementation

This facility has identified key components for pandemic Coronavirus preparedness and is continuously updating its readiness efforts.

A multidisciplinary Pandemic Coronavirus Planning Committee has been established to develop and oversee the facility's pandemic preparedness planning, including the written policy.

A Pandemic Response Coordinator has been assigned to coordinate pandemic preparedness planning and to monitor public health advisories on a weekly basis (or more often, as necessary).

Components of the written pandemic Coronavirus preparedness plan include the following:

a. A protocol for monitoring pandemic Coronavirus symptoms in staff and residents, including new admissions;
b. A facility communications plan;
c. Education and training programs and materials for staff, residents, families and visitors;
d. An infection control plan for managing residents and visitors with symptoms of pandemic Coronavirus;
e. A plan for addressing staff absences and working with skeleton staff;
f. A plan for the use medications; and
g. A surge capacity determination and plan, including staffing and supplies.

Lincoln Park Health Care Nursing Department POLICY AND PROCEDURE STANDARDS MANUAL	Date: February 1st, 2020 Revised 2/26/2020 Approved by: Antoinette Loyas Chief Operating Officer
Novel Coronavirus COVID19	

On February 11,2020, The World Health Organization announced an official name for the disease that is causing the current outbreak of CORONAVIRUS DISEASE. COVID-19

POLICY STATEMENT:

It is the policy of Lincoln Park Health Care to establish guidelines for the prevention, control, and care of the persons with **COVID-19 Novel Coronavirus.**

PURPOSE:

To implement protocols in accordance with the CDC recommendations to prevent the transmission of the **Novel Coronavirus- COVID -19** When a resident is admitted/ readmitted or a diet change is made,

DEFINITION:

Coronavirus (COVID-19) is a new virus and currently exact information about incubation period, shedding period and contagious periods is unknown. All suspected case of COVID19 requires immediate notification of both the local and state health departments for further guidance. CDC guidance will be used to update this protocol as new information becomes available.

COVID19 Virus Transmission & Incubation

- The COVID19 virus is spread from person-to-person. Transmission is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. It's currently unclear if a person can get COVID19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (the sickest). The incubation for COVID19 is not known at this time but
- It's important to note that how easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so. There is much more to learn about the transmissibility, severity, and other features associated with COVID19 and CDC investigations are ongoing.

COVID19 Symptoms

- For confirmed COVID19 infections, reported illnesses have ranged from people with mild symptoms to people being severely ill and dying. Symptoms can include:
    - Fever
    - Cough
    - Shortness of breath
- CDC believes that symptoms of COVID19 may appear in as few as 2 days or as long as 14 after exposure.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including health care workers, who has had close contact with a laboratory-confirmed COVID19 Resident within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

The criteria are intended to serve as guidance for evaluation. Residents should be evaluated and discussed with public health departments on a case-by-case basis. For severely ill individuals, testing can be considered when exposure history is equivocal (e.g., uncertain travel or exposure, or no known exposure) and another etiology has not been identified.

Testing

- CDC has developed a new laboratory test kit for use in testing Resident specimens for **2019 novel coronavirus**. The test kit is called the "***Centers for Disease Control and Prevention (CDC) 2019-Novel Coronavirus Real-Time Reverse Transcriptase (RT)-PCR Diagnostic Panel***." It is intended for use with the Applied Biosystems 7500 Fast DX Real-Time PCR Instrument with SDS 1.4 software.

- This test is intended for use with upper and lower respiratory specimens collected from persons who meet CDC criteria for **COVID19 testing**.

- **Please contact the local and State Health Department for instructions regarding testing.**

Prevention
There is currently no vaccine to prevent **COVID19 infection**. The best way to prevent infection is to avoid being exposed to this virus. CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:

- Avoid close contact with people who are sick. Keep at least a six foot distance.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Follow CDC's recommendations for using facemask.
  CDC does not recommend that people who are well wear facemask to protect themselves from respiratory viruses, including 2019-nCoV.

  Facemask should be used by people who show symptoms of 2019 novel coronavirus, in order to protect others from the risk of getting infected.

  The use of facemasks is crucial for health workers and people who are taking care of someone in close settings (at home or in a health care facility).

- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.

- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

Minimize Chance for Exposures
Before Admission/Readmission/Discharge

- When scheduling admissions/readmissions, instruct Residents and persons who accompany them to call ahead or inform facility staff upon arrival if they have symptoms of any respiratory infection (**e.g., cough, runny nose, fever)** and to take appropriate preventive actions (**e.g., wear a facemask upon entry to contain cough, follow triage procedures).**

- If a Resident is arriving via transport by emergency medical services (EMS), the driver should contact the facility and follow previously agreed upon local or regional transport protocols.

- Discharge of symptomatic or known exposed Residents requires notification of transportation and receiving facility prior to discharge.

Upon Arrival

- Take steps to ensure all persons with symptoms of suspected COVID19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures.

- Post visual alerts (e.g., signs, posters) at the facility entrance and in strategic places (e.g., waiting areas, elevators) to provide Residents and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette.

- Instructions should include how to use facemasks or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.

- Ensure that Residents with symptoms of suspected COVID19or other respiratory infection (e.g., fever, cough) are not allowed to be among other Residents.

- Identify a separate, well-ventilated space that allows residents to be separated by 6 or more feet, with easy access to respiratory hygiene supplies.

- Ensure rapid triage and isolation of Residents with symptoms of suspected COVID19 or other respiratory infection (e.g., fever, cough):

- Identify Residents at risk for having COVID19 infection before or immediately upon arrival to the healthcare facility.

- Implement triage procedures to detect **persons under investigation (PUI) for 2019-nCoV** during or before Resident admission and ensure that all Residents are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of **COVID19** or contact with possible **COVID19** Residents.

- Implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the Resident's nose and mouth if that has not already been done) and isolate the **PUI for 2019-nCoV** in an Airborne Infection Isolation Room (AIIR), if available. ***LP Health Care does not have a AIIR room***.

- Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for 2019-nCoV.

- Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, Resident check-ins, etc.

Manage Visitor Access and Movement Within the Facility

- Restrict visitors from entering the room of known or suspected **COVID19** Residents (i.e., PUI). Alternative mechanisms for Resident and visitor interactions, such as video-call applications on cell phones or tablets should be explored. Facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the Resident's emotional well-being and care.

- Visitors to Residents with known or suspected **COVID19** should be scheduled and controlled to allow for:
  - Screening visitors for symptoms of acute respiratory illness before entering the healthcare facility.

  - Evaluate risk to the health of the visitor ***(e.g., visitor might have underlying illness putting them at higher risk for 2019-nCoV)*** and ability to comply with precautions.

  - Provide instruction, before visitors enter Residents' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the Resident's room.

  - All visitors who enter Resident rooms must sign a logbook.

  - Visitors should not be present during aerosol-generating procedures.

  - Visitors should be instructed to limit their movement within the facility to that unit only.

  - Exposed visitors (e**.g., contact with COVID19Resident prior to admission)** should be advised to report any signs and symptoms of acute illness to their health care provider for a period of at least 14 days after the last known exposure to the sick Resident.

  - All visitors should follow respiratory hygiene and cough etiquette precautions while in the common areas of the facility.

Implement Engineering Controls

- Engineering controls include:
  - Physical barriers or partitions to guide Residents around affected areas,

  - Curtains between Residents in shared areas,

  - Closed suctioning systems for airway suctioning for intubated Residents, as well as appropriate air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are installed and properly maintained.

Monitor and Manage Ill and Exposed Healthcare Personnel (HCP)

- Movement and monitoring decisions for HCP with exposure to COVID19 should be made in consultation with public health authorities. Refer to the **Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Residents with 2019 Novel Coronavirus (2019-nCoV)** for additional information.

- The facility **sick leave policies** for HCP are non-punitive, flexible, and consistent with public health guidance.
- Exposed HCP will not be allowed to return to work until 14 days post exposure if non symptomatic.
- Symptomatic HCP will not be allowed to return to work until medically cleared following CDC guidance.

Train and Educate Healthcare Personnel

- Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.

- HCP must be medically cleared, trained, and fit tested for respiratory protection device in the event of a pandemic outbreak (e.g., N95 filtering facepiece respirators), or medically cleared and trained in the use of an alternative respiratory protection device (e.g., Powered Air-Purifying Respirator, PAPR) whenever respirators are required. (OSHA has a number of **respiratory training videosexternal icon.**)

- HCP will be educated, trained, and have practiced the appropriate use of PPE prior to caring for a symptomatic or exposed Resident, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

Implement Environmental Infection Control

- Dedicated medical equipment will be used for Resident care.

- All non-dedicated, non-disposable medical equipment used for Resident care must be cleaned and disinfected according to manufacturer's instructions and CDC guidelines.

- Ensure environmental cleaning and disinfection procedures are followed consistently and correctly.

- Routine cleaning and disinfection procedures (e.g., 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 COVID19, including those Resident-care areas in which aerosol-generating procedures are performed.
- Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID19. These products can be identified by the following claim:
  - **"[Bleach wipes**] has demonstrated effectiveness against viruses similar to COVID19 on hard non-porous surfaces. Therefore, this product can be used against COVID19 when used in accordance with the directions for use against [**Human Coronavirus** COVID-19] on hard, non-porous surfaces."
  - This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to health care facilities, physicians, nurses and public health officials, "1-800" consumer information services, social media sites and company websites (non-label related). Specific claims for "COVID19" will not appear on the product or master label.
  - See additional information about EPA-approved emerging viral pathogens claimsexternal icon.

- If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID19, products with label claims against human coronaviruses should be used according to label instructions.

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

Establish Reporting within Healthcare Facilities and to Public Health Authorities

- Key facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff will be promptly notified about known or suspected COVID19 Residents (i.e., PUI).

- The ICP will communicate and collaborate with public health authorities.

- The ICP will promptly notify state or local public health authorities of Residents with known or suspected COVID19 (i.e., PUI).

Adherence to Standard, Contact, and Airborne Precautions, Including the Use of Eye Protection

- Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting.

- Elements of Standard Precautions that apply to Residents with respiratory infections, including those caused by 2019-nCoV, are summarized in the table above.

- Attention should be paid to training on correct use, proper donning (putting on) and doffing (taking off), and disposal of any PPE.

- This document does not emphasize all aspects of Standard Precautions (e.g., injection safety) that are required for all Resident care; the full description is provided in the **Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings**.

- All HCP (see section 3 for measures for non-HCP visitors) who enter the room of a Resident with known or suspected COVID19(i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the following:

Resident Placement

Lincoln Park Health care does not Have AIIR rooms so we will not be able to care for theses type of residents. We will need to isolate them and prepare for them to be transferred out via the guidelines of the CDC and local and state health Department.

- Place a Resident with known or suspected COVID19(i.e., PUI) in an AIIR that has been constructed and maintained in accordance with current guidelines.
- AIIRs are single Resident rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a

high-efficiency particulate air (HEPA) filter before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.

- If an AIIR is not available, Residents who require hospitalization should be transferred as soon as is feasible to a facility where an AIIR is available. If the Resident does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the Resident and isolate him/her in an examination room with the door closed. Ideally, the Resident should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
- Once in an AIIR, the Resident's facemask may be removed. Limit transport and movement of the Resident outside of the AIIR to medically-essential purposes. When not in an AIIR (e.g., during transport or if an AIIR is not available), Residents should wear a facemask to contain secretions.
- Personnel entering the room should use PPE, including respiratory protection, as described below.
- Only essential personnel should enter the room.
- Facilities should consider caring for these Residents with dedicated HCP to minimize risk of transmission and exposure to other Residents and other HCP.
- Keep a log of all persons who care for and/or enter the rooms or care area of these Residents.
- Use dedicated or disposable noncritical Resident-care equipment (e.g., blood pressure cuffs). If equipment will be used for more than one Resident, clean and disinfect such equipment before use on another Resident according to manufacturer's instructions.
- HCP entering the room soon after a Resident vacates the room should use respiratory protection.
- Standard practice for pathogens spread by the airborne route is to restrict unprotected individuals, including HCP, from entering a vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles.
- CDC does not know how long COVID19 remains infectious in the air. In the interim, it is reasonable to apply a similar time period before entering the room without respiratory protection as used for pathogens spread by the airborne route (e.g., measles, tuberculosis).
- The room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

Hand Hygiene

- HCP should perform hand hygiene using ABHS before and after all Resident contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.
- Hand hygiene in healthcare settings also can be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS.
- Hand hygiene supplies are readily available in every care location.

Personal Protective Equipment

- HCP receive training on and demonstrate an understanding of:
    - When to use PPE; what PPE is necessary;
    - How to properly don, use, and doff PPE in a manner to prevent self-contamination;
    - How to properly dispose of or disinfect and maintain PPE; and
    - The limitations of PPE.
    - Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.
    - The facility uses the CDC procedure describing the recommended sequence for safely donning and doffing PPE.

- **Gloves**
  - Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the Resident room or care area. Change gloves if they become torn or heavily contaminated.
  - Remove and discard gloves when leaving the Resident room or care area, and immediately perform hand hygiene.

- **Gowns**
  - Put on a clean isolation gown upon entry into the Resident room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the Resident room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.

- **Respiratory Protection**
  - Use respiratory protection (i.e., a respirator) that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator before entry into the Resident room or care area.
  - Disposable respirators should be removed and discarded after exiting the Resident's room or care area and closing the door. Perform hand hygiene after discarding the respirator.
  - If reusable respirators (e.g., powered air purifying respirator/PAPR) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
  - Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard (29 CFR 1910.134external icon).
  - Staff should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.

- **Eye Protection**
  - Put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the Resident room or care area.
  - Remove eye protection before leaving the Resident room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
  - Disposable eye protection should be discarded after use.

Use Caution When Performing Aerosol-Generating Procedures

- Some procedures performed on COVID19 Residents could generate infectious aerosols. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible.

- If performed, these procedures should take place in an AIIR and personnel should use respiratory protection as described above. In addition:

- Limit the number of HCP present during the procedure to only those essential for Resident care and procedural support.

- Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

Diagnostic Respiratory Specimen Collection

- Collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) are likely to induce coughing or sneezing. Individuals in the room during the procedure should, ideally, be limited to the Resident and the healthcare provider obtaining the specimen.

- HCP collecting specimens for testing for COVID19from Residents with known or suspected COVID19(i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection.

- These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the Resident should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.

Duration of Isolation Precautions for PUIs and confirmed COVID19 Residents

- Until information is available regarding viral shedding after clinical improvement, discontinuation of isolation precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.

- Factors that should be considered include:
    - Presence of symptoms related to 2019-nCoV
    - Date symptoms resolved
    - Other conditions that would require specific precautions (e.g., tuberculosis, *Clostridioides difficile)*
    - Other laboratory information reflecting clinical status, alternatives to inResident isolation, such as the possibility of safe recovery at home.

  For additional information refer to the Interim Considerations for Disposition of Hospitalized Residents with COVID19Infection

CDC Guidance for HCP Exposure
Definitions Used in CDC Guidance

- ***Self-monitoring*** means HCP should monitor themselves for fever by taking their temperature twice a day and remain alert for respiratory symptoms (e.g., cough, shortness of breath, sore throat)*. Anyone on self-monitoring should be provided a plan for whom to contact if they develop fever or respiratory symptoms during the self-monitoring period to determine whether medical evaluation is needed.

- ***Active monitoring*** means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat)*. For HCP with *high-* or *medium-risk* exposures, CDC recommends this communication occurs at least once each day. The mode of communication can be determined by the state or local public health authority and may include telephone calls or any electronic or internet-based means of communication.

- For HCP, active monitoring can be delegated by the health department to the HCP's healthcare facility occupational health or infection control program, if both the health department and the facility are in

agreement. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

- ***Self-Monitoring with delegated supervision*** in a healthcare setting means HCP perform self-monitoring with oversight by their healthcare facility's occupational health or infection control program in coordination with the health department of jurisdiction, if both the health department and the facility are in agreement. Occupational health or infection control personnel should establish points of contact between the organization, the self-monitoring personnel, and the local or state health departments of authority in the location where self-monitoring personnel will be during the self-monitoring period. This communication should result in agreement on a plan for medical evaluation of personnel who develop fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat)* during the self-monitoring period. The plan should include instructions for notifying occupational health and the local public health authority, and transportation arrangements to a designated hospital, if medically necessary, with advance notice if fever or respiratory symptoms occur. The supervising organization should remain in contact with HCP through the self-monitoring period to oversee self-monitoring activities. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

- ***Close contact*** for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with 2019-nCoV infection for a prolonged period of time (such as caring for or visiting the Resident; or sitting within 6 feet of the Resident in a healthcare waiting area or room); or b) having unprotected direct contact with infectious secretions or excretions of the Resident (e.g., being coughed on, touching used tissues with a bare hand).

- 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), clinical symptoms of the Resident (e.g., coughing likely increases exposure risk) and whether the Resident was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment). It is not possible to define the duration of time that constitutes a prolonged exposure. However, until more is known about transmission risks, it would be reasonable to consider anything longer than a brief (e.g., less than 1 to 2 minutes) exposure as prolonged.

- Currently brief interactions are considered to be less likely to result in transmission; however, as described above, this is dependent on the clinical symptoms of the Resident and type of interaction (e.g., did the Resident cough directly into the face of the HCP). Information about this will be updated as more information becomes available. Risk stratification can be made in consultation with public health authorities. Examples of brief interactions include: briefly entering the Resident room without having direct contact with the Resident or their secretions/excretions, brief conversation at a triage desk with a Resident who was not wearing a facemask. See Table 1 for more detailed information.

- ***Healthcare Personnel:*** For the purposes of this document HCP refers to refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to Residents or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

Defining Exposure Risk Category

- While body fluids other than respiratory secretions have not been clearly implicated in transmission of 2019-nCoV, unprotected contact with other body fluids, including blood, stool, vomit, and urine, should also be considered as potentially putting HCP at risk of 2019-nCoV infection, until further data are available.

- When assigning risk, factors to consider include: the duration of exposure (e.g., longer exposure time likely increases exposure risk), clinical symptoms of the Resident (e.g., coughing likely increases exposure risk), whether the Resident was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment), whether an aerosol generating procedure was performed, and the type of PPE used by HCP. However, data on the risk of transmission of 2019-nCoV are currently incomplete and the precision of current risk assignment is limited. Table 1 describes possible scenarios that can be used to assist with risk assessment. These scenarios do not cover all potential exposure scenarios and should not replace an individual assessment of risk for the purpose of clinical decision making or individualized public health management. Any public health decisions that place restrictions on an individual's or group's movements or impose specific monitoring requirements should be based on an assessment of risk for the individual or group. Healthcare facilities, in consultation with public health authorities should use the concepts outlined in this guidance along with clinical judgement to assign risk and determine need for work restrictions.

- For this guidance *high-risk* exposures refer to HCP who performed or were present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on Residents with 2019-nCoV when the healthcare providers' eyes, nose, or mouth were not protected.

- *Medium-risk* exposures generally include HCP who had prolonged close contact with Residents with 2019-nCoV where HCP mucous membranes or hands were exposed to material potentially infectious with 2019-nCoV. These exposures could place the exposed HCP at risk of developing disease that is less than that described under *high-risk*

- Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with Residents infected with 2019-nCoV. However, HCP in this category are classified as having *low-risk* to account for any inconsistencies in use or adherence that could result in unrecognized exposures.

- HCP with no direct Resident contact and no entry into active Resident management areas who adhere to routine safety precautions are not considered to have a risk of exposure to 2019-nCoV (i.e., they have *no identifiable risk.*)

- *Currently the guidance is intended to apply to HCP with potential exposure in a healthcare setting to Residents with confirmed 2019-nCoV infection. However, HCP exposures will commonly involve a PUI who is awaiting testing. Implementation of the monitoring and work restrictions described in this guidance could be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. A record of HCP exposed to the PUI should still be maintained and HCP should be encouraged to perform self- monitoring while awaiting test results. If the results will be delayed more than 72 hours or the Resident is positive for 2019-nCoV then all monitoring and work restrictions described in this document should be followed.*

Table 1: Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Residents with 2019 Novel Coronavirus (2019-nCoV) Infection or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations

- ***The distinction between the high- and medium-risk exposures in this document is somewhat artificial as they both place HCP at risk for developing infection; therefore the recommendations for active monitoring and work restrictions are the same for these exposures. However, these risk categories were created to align with risk categories described in the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings, which outlines criteria for quarantine and travel restrictions specific to high-risk exposures. Refer to that Interim Guidance for information about the movement, public activity and travel restrictions that apply to the HCP included here.***
- *The highest risk exposure category that applies should be used to guide monitoring and work restrictions.*