Q&A Session from COVID-19: Infection Prevention and Control Strategies Webinar and Other Questions Submitted

The National Association for Home Care & Hospice (NAHC) has partnered with **Mary McGoldrick, MS, RN, CRNI®** to discuss ways you and your staff can continue to operate safely during the COVID-19 crisis.

Categories:

1. PERSONAL PROTECTIVE EQUIPMENT (PPE)
2. TRANSMISSION AND INFECTION CONTROL
3. OPERATIONS

Personal Protective Equipment (PPE)

PPE Q: Is there any recommendation for an alternative to gowns? We are very stretched for gowns and unable to get more for at least two weeks or more.

A: If isolation gowns are not available, the next option to consider would be "expired" isolation gowns, full coveralls, or plastic aprons with long sleeves to be use on a single-use basis. Others options to consider would be combinations of products (e.g., such as a full apron and adding arm sleeves).

Cloth gowns would be the next best alternative, and consideration could be given to leasing cloth gowns from a healthcare linen supplier or using homemade, long-sleeved cloth gowns on a single-use basis. The linen supplier would also be responsible for laundering the cloth gowns and delivering them to the office.

In home care, the use of cloth gowns could cause *numerous* logistical and potential infection control problems. A cloth gown would need to be removed after the home visit, temporarily stored in the vehicle (which is not best practice). The used gowns should not be stored overnight in the vehicle and should be taken to a designated drop- off location at the end of each work day, and if gowns were not provided in bulk, new, clean cloth gowns would need to be picked up for the next workday (and staff may not work close to that area). A drive-through process could be used for the pick-up and drop-off of gowns so that the field staff do not need to come into the office.

For in-home private duty cases or in-home continuous care for hospice patients, or in an ALF, a single use isolation gown can be worn continuously for an extended period of time (the entire shift). When the staff is going to care for more than one patient, such as in an ALF, the gown can only be worn continuously when the other patients are also COVID+. If the patient has another infectious illness, such as *C. diff*, the gown would need to be used on just that patient only and cannot be continuously worn.

The gown needs to be removed and never re-used if becomes damaged, contaminated with blood or body fluids, becomes wet or visibly dirty, or was used during an aerosol-generating procedure.

In home care, the re-use of any type of gown is not recommended. Removing the gown worn during the visit, folding it up and storing it, and then re-donning it in a manner that does not result in contamination to the staff's skin or clothing is a very high-risk procedure. All options need to be explored before reusing a gown, especially on an intermittent basis.

PPE Q: Recent guidance is to wear gloves with all patient encounters?

A: It is important that PPE be conserved whenever possible. When caring for a patient that is confirmed or suspected of having COVID-19, gloves must be worn during all patient encounters or when state-mandated. When caring for a patient who is not suspected or confirmed of having COVID-19, gloves should be conserved and worn only when there is a potential for exposure to a patient's blood and body fluids, when required by state regulations, or when required by a disinfectant manufacturer when disinfecting equipment after use. When gloves are not worn, it is important to remind staff to perform hand hygiene using the correct technique and when indicated, and to avoid touching their face, which may inadvertently result in the self-inoculation of SARS-COV-2.

PPE Q: The CDC recommends decontaminating N95 respirators. How do we decontaminate our N95s?

A: The CDC recommends that N95 respirators be decontaminated with vaporous hydrogen peroxide, ultraviolet germicidal irradiation, or moist heat. Unless a home care-organization is a department of or affiliated with a hospital that has the equipment available to decontaminate the N95 using one of these methods, the N95 respirator will have to be re-used without decontamination. Even home care organizations that have access to these decontamination methods may have many logistical challenges for collecting and redistributing the N95 respirators after decontamination. It's important to note that even when an N95 respirator is decontaminated, it is not considered sterile.

PPE Q: I'm assuming all this is for COVID-19 positive patients. For asymptomatic patients with no criteria what are the recommendations for face masks? Since patients may be carriers?

A: The transmission of SARS-CoV-2 from asymptomatic carriers is a risk to all, although the risk for transmission is highest when the patient is symptomatic. When with a patient *not* suspected or confirmed of having COVID-19, wear either a cloth face mask or a face mask (*preferred if not state-mandated* – as it protects the staff; whereas, a cloth face mask protects

the patient and others present). A cloth face mask worn under general conditions is not considered PPE.

In a hospice IPU:

- Consider implementing "extended use" mode (i.e., staff wear their face mask or respirator the entire shift when there are patients in the IPU that are confirmed or suspected of having COVID-19). Avoid switching back and forth throughout the shift (if possible) between a cloth face mask and a face mask or respirator. At the end of the shift, the cloth face mask can be applied before exiting the building.
- Offer a face mask (if available) or a cloth face mask to anyone age 2 and over entering the facility (if they are not wearing one), and instruct them to wear it (if tolerated) when in the facility.
- When the patient arrives at the facility, if they are alert and are not in respiratory distress, offer the patient a cloth face mask (which is to be removed upon entering the patient's room and put back on if leaving the room). A face mask should not be put on a patient entering the facility that is heavily sedated, unconscious, incapacitated or otherwise unable to remove a mask without assistance.

When not state-mandated that staff wear a face mask at all times, *if* the home care provider has sufficient quantities of face masks (not cloth masks), consider the use of universal face masking for all home health and hospice healthcare workers when they are in the presence of the patient, regardless of the care setting (i.e., in-home visit, nursing home, assisted living facility, etc.) to protect the safety of both the staff and the patients.

If the healthcare worker finds out at a future date that their patient was COVID-19 positive at the time of their home visit, unless they were performing a high-risk procedure, they would be classified as a low risk exposure and may continue to work (as long as the healthcare worker is not symptomatic) and do not need to be excluded from work for 14 days (which alleviates issues with staffing shortages).

PPE Q: Is it recommended that staff use a surgical mask daily when going into homes even if the patient says 'no' to the screening questions?

A: Either a face mask or a cloth face mask needs to be worn when going into the home. A (surgical) face mask would be preferred over a cloth face mask. Be aware that some states mandate that a face mask be worn at all times in a facility or in the home. Cross-reference the reply to the question above.

PPE Q: Is it your recommendation that all staff wear a mask during home visits regardless of the patient having symptoms of COVID?

A: To meet CDC updated recommendations, all staff need to wear either a face mask or a cloth face mask when going into the home. Be aware that some states mandate that a face mask be worn at all times in a facility or in the home.

PPE Q: We are in an area with no known positive patients. Should the visiting staff be wearing masks with every visit or is the mask only necessary if the patient has either symptoms or positive test?

A: Yes, to meet CDC updated recommendations, all staff need to wear either a face mask or a cloth face mask with every visit. Be aware that some states mandate that a face mask be worn at all times in a facility or in the home.

PPE Q: As you know, the CDC is advising the public to wear face coverings when it is likely that they will come within 6 feet of others. We believe that this advice will result in our home care patients being more demanding that our staff wear masks when rendering care. Are you in support of the public wearing face coverings in general or just in hot spots?

A: All staff need to wear either a face mask or a cloth face mask with every home visit. Be aware that some states mandate that a face mask be worn at all times in a facility or in the home. *If* the home care provider has sufficient quantities of face masks (not cloth masks), consider the use of universal face masking (not a cloth face mask) for all home health and hospice healthcare workers when they are in the presence of the patient, regardless of the care setting (i.e., in-home visit, nursing home, assisted living facility, etc.) to protect the safety of both the staff and the patients.

PPE Q: Is there a study that shows the homemade mask with a filter is effective?

A: Studies have been conducted using different materials to test their filtering ability against infectious aerosols. There are no studies that demonstrate that a homemade mask with a filter is effective against SAR-CoV-2 (as this is a new pathogen), but the studies have been conducted. A homemade face mask may include a filter material; however, if the homemade face mask does not fit well around the nose and mouth, it will not be effective regardless of the filtering material that may be inserted into the fabric of a homemade mask.

If a homemade cloth face mask is made for the staff's use as respiratory protection (when used as a last resort only for PPE), *consider* the one-time use of a filter inserted (e.g., vacuum cleaner HEPA type filter, or other filtration material) that can be cut to size to insert in the cloth face mask. Otherwise, for cloth face masks for general use, pre-wash and dry the material before cutting the pattern and sewing the material. This will pre-shrink the material and ensure a

better fit around the face and mouth after laundering (which is key for to it effectively protecting the staff). If there is a sufficient quantity of cloth masks available per person for general use (i.e., ideally one per home visit), the cloth portion can be laundered daily and the staff protected.

PPE Q: How do we wash a cloth face mask?

A: Even though the homemade face mask is not "official PPE" as defined by OSHA, staff should not launder "homemade" cloth face masks at home, whenever possible. For example, staff working in a hospice IPU may have the facility or linen launder cloth face masks worn during the shift. If other staff do need to launder cloth face masks at home, instruct the staff to wash the cloth face mask (and their uniform worn or a duffle bag used for home visits) in the hottest water for the longest wash cycle with detergent, preferably with chlorine or an oxidizing bleach added, and dried on high-heat for 50-minutes.

PPE Q: According to the CDC, COVID-19 is transmitted by droplets. The N95 is recommended / required for aerosol transmitted viruses. If no aerosol producing procedures are be performed, is a regular surgical mask acceptable / safe????

A: A regular face mask can be worn as a contingency plan when there are not sufficient quantities of N-95 respirators available, but N-95 respirators are always the first choice for respiratory protection when caring for a patient that is confirmed or suspected of having COVID-19. Otherwise, a cloth face mask should be worn.

PPE Q: After removing PPE where are nurses supposed to wash her hands? In pt's house? Isn't it putting herself at risk of contamination again?

A: After removing the PPE, the nurse would perform hand hygiene using an alcohol-based hand sanitizer (assuming that the hands are not wet or visibly soiled). If partial PPE is removed in the home, hand hygiene should be performed after removing the gloves and before exiting the home and again if there was any contact with the door knobs or other surfaces when exiting the home. If any or all remaining PPE is removed after exiting the home, hand hygiene is to be performed again after each type of PPE is performed (e.g., N95 respirator or face mask). If the PPE is properly removed (to prevent clothing contamination), when hand hygiene is performed using the correct hand hygiene technique, the SARS-CoV-2 virus would be inactivated from the surface of the hands and the risk of transfer from the hands would be temporarily eliminated until the hands touch another surface, and thus the importance of performing hand hygiene and not touching the face.

PPE Q: Paper bags are not available in any quantity in many parts of the country. Grocery stores do not provide them. And plastic bags you have to pay for by the each. Please address proper techniques when paper is not available.

A: Paper grocery and shopping bags are available of different sizes and prices based on the quantity purchased and can be purchased on-line. One large, reputable vendor to consider is Uline and purchase options can be explored at https://www.uline.com/BL_5504/Grocery-Bags and https://www.uline.com/BL_5505/Kraft-Paper-Shopping-Bags.

PPE Q: What was the name of the labels we can put on our sani cloths if we put them in baggies?

A: The sani-cloth wipes are sold in individual wipes and should be purchased for use in that manner, unless the manufacturer can no longer provide the individual wipes. Repackaging the wipes may also void any manufacturer responsibility for their product. If the sani wipes are going to be repackaged, they should be removed from the manufacturer's container and the wipes placed in a baggie, *just prior* to the home visit and placed in an appropriately labeled package. The organization should not repackage the equipment in bulk and distribute it to the staff to store in the office or in the staff's nursing bag. If the wipes will be repackaged for a home visit, place a completed Hazardous Materials Information System (HMIS) label on the outside of the package and discard any wipes not used in the home. When disinfecting equipment outside of the home (such as when disinfecting the eye protection for re-use), perform hand hygiene and enter the nursing bag to remove a disinfectant wipe from the manufacturer's container. If the wipes in the baggie remained in the bag (that is removed from the home) and never had contact with soiled gloves or the patient's environment, extra wipes from that baggie *only* could be used to disinfect the eye protection for re-use (on that home visit only and not saved for the next home visit). For additional information, refer to https://www.epa.gov/sites/production/files/2013-08/documents/fact_sheet_how_to_properly_label_a_cleaning_product_container1.pdf.

PPE Q: If someone has been fit tested and was unable to wear the mask due to fit issues, what then?

A: If someone was fit tested and could not wear the N95 respirator due to fit issues, they should be refit tested using another size, or another make and model of N95 respirator until they can pass a fit test and be relatively comfortable, and never assigned to care for a patient requiring an aerosol generating procedure. The N95 could be worn voluntarily as a face mask, and not as an N-95 respirator.

PPE Q: You mentioned doffing PPE outside of home however, I don't believe you mentioned when to don. Per QSO-20-18-HHA released March 10, it recommends donning outside of the home for known positive or suspected. What is your recommendation on this?

A: Both donning and doffing of PPE should be performed outside of the home. If the staff member is not able to, based on their judgment at the time of the home visit (due to weather, personal safety, etc.), minimally they should don respiratory protection (i.e., N95 respirator or face mask) before entering the home and put the rest of the PPE on just inside of the home. At the end of the home visit, if they are not able to remove all PPE outside, all PPE except for the respiratory protection can be removed inside the home and the respiratory protection (i.e., N95 respirator or face mask) removed after exiting the home. The cloth face mask worn when caring for a non-COVID positive patient should ideally be put on and removed outside of the home, but the cloth face mask is not technically PPE.

PPE Q: The State of Texas had an HHS webinar earlier this week that stated they wanted all clinicians to wear gloves at all visits at this time.
A: State regulations would need to be followed then. Note, this is not a current CDC recommendation.

PPE Q: Would you please discuss again the labeling of the disposal bag for the used PPE.

A: First check your state regulations to confirm whether COVID-19 waste from PPE would be required to be treated as medical waste (e.g., placed in a red bag) versus general household waste. If there are no state-mandated requirements, place the used PPE for final disposal in a bag of sufficient size for the staff to safely remove their PPE without having contact with the outside of the bag. The bag is not required to be labeled in any specific manner, unless the state mandates that the PPE be disposed of as medical waste.

PPE Q: I know that the vacuum cleaner bag with a homemade mask would be a last resort, but can you send us a link to the information on how those have been used? (Is the filter just placed inside of the mask or can it be cut, etc.)

If a homemade cloth face mask needs to be made for the staff's use (when used as a last resort when no other PPE is available for respiratory protection and not as a general cloth face mask), there are *numerous* websites and YouTube videos that have developed sewing patterns, and instructions. The CDC also released instructions for how to make a cloth face mask which can be viewed at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/DIY-cloth-face-covering-instructions.pdf.

After a pattern is selected, pre-wash and dry the material before cutting the pattern and sewing the material. This will pre-shrink the face mask material and ensure a better fit around the face and mouth after laundering (which is key to it effectively protecting the staff). Sew it with two layers and leave a side pocket with a Velcro closing to allow for a filter to be inserted and removed after a home visit.

The homemade cloth face mask should be used on a one-time basis (i.e., one per home visit), if possible (when used as a last resort when no other PPE is available for respiratory protection and not as a general cloth face mask). The filter material can be removed and disposed of as household waste outside of the home and the cloth face mask placed in a separate bag (as the sole item in the bag) for laundering and re-used after laundering. Even though the homemade face mask is not "official PPE" as defined by OSHA, staff should not be responsible for laundering the cloth face mask at home. Arrangements for laundering would need to be made on an agency basis.

In home care, the use of cloth face masks (or cloth gowns) could cause *numerous* logistical and potential infection control problems (when used as a last resort when no other PPE is available for respiratory protection and not as a general cloth face mask). A cloth face mask would need to be removed after the home visit, temporarily stored in the vehicle (which is not best practice). At the end of a work day, there would be numerous potentially contaminated cloth face masks that should not be stored overnight in the vehicle, should be taken to a designated drop off-location at the end of each work day, and if cloth products were not distributed in bilk, new, clean cloth face masks would need to be picked up for the next work day (and staff may not work close to that area). A drive-through process could be used for the pick-up and drop-off of cloth face masks so that the field staff do not need to come into the office.

PPE Q: Is it better to reuse the N95 or use new reg surgical mask?

A: Using a new face mask is the best choice because re-using any PPE is a high-risk procedure. If an aerosol-generating procedure needs to be conducted, an N95 respirator needs to be worn, even if reused (assuming it has been properly stored) and safe for re-use.

PPE Q: If KN95 masks do not require a fit test and are acceptable for use, would it be best to use the KN95 mask over an unfitted N95 mask?

A: KN95 respirators do require fit testing. On April 3, 2020, the FDA approved, under the emergency use authorization (EUA), the use of non-NIOSH-approved N95 respirators. The KN95 respirator, which is made in China, can be used by home care and hospice staff when:

1. The organization is using the KN95 consist with the CDC's list of respirator alternatives located: https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Frespirators-strategy%2Fcrisis-alternate-strategies.html; *and*
2. The KN95 make and model is listed in Appendix A of the "FDA authorized imported Non-NIOSH Approved Respirators Manufactured in China." The list will be updated ongoing and is located at: https://www.fda.gov/media/136663/download; *and*
3. The OSHA requirements are met for having a respiratory protection program in place and that a staff member undergo a medical evaluation and fit test for the KN95 make and model that will be used by the individual.

The KN95 respirator can be used in lieu of the N95 respirator when the above criteria are met and should not be worn over an unfitted N95 respirator, as the KN95 will not make a proper seal on the face to protect the home care and hospice staff member. The use of a fit-tested N95 respirator with a tight seal on the face is the first choice.

PPE Q: We do have some limited supplies of N95 respirator masks, but have been unable to get a fit test kit for them. Do you recommend we still use the N95 masks if we are unable to fit test?

A: An N95 respirator should only be worn by staff after fit testing. An N95 that has not been fit tested cannot be worn as an N95 respirator. When supplies are limited, on a voluntary basis, the N95 could be worn by staff as a face mask (when they are not available).

In order to maximize the benefit of having N95 respirators:

1. Establish a core group of staff that have been fit tested and only allow them to visit patients confirmed or suspected of having COVID-19; and
2. Contract with a local hospital's occupational health department, health department, or other occupational health vendor to perform fit testing using their equipment (which is acceptable); and
3. Avoid allowing the staff to wear non-fit tested N95s as face masks, whenever possible, as it can cause confusion for staff.
4. If N95s cannot be obtained under any circumstances, routinely use face masks for respiratory protection when the staff do not participate directly in or are not present during an aerosol-generating procedure, such as CPR, nebulized medication administration, open suctioning, tracheostomy changes, etc., or enter the home of a patient who had an aerosol generating procedure performed within three hours. That will help protect your staff until you are able to get N95 respirators and get the staff fit tested.

PPE Q: In preparation for the need to have all staff wearing masks, we are working on how to provide masks to our staff without running out, which calls the question of safe re-use of masks. We have about 30 home health clinicians and about 90 private duty caregivers and nurses. As you know in home care, on any given day, clinicians and caregivers visit multiple patients in multiple locations, including facilities. Assuming we are speaking of completely asymptomatic patients, our question is whether we should attempt to provide one mask per patient for multiple uses with that patient only, or perhaps one mask per location if the clinician is seeing multiple patients in one facility.

A: For staff that work in a facility, one face mask per clinician per day, with the option of continuing re-use of the same face mask is preferred. The face mask can continue to be used as long as it does not become heavily soiled with respirations, become soiled or damaged. Preferable, the face mask should be disposed of at the end of the day. The face mask should remain properly "planted" on the face for the entire shift and only removed (in full and not just dropped below the chin when speaking or eating) when necessary. The front of the face mask is considered contaminated and if the staff touch the front of the face mask by mistake, they need to immediately perform hand hygiene. When a break is needed or at the end of the shift, perform hand hygiene, carefully remove the face mask by the ties or ear loops, fold the face mask inward with the contaminated sides touching each other, and carefully place in a paper bag. Store the bag until their next shift or patient encounter in a secure location (e.g., the trunk of their vehicle or secure location in a facility). For staff conducting intermittent visits, the face mask can be reused throughout the day when carefully removed and properly stored in between home visits, and preferable disposed of at the end of the day.

PPE Q: If the clinician has to re-use one mask per patient, there could be a lot of masks to keep track of, since they may see 10 or more patients in a given week. We would instruct them to put each mask in its own paper bag between visits and then reuse the mask on the next visit with that patient. It seems somewhat cumbersome and a fair amount of work.

A: One face mask can be reused for multiple home visits when carefully removed and properly stored in between home visits. I agree with the comment about there being a lot of masks to keep track of!

PPE Q: Many of our caregivers are working long shifts. Is it allowable to wear the same mask for a 12-hour shift and take it off to eat?

A: Yes, as long as it does not become heavily soiled with respirations, become soiled or damaged. The face mask should remain properly "planted" on the face for the entire shift and only removed (in full and not just dropped below the chin when eating or talking) when necessary. When a break is needed to eat or at the end of the shift, perform hand hygiene,

carefully remove the face mask by the ties or ear loops, fold the face mask inward with the contaminated sides touching each other, and carefully place in a paper bag with the ear loops or ties at the top. Preferably dispose of the face mask at the end of the shift or store the paper bag until their next shift in a secure location (e.g., the trunk of their vehicle). If it is stored in the home, there is no way to ensure the safety of the face mask or respirator (i.e., as it is removed from the home by someone and then there is no PPE in the home and cannot be donned outside of the home or could be worn by someone else in the home).

PPE Q: Is there any scenario in which you feel we would NOT have to change out masks between patients?

A: The respiratory equipment should be changed or re-used after each patient encounter in the home or when implementing extended used during private duty, or continuous care in the home or when providing facility-based hospice care. An N95 respirator can never be re-used when worn during an aerosol generating procedure.

PPE Q: There has also been some recent discussion of allowing 72 hours between uses of a given mask so that there will be sufficient time for the virus to be inactivated. Do you believe this is essential?

A: Yes, that would be the preferred approach, *IF*, you had sufficient quantities of N95 respirators or face masks available for all staff, or you could prioritize distribution to those staff that see patients that are suspected or confirmed of having COVID-19. By issuing multiple face masks or N95 respirators, this allows for the rotating of inventory and allow the N95 or face mask not to be worn for several days, thus giving the filtering material time to dry out (when stored in a paper bag) and the virus inactivated.

PPE Q: We would only consider re-use when there has not been a COVID-19 positive test and the patient is not symptomatic of an upper respiratory condition.

A: In that scenario, that would be very reasonable.

PPE Q: Do you have a recommended PPE removal procedure outside of the patient's home to reduce contamination of a clinician's vehicle or other equipment?

A: Yes, and that will be provided in an update or posted in a separate document.

PPE Q: Do you agree that we should have the pt./family put on a mask if they are identified as being a potential risk for the coronavirus while we are in the home.

A: Even when the staff are wearing a face mask, the patient is not required to wear one. If the patient is symptomatic, a request could be made to put on a cloth face mask (if available), especially when the staff is only wearing a cloth face mask. It is our professional responsibility to wear the appropriate personal protective equipment to protect the patient and caregiver when a patient is confirmed or suspected of being infected with the coronavirus. If a person in the home is suspected or confirmed of being infected with coronavirus, he/she can be asked to self-isolate until the staff leave the home, or maintain a social distance of 6 feet at all times.

PPE Q: If a clinician uses their mask all day in the home setting and stores in a paper bag for disposal at end of the day, where should the bags be disposed of?

A; When it's time to dispose of the bag used to store either a face mask or an N95 respirator, the bag (and the face mask or respirator) can be disposed of as regular household waste and not "red bag" medical waste, unless required by state regulations. The bag can be disposed of in the patient's trash outside of the home at their last home visit (if you have ample supplies of paper bags and respiratory protection). If the supplies dwindle significantly, you may need to reuse the mask for longer than one day or perhaps only use the mask more than one day on non-Covid+ or suspected patients.

TRANSMISSION AND INFECTION CONTROL

Transmission/Infection Control Q: I saw some information from the DME world that staff should not visit a patient up to three hours after a nebulizer treatment was given. Can you validate?

A: A nebulizer treatment is considered an aerosol-generating procedure. The staff can visit the patient at any time; however, anyone present during the procedure or in the room within three hours of where the procedure was performed needs to wear an N-95 respirator, eye protection, gown, and gloves. The reason for the time frame is based on a study that identified the SARS-COV-2 virus can remain in aerosols for up to three hours. The source of this data is: van Doremalen, N., Bushmaker, T., Morris, D. H., Holbrook, M. G., Gamble, A., Williamson, B. N., ... & Lloyd-Smith, J. O. (2020). Aerosol and surface stability of SARS-CoV-2 as compared with SARS-CoV-1. *New England Journal of Medicine*.

Transmission/Infection Control Q: Concern that staff unknowingly become vectors of COVID-19 during the incubation period if they see a patient diagnosed with COVID-19, and then there is an increased risk of spread to the next patient, our office staff, a facility, etc. - exacerbating the problem.

A: The staff could serve as a vector of COVID-19 during the incubation period and be an asymptomatic carrier and put others at risk. However, when the staff wear a face mask or cloth face mask during all patient encounters, effectively perform hand hygiene using the correct technique and when indicated, stay more than six feet away from the patient in the home (if possible), and properly manage all equipment and supplies brought into the home or patient's care area, the risk is *significantly* reduced. Thus, the need to make sure that staff are properly trained and have their competency assessed in infection prevention and control strategies.

Transmission/Infection Control Q: Is there any guidance if staff should continue to obtain patient/cg signatures on iPads, etc. for verification of visit for patient visits not positive for COVID or PUI?

A: A patient's signature can be obtained safely via an electronic method when a waiver has not been granted. If a waiver has been granted, do not obtain the patient's signature electronically for verification of visits. Although a patient's signature may still be required for other documents, such as consent for care, acknowledgement of receipt of patient rights, financial liability, etc.

A patient's signature can be obtained using an electronic device. To conduct this safely, disinfect the surfaces of the electronic equipment with a disinfectant from epa.gov "List N." As an additional safety measure, offer the patient an alcohol-based hand hygiene product and request that they perform hand hygiene prior to contact with the electronic device. Apply a sufficient quantity of product on the patient's hands and require that they rub all surfaces of the hands until dry. If the hands are dry in less than 15 seconds, use a higher quantity of alcohol and repeat the process. Instruct the patient not to touch anything after performing hand hygiene until the signature process has been completed. Then after capturing the patient's signature electronically, disinfect the electronic device again with a new disinfectant wipe from epa.gov "List N" for the required contact time and place the electronic equipment on a *new* surface barrier or place it directly in the bag that will be used to remove items from the home. This procedure will ensure that the virus is not transferred from the patient's skin or droplets to the electronic device. It is key that all surfaces of the electronic device be disinfected properly after the signature using the contact time specified at epa.gov for the disinfectant product used.

A patient's signature can also be obtained on paper using a "no-touch technique"; however, there is a risk for respiratory droplets "landing" on the paper (as the patient will be in such close proximity to the document being signed). The *ideal* scenario would permit the patient to sign the document and scan the signed document using an electronic device in the home and leave the paper in the home. Otherwise, although not ideal, when a signature on paper must be obtained, request that the patient perform hand hygiene and not have any contact with the

paper when signing and only touch the pen used to obtain their signature. A pen provided by the home care organization should be left in the home, or the patient's pen may be used. After obtaining the patient's signature, place the paper directly in the separate storage bag and do not allow the paper to have contact with any surfaces in the home. Consideration could be given to letting the paper in the bag "sit" for several days under the assumption that the virus would be inactivated and safe for handling. Other options should be explored.

Transmission/Infection control Q: My agency is telling staff that 45min post nebulizer treatment is adequate for initiating a patient visit in the home, you say 2 to 3 hours. Are we safe?

A: Staff may enter the home at any time post-nebulizer treatment when they are wearing an N95 respirator, eye protection, gown, and gloves. If an N95 respirator is not available for the staff's use, then waiting to initiate the visit would be reasonable.

The time frame to enter an area after a nebulizer treatment was performed is based on where the nebulizer treatment was performed. If the treatment was performed in a facility, 45 minutes may be the correct time. The time frame is determined by the number of air exchanges per hour. The lower the frequency of air exchanges, the longer the period of time. The engineers in a facility providing inpatient or residential care can calculate the time and let you know. The CDC has provided guidance for facilities and it's located at: https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1
If the nebulizer treatment was performed in the home setting, the settings for home ventilation cannot be validated and some patients may not have heat or air conditioning on, depending on the time of the year. Therefore, the extended timeframe for safety of entering the home after a nebulizer treatment, or any aerosol generating procedure, is based on the study conducted by N van Doremalen, *et al*. (2020). Aerosol and surface stability of HCoV-19 (SARS-CoV-2) compared to SARS-CoV-1. *The New England Journal of Medicine,* where the scientists determined that the SAR-CoV-2 virus may remain in aerosols for up to three hours.

Transmission/Infection Control Q: What's recommended to clean the Pulse oximeter if used with possible suspected or positive COVID patient?

A: When the pulse oximeter's manufacturer's instructions for use specifically include a brand or type of disinfectant (e.g., alcohol) to be used, the MIFUs need to be followed. If the MIFUs are not specific (which most are not), then any disinfectant listed on epa.gov "List N" can be used for the EPA's-recommended contact time. Chemicals can potentially damage the sensor plate and decrease the life expectancy of the pulse oximeter, but the risk is greater of not to properly cleaning and disinfecting the pulse oximeter in between patient use.

Transmission/Infection control Q: Would you please repeat what you mentioned about disinfecting medical equipment? Alcohol wipes are not EPA-approved for disinfecting medical equipment, correct?

A: The alcohol prep pad commonly used by staff during home visits to disinfect their vital sign equipment is commonly registered by the FDA (for use on the skin as an antiseptic) and is not an EPA-registered disinfectant. If the packaging on the alcohol wipes contain an EPA-registration number, it can be used, when the registration number is confirmed to be on the EPA's website in List N. Alcohol is a disinfectant and a common active ingredient in disinfectants. However, only an EPA-registered disinfectant should be used to disinfect medical equipment and not a skin antiseptic. At this time, a disinfectant should only be used on medical equipment if it is listed on epa.gov "List N."

Transmission/Infection control Q: What about using thermometer covers for the oral thermometer?

A: Thermometer covers placed over a small digital thermometer (not the large portable Welch Allyn thermometers commonly used during inpatient care) contain microscopic holes where the respiratory droplets from a patient with COVID-19 can be deposited. An oral thermometer cover could be used; however, it would need to be very carefully removed without contaminating the gloves and properly disinfected after use. The thermometer would need to be disinfected for the required contact time with a disinfectant listed on epa.gov "List N". It's also important to check the manufacturer's instructions for use as many disinfectants are not to be used on equipment that have contact with a patient's mucous membranes, such as an oral thermometer.

Whenever possible, taking the patient's temperature using an oral thermometer is not suggested during this time of ongoing COVID-19 transmission. The best choice is to use the patient's thermometer in the home or use a thermometer that uses alternative methods (e.g., temporal thermometer).

Transmission/Infection control Q: How far back (days) should we backtrack to advise and monitor pts who staff may have exposed before they themselves became ill?

A: Once the home care organization becomes aware and can confirm that a staff member was COVID-19 positive and/or symptomatic, the patients that the staff made a home visit to the two days prior to before becoming symptomatic, would potentially be at risk. One factor to consider is whether the staff was wearing any personal protective equipment at the time of exposure, especially respiratory protection. A list of patients can be developed and the date of the last contact with the staff determined to determine their future days at risk. Otherwise, the

patient(s) and other at-risk individuals present in the home at the time of the home visit should be advised to stay at home for 14 days (if they are physically able to leave the home) after their last contact with the staff member, self-monitor their health, practice social distancing, perform frequent hand hygiene, and consider wearing a cloth face mask to protect the health of others if/when leaving the home.

Transmission/Infection control Q: Is your screen on page 29 (about staff exposure) applicable for only known COVID patients or also PUIs?

Yes, it is applicable for COVID-19 patients and PUIs only.

Transmission/Infection Control Q: When cleaning equipment using a spray with positive COVID-19 patients does that aerosolize the virus and would a regular loop mask be safe?

When cleaning equipment using a spray disinfectant, first you would need to check the manufacturer's instructions for use to determine if they have guidance for product application, such as how to apply the spray and how far from the surface the disinfectant should be sprayed. If not, at this time, to reduce the risk for aerosolization, spray the disinfectant on a disposable paper towel, and then wipe all surfaces of the item being disinfected and keep the surfaces wet for the recommended contact time as listed on epa.gov for the disinfectant being applied. Many disinfectants are single cleaners and disinfectants. Just be aware that before disinfecting a surface, it may need to be cleaned first as a disinfectant can only be effective on a clean surface.

A regular face mask with ear loops would be acceptable to wear when caring for a patient that is suspected or confirmed of having COVID-19 when N95 respirators are not available and no aerosol generating procedures are being performed. Be aware that the front of the mask is considered contaminated and should not be touched and only removed by the ear loops.

Transmission/Infection control Q: If both the caregiver and the client were wearing a surgical face mask during visits, would it be safe to say that in the event that the client were found COVID positive the exposure to the caregiver would be considered low risk?

A: Yes, if both the client and caregiver were wearing masks at the time of the home visit, the risk to the caregiver would be considered low.

Transmission /Infection control Q: Can we use hydrogen peroxide to help with disinfecting items?

A: A product that contains hydrogen peroxide as an active ingredient can be used to disinfect hard, non-porous items as long as its EPA registration number is listed at: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

Transmission/Infection control Q: What can you use to clean the blood pressure cuff because it is made of cloth.

A: A traditional blood pressure cuff made of cloth can only be sanitized and not disinfected. At this time when the risk of transmission of COVID-19 is higher, it is recommended that a disposable blood pressure cuff and stethoscope be used on a patient who is suspected or confirmed of having COVID-19. If disposables are not available, a blood pressure cuff and stethoscope can be brought into the home and remain there until the time of discharge, and either be given to the patient or removed from the home and reprocessed. For other non-COVID-19 patients, it is still suggested that a disinfectant listed at https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 be used to clean, sanitize, and disinfect any equipment or supplies brought into the home.

Transmission/Infection control Q: What type of barrier would you suggest between equipment and surface? Paper towel from client's home or something the agency brings in?

A: The agency should bring a surface barrier into the home, as not all patients may have paper towels, especially now due to shortages and purchase limitations. The ideal surface barrier material would be a water-resistant material used on a one-time basis and discarded as household waste in the home. Disposable, one-time use surface barrier materials may include, but not be limited to: parchment paper sheets, wax paper, plastic bag, cafeteria tray liner, sheet pan liner, waterproof changing table liner, disposable pads (Chux), industrial paper sheets, or poly-backed towels. Surface barrier materials of newspaper, paper towels or paper hand drying material should be avoided, if possible, but could be used on a clean dry surface on a single-use basis.

OPERATIONS

Operations Q: Could you share regarding what agencies are doing with office staff, support, administrative, etc., i.e., are they working remotely vs. in the office every day? Any recommendations on this?

A: The organization's response to COVID-19 from an in-office staff perspective varies by the size of the organization and the local community's transmission rates. In areas that are "hot spots," some offices are closed and all staff are working remotely when possible. When staff are still working in the office, consider the following suggestions:

1. After the staff open the front door to enter the office, require all staff to perform hand hygiene using an alcohol-based hand sanitizer, keep their cloth face mask (as recommended by the CDC) on until they get to their work location, and proceed directly to where they sit to work. Once they arrive at their work location, they can remove the cloth face mask.
2. After the office has opened at its scheduled opening time, keep the door closed and locked. Post a sign for guests or delivery vendors to call the office and speak with the receptionist. Limit/restrictor visitors to essential needs only (e.g., repair office equipment), and have vendors leave deliveries just inside the office door. If a vendor needs to access the office, request that he/she perform hand hygiene and wear a cloth face mask.
3. Relocate desks or temporarily move them to another in-office location to work to maintain a 6-foot separation.
4. Limit in-office movement and do not conduct in-person face-to-face meetings. When in-office movement is required to meet essential needs (e.g., using the restroom or getting a refreshment), request that staff perform hand hygiene and don a cloth face mask prior to leaving their in-office work area.
5. Require that staff maintain a social distance at all times in the office (e.g., when using office equipment [e.g., copy machines], going to a community room to get coffee or put their lunch in a refrigerator).
6. Require staff to eat at their desks, unless a multi-purpose room it is large enough to maintain a 6-foot separation.
7. Before accessing medical supplies in a storage area, perform hand hygiene before entering the area (and continue to wear a cloth face mask).
8. Establish a routine, in-office cleaning and disinfecting schedule, and assign one person to conduct this activity. Use an EPA-registered disinfectant from epa.gov "List N" and frequently (e.g., before opening, after closing, and hourly when open – depending on the number of staff in the office, as this could be less frequent) disinfect all high-touch surfaces (e.g., all door knobs, light switches, surfaces on all in-office equipment, including vending machines buttons, coffee pot handles, in-office restroom surfaces, etc.) for the recommended contact time. Suggest that each person disinfect his/her electronic equipment, peripherals, and work-space area minimally before work and at the end of the day, and try to avoid touching his/her face throughout the work day.
9. Change from a cloth face mask to a medical-grade face mask if any employees have been identified to be suspected or confirmed of having COVID-19.

Operations Q: Is compression-only CPR acceptable for patients with confirmed or suspected COVID-19?

A: The conventional method of having a healthcare worker who is certified in basic life support (BLS) perform cardiopulmonary resuscitation (CPR) with rescue breaths could be modified at this time. Performing compression-only CPR would reduce, but not eliminate the risks to the staff member when performing chest compressions. An organization also has the option to not perform CPR and call 911, if applicable. Any CPR policy changes need to be approved by the appropriate committees, if any, and the governing body, and the staff and patients be informed of any modified CPR policies. More information about CPR options is available at: https://eccguidelines.heart.org/circulation/cpr-ecc-guidelines/part-5-adult-basic-life-support-and-cardiopulmonary-resuscitation-quality/?strue=1&id=9.

Operations Q: We are a border city to Mexico and we have a clinician that had surgery in February and went back for follow up appointment after March 6, should this clinician self-quarantine?

A: The question did not specify the date that the clinician returned to the United Sates, therefore, a general answer is provided. As of April 3, 2020, anyone entering the US from another country is advised to stay at home, not go to work for 14 days after their return to the US, self-monitor his/her health, practice social distancing, and consider wearing a cloth face mask when/if leaving the home to protect the health of others.

Operations Q: A staff member tested positive for COVID, was removed from work and sent home as soon as symptoms started six days ago. Do we need to notify all patients that a staff member was treated and how long from before symptoms developed? Thank you

A: The patients should be informed that during a specific time frame they were cared for by a nurse that subsequently tested positive for COVID-19. Because of their potential exposure, they should stay at home and not go outside of the home for 14 days (after their estimated last date of exposure – i.e., last home visit), self-monitor their health, practice social distancing, perform frequent hand hygiene and consider wearing a cloth face mask if he/she needs to leave the home (to protect the health of others).

The other fact to consider is whether the staff member was wearing any PPE at the time of the home visit, especially the use of a face mask or N95. If the staff member was wearing a face mask or respirator, their risk of transmission would be low, but there is still a risk and the patients should be made aware.