



The following Recommended Operational Protocols are the result of a collaborative effort among several of the leading providers in the home health and home care industries to help providers of all types and sizes respond to the COVID-19 crisis in a responsible way that protects the vulnerable patients and clients they serve and protects the fearless direct care workers who risk their own safety and the safety of their families to provide essential services. A list of those contributors is available at the end of this document. Each agency must make a decision about its best practices based on the information available to it and the circumstances it faces in its area. There is no obligation or expectation that any one agency will follow all of these Recommended Operational Protocols. Please note this document may evolve as new developments inform our understanding of this novel disease, governmental and non-governmental agencies provide additional guidance and information about how it spreads and the best ways to combat it. Please pay attention to the version date in the footer and independently review the source guidance. These protocols are not a substitute for experienced legal counsel. For use in practice, it is highly recommended that experienced counsel assist with development of protocols for your agency pursuant to the circumstances of each specific employer and factual situation.

RECOMMENDED OPERATIONAL PROTOCOLS

AGENCY MANAGEMENT ACTION STEPS

- Keep apprised of current guidance (the agency can sign up for automatic email updates from many governmental agencies)
 - Regularly visit the Centers for Disease Control and Prevention (CDC) website
 - Regularly visit the Occupational Safety and Health Administration (OSHA) website
 - Regularly visit the state and local health department websites
- Provide updates to staff as the situation changes
- Provide training to staff and document this activity on the topics of:
 - Hand hygiene
 - Infection prevention and control practices
 - Use of personal protective equipment (PPE)
 - Infectious or communicable diseases
- Screen clients or patients **and other household members** for COVID-19-like illness
 - **Minimum**: in advance and by phone if possible
 - **Better**: by phone immediately before a visit (if community spread is ongoing in the area and the care is not 24 hours a day)
 - **Better**: communicate with the local health department where the client or patient resides to determine if any prospective clients or patients are under mandatory quarantine or

precautionary quarantine for possible COVID-19 infection before providing services to a new client or patient

- Maintain a written record of screening in patient or client files
- Develop plans for:
 - Maintaining PPE levels during crisis supply periods – strive for multiple supplier sources
 - Advising and referring direct care workers for medical attention when they exhibit signs or symptoms consistent with COVID_19, such as a fever or chills, cough, shortness of breath/difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, or nausea or vomiting, diarrhea
 - Continuing client or patient care should a large proportion of staff become sick or need to be absent for other COVID-19-related reasons, or there is an unexpected influx of clients due to COVID-19-related reasons
 - Addressing the emotional health of your direct care workers
 - Addressing hiring, orientation and training in a virtual environment
- Develop/update/maintain the following policies:
 - Addressing how the Agency will respond to an employee with a communicable disease (with reference to COVID-19, as well as others)
 - Care and management of a patient or client with a communicable disease
 - Emergency preparedness plan (and/or emergency management plan)
 - Infection prevention and control policies
 - Telecommuting policy for non-direct care staff
 - Families First Coronavirus Response Act (FFCRA) compliant policies, to the extent your agency is or may be covered

AGENCY COMMUNICATIONS TO CLIENTS OR PATIENTS

- The agency cares about them and will be monitoring them and the direct care workers
- The agency will be using enhanced infection control protocols (to the extent possible)
 - Highlight staff training
 - Discuss screening of direct care workers and patients or clients

- The agency is tracking the latest developments on COVID-19 to remain current with CDC and health department guidelines
 - Provide information from the CDC on [prevention](#), [social distancing](#) and [cloth face covers](#)
- Review the agency's emergency preparedness plan and reiterate that home is the safest place
- The agency will continue to communicate to the clients or patients and direct care workers as its plans or operations change

AGENCY SCREENING OF CLIENTS

- When screening a client or patient, the agency should ask: "Does anyone in the residence currently, or who has been in the residence in the past seven (7) days, have new onset of fever or chills, cough, shortness of breath/difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea that either cannot be attributed to an underlying or previously recognized condition or a worsening of an underlying or previously recognized condition (e.g., asthma, emphysema)?"
 - If NO – COVID-19 is not likely a risk
 - There is no need to cancel or postpone the visit
 - If client or patient reports other illness, manage as per the agency's usual protocols
 - Be aware of the risk for pre-symptomatic and asymptomatic transmission by the patient and others in the home
 - If YES – Someone in the residence may have COVID-19 and precautions outlined in the below section titled: "Response to suspected COVID-19 in a patient/client home"
- If the answer to the above question is NO, but the client or patient resides in a state that has mandated quarantine or isolation restrictions on certain travelers, the agency should also ask: "In the past 14 days, has anyone in the residence traveled to a state determined by our state government to have moderate to substantial community transmission or traveled internationally?"
 - If NO, then there is no need to cancel or postpone the visit
 - If YES, consider the precautions outlined in the below section titled: "Response to suspected COVID-19 in a patient/client home"

PATIENT/CLIENT TRAINING AND INSTRUCTION

- **Minimum:** Encourage clients and patients to maintain good hygiene habits, including:
 - Frequent handwashing (as noted below) or use of an alcohol-based hand sanitizer
 - Covering coughs and sneezes with a tissue or sleeve (not hands)

- If the client is suspected to have, or has been confirmed to have, COVID-19, use tissue when coughing or sneezing and place tissues immediately in a bag for disposal in regular trash and perform hand hygiene
- Avoiding touching the eyes, nose and mouth with unwashed hands
- Request the patient and others in the home wear a cloth face covering when within 6 feet of the caregiver
- **Better:** If available, the client or patient should be encouraged to provide (at client's or patient's expense) a portable High-Efficiency Particulate Air ("HEPA") filtration system for use in the client's or patient's room if someone with a possible or confirmed case of COVID-19 is in the home
- One-to-one ratio between direct care worker and the client or patient in the home should be maintained to the extent possible. When not possible:
 - Clients and patients should be encouraged to post a notice on their home's door asking that anyone entering do so only if:
 - They do not feel sick, and
 - They have not been in close contact (within six feet for 15 minutes or more) with anyone who is suspected to have, or has been diagnosed with, COVID-19
 - The notice also should encourage proper hand hygiene and require the wearing of a cloth face covering for anyone entering the home. They should also stay six feet away from the client or patient if possible
 - Request the patient and others in the home wear a face mask when within 6 feet of the caregiver.

DIRECT CARE WORKER COMMUNICATIONS/TRAINING

- Notify direct care workers that they may not continue to work while symptomatic, because they risk causing the continued spread of COVID-19
- Train on standard and transmission-based precautions. Standard precautions include but are not limited to hand hygiene, as follows:
 - Perform hand hygiene by washing the hands with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer (at least 60% alcohol), which should occur at a minimum:
 - When you arrive at a client's home
 - Before and after patient or client contact
 - Before and after handling food
 - After contact with the patient's or client's immediate environment

- After contact with blood, bodily fluids and other potentially infectious materials, or contaminated surfaces
- When soiled
- Before and after putting on and taking off PPE, including, but not limited to, gloves and masks
- Have tissues and hand sanitizer available
- Cover coughs and sneezes with a tissue or sleeve (not your hands)
- Avoid touching your eyes, nose and mouth with unwashed hands
- Explain when and how direct care workers should clean and disinfect equipment and supplies, including electronic equipment, high touch surfaces in the patient's or client's care area with a U.S. Environmental Protection Agency ("EPA") [registered disinfectant](#) with a label claim of effectiveness against human coronavirus or emerging viral pathogens for the EPA's recommended contact time
 - High touch surfaces in the patient's immediate care area may include: television remotes, doorknobs, light switches, bathroom fixtures, phones, keyboards, remotes, tablets, and bedside tables
 - Wear gloves when cleaning to prevent exposure to the chemicals in the disinfectant
 - Do not mix chemicals
 - Follow the cleaning product's label instructions. If the manufacturer's instructions are not specific, then any disinfectant listed on the EPA's website (in List N) can be used for the EPA's recommended contact time. If a product from List N is not available, a disinfectant may be used if the product label states that it is effective against coronaviruses. Chemicals can potentially damage the electronics being cleaned, but the risk is greater of not properly cleaning and disinfecting the device, particularly if it will be used by multiple clients or patients. Dry surfaces thoroughly.
 - For electronics, consider putting a wipeable cover on the item
- Train on proper donning and doffing PPE, with follow up demonstrations
- Review emergency preparedness plans (and/or emergency management plans) with **all** staff
- Remind **all** staff about applicable company and statutory sick leave policies (including leave available under the FFCRA, if applicable)

DIRECT CARE WORKER ACTION STEPS

- Monitor personal health daily for COVID-19 symptoms (e.g., new onset of fever or chills, cough, shortness of breath/difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea)
- Temperature checks and self-assessment of COVID-19 symptoms:
 - **Minimum:** Self-assess for COVID-19 symptoms and check personal temperature before the workday begins at either the office or before seeing the first patient or client of the day
 - **Better (and after an exposure):** Self-assess for COVID-19 symptoms and check personal temperatures twice a day **and** before the workday begins at either the office or before seeing the first patient or client of the day
 - Report any fever above 100.0° Fahrenheit or any other COVID-19-like symptoms directly to your agency immediately for further instructions¹
- Certify at the beginning of each shift, **but before having contact with other employees or the client or patient**, that the worker is not currently experiencing COVID-19 signs or symptoms
 - Direct care worker should contact the agency daily to confirm compliance with this requirement, whether by speaking to someone directly, leaving a voicemail, text message or through an app
- Maintain a distance of six feet from all persons in the residence when possible, or wear a cloth face covering. Wear a face mask when possible or when state-mandated
 - Note, cloth face coverings are not PPE and should not be used when caring for someone suspected to have, diagnosed with, or under quarantine due to exposure to COVID-19. For the appropriate PPE in those circumstances, see the section titled: “Personal Protective Equipment if people with possible or confirmed COVID-19 are in the home (including clients/patients) – this includes those under quarantine”
- Use **standard** and transmission-based precautions when caring for **clients or patients with possible or confirmed COVID-19**, which include:
 - Hand hygiene
 - Wear appropriate PPE (see below)
 - Follow respiratory hygiene and cough etiquette principles

¹ According to the most recent version of the [CDC guidance](#) on risk assessment of Healthcare Personnel with potential exposure in a healthcare setting to patients with COVID-19, health care worker should immediately self-isolate and notify their local or state public health authority and healthcare facility if they develop a fever of ≥100.0°F (or subjective fever).

- Properly clean and disinfect the immediate area where the client or patient is located
- Handle laundry carefully
- Contact the agency **immediately** if signs or symptoms develop
 - If signs or symptoms of a respiratory infection develop during the workday, cover your nose and mouth with a face mask, if one is available, or a cloth face covering, and **immediately cease visiting clients or patients**
- Stay home if sick
 - Direct care workers who are not severely immunocompromised and experience mild to moderate illness should remain home for at least **ten** days after the symptoms first appeared, AND for **24** hours after a fever has stopped without the use of fever-reducing drugs, such as Tylenol, and any symptoms have improved (for example, when cough or shortness of breath have improved). See the below section titled “Steps To Take If A Direct Care Worker Is Diagnosed With COVID-19” for additional information on returning to work.

OR

- Remain home until released to return to work by their health care provider, provided the release is consistent with CDC guidelines in effect at the time of the release

PERSONAL PROTECTIVE EQUIPMENT FOR NON-COVID-19 CLIENTS/PATIENTS

The CDC issued guidance that everyone in a public area where social distancing may not be maintained should wear a cloth face covering. A cloth face covering may prevent respiratory droplets coming from either a person’s nose or mouth from reaching another person. Note, a cloth face covering is not a substitute for proper hand hygiene and other precautions. Cloth face coverings also are not PPE. The appropriate PPE to wear when caring for someone suspected to have, diagnosed with, or under quarantine due to exposure to COVID-19 is addressed in the section titled: “Personal Protective Equipment if people with possible or confirmed COVID-19 are in the home (including clients/patients) – this includes those under quarantine.” Also, direct care workers should perform appropriate hand hygiene when donning and doffing PPE.

Minimum:

- Direct care worker wears a cloth face covering or face mask (preferred) when within six feet of a client or patient.² Be aware that state regulations may require the use of a face mask

² When an employee is NOT caring for a COVID-19 patient or client (*i.e.*, someone who is suspected or confirmed to have COVID-19 or is under quarantine), an employee may voluntarily wear an N95 respirator. Before an employer allows an employee to wear an N95 respirator on a voluntary basis, the employer must: (1) make sure that wearing the mask is safe for that particular employee; and (2) have the employee complete and sign a one-page document, Appendix D of the OSHA standard, which is available online and at the end of this document. There are many ways to determine that wearing the mask is safe. One method would be to have the employee complete the medical evaluation that is part of the OSHA respiratory standard, which you can find [here](#). The

- Client or patient wears a cloth face covering when possible if direct care worker is within six feet, even when the direct care worker is wearing a cloth face covering
- If the direct care worker is at higher risk (or has a close family member who is at higher risk) for severe illness from COVID-19, and the client or patient is known or suspected to be COVID-19 positive, wear a face mask or an N95 respirator (preferred) with eye protection **throughout the day** when caring for a client
- Gloves are used at all times when providing personal care for a client or patient and anytime there may be contact with body fluids, mucous membranes, or non-intact skin, or when state-regulated. They should also be used when handling dirty linen or tissues.

Better:

- Cloth face covering or face mask if possible for the client or patient and a face mask for the direct care worker
- Gloves
- Gown or outer covering – worn when client or patient care activity may include contact with blood, bodily fluids and respiratory excretions
- Eye protection

Facility Setting:

- Direct care workers in long-term care facilities or other communal living settings should follow facility protocol, which may include wearing gown, gloves, eye protection, N95 respirator or, if not available, a face mask for the care of all residents, regardless of the presence of symptoms

PERSONAL PROTECTIVE EQUIPMENT IF PEOPLE WITH POSSIBLE OR CONFIRMED COVID-19 ARE IN THE HOME (INCLUDING CLIENTS/PATIENTS) – THIS INCLUDES THOSE UNDER QUARANTINE

Direct care workers who are at higher risk for severe illness from COVID-19 due to contact with known or suspected COVID-19 clients or patients should not be assigned to care for a client or patient who has possible or confirmed COVID-19, or if anyone in the home has possible or confirmed COVID-19. This includes situations where a client, patient or other person living in the home is under quarantine because they were in close contact with someone who has contracted COVID-19. The agency should consider

employee would need to confirm that he or she has none of the underlying conditions or problems identified in Part A, Section 2, questions 1 through 9 of the form, and be told that if he or she experiences any problem breathing while wearing the mask that it should be removed until a medical evaluation can be completed, which can be done through on-line services with most follow-up consults being done by phone. A registered or licensed nurse employed by you may also be competent to handle the evaluation and certify that the worker can safely wear the mask, depending on state law. If you have any questions or would like assistance implementing a voluntary program, we recommend you discuss with a safety consultant, an attorney knowledgeable in this area, or a physician or other licensed health care professional whose scope of practice covers these types of matters.

designating those direct care workers who have recovered from COVID-19 to provide care for such clients or patients.

Minimum:³

- Face mask and eye protection (*e.g.*, goggles that seal around the eyes)
 - Note, OSHA’s guidance does not permit face masks to be used in lieu of required respiratory protection. These masks do not seal tightly to the wearer’s face, nor do they provide a reliable level of protection from inhaling smaller airborne particles.
- Gloves
- Gown

Better:

- Require the use of a fit tested respirator, such as an N95 or one offering the same or better protection.

³ A face mask is not a substitute for an N95 or similar respirator. Respirators, like an N95 or better, are the required standard of care to protect employees. The [CDC notes](#), “while respirators confer a higher level of protection than face masks, and are recommended when caring for patients with COVID-19, face masks still confer some level of protection.” The CDC also [notes](#) that caregivers “who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator or face mask, gown, gloves, and eye protection. When available, respirators (instead of face masks) are preferred.” As of March 10, 2020, the CDC [reported](#) that “based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative **when the supply chain of respirators cannot meet the demand**” (emphasis added) along with eye protection, gown and gloves. The CDC places the risk of transmission as “Low” for a health care provider who uses a face mask, instead of an N95 or similar respirator, with a face shield, gown and gloves. Exposures with this level of PPE do not require any sort of self-quarantine or other action by the caregiver. **Nevertheless, CDC says there is a “Low” risk as opposed to no risk when using an N95 type respirator.**

On April 3, 2020, [OSHA reconfirmed](#) that employers are required to comply with its respiratory standard requiring a written respiratory program, ensuring employees have medical evaluations before using a respirator, and be fit-tested and trained. However, when an employer has not fully complied with the standard due to a lack of availability of respirators, the guidance directs OSHA investigators to consider all other measures an employer has done to try and comply with OSHA’s respiratory standard in mitigation of a citation. Those other measures would include using a face mask with face shield, gloves, gown, and having policies that keep a caregiver six feet away except when absolutely necessary and, then, limiting the time of each exposure (*i.e.*, when a caregiver has to be within six feet). Where an employer does not take all feasible measures, OSHA reiterated that it will issue serious citations for violations of its respiratory standard that continues to require N95 or better respirators be used in caring for symptomatic or infected clients.

Thus, following these minimum guidelines will not prevent an OSHA citation if respirators are available in your area and/or you do not take other feasible measures to protect direct care workers. An agency should seriously consider not accepting a new client with COVID-19 if the agency does not have access to an N95 (or foreign equivalent). The risks may outweigh the benefits.

- Note: an employer must have a respiratory program pursuant to OSHA's respiratory standard at 29 CFR 1910.134 to require an employee to wear an N95, which requires:
 - A written respiratory program;
 - A successful medical evaluation for each employee who will wear the respirator to ensure wearing the mask does not pose a hazard;
 - Fit-testing to ensure the employee has a proper mask that will prevent the virus from entering around the mask; and
 - Training.
- Note: the CDC has also [authorized](#) use of non-National Institute for Occupational Safety and Health ("NIOSH") approved masks that meet other countries' standards for N95s, such as KN95, R95, P95, PFF2, PFF3, DS, DL2, P2 and P3 masks, because of the crisis level of stock available
- Eye protection – preferably face shield that covers the entire front and sides of the face and that extends to the chin or below
- Gloves
- Gown
- Client or patient wears a face mask, if available, or a cloth face covering, when possible if direct care worker is within six feet
- Client or patient wears a face mask (preferred) or cloth face covering when out of the patient's or client's isolation room and in the presence of others in the home

RESPONSE TO SUSPECTED COVID-19 PERSON IN A PATIENT/CLIENT HOME

- Ask if the person has been in contact with their health care provider or local health department
- Notify the client's or patient's medical provider and/or designated family member if that has not already happened and the agency is authorized to do so
- The client's or patient's medical provider may need to evaluate whether the client or patient can still safely receive home care or home health or should be transferred to a hospital or other healthcare facility
- Ask if the person has been diagnosed with, or is seeking a test for, COVID-19
- If possible, postpone the visit for a time when the person who is ill has had at least ten days after the symptoms started (if severely immunocompromised or the person has severe or critical illness, wait 20 days), and 24 hours after a fever has stopped without the use of fever-reducing drugs, such as Tylenol, and any respiratory symptoms have improved

- If postponing is not possible, and if it is the client or patient who is sick, and the agency has decided that it can continue to provide care, prepare to manage the client or patient with the most appropriate PPE available (see above) and in accordance with the agency's COVID-19 protocols. See also the above section on client/patient training and instructions for additional steps.
- If the client or patient is sick and needs immediate medical attention (*e.g.*, difficulty breathing persistent pain or pressure in the chest, new confusion or inability to arouse, bluish lips or face) call 911 for transport to a hospital
 - Inform 911 that the client or patient may have COVID-19 to ensure appropriate infection control is implemented
- Once the person has been diagnosed with COVID-19, the home should be cleaned and disinfected:
 - **Minimum:** Clean and disinfect the high-touch surfaces in the patient's or client's immediate care area of the home with an EPA-registered disinfectant with a label claim of effectiveness against human coronavirus or emerging viral pathogens for the EPA's recommended contact time. This should also be done throughout the period the client or patient is in the home.
 - **Better:** A professional cleaning service should thoroughly clean and disinfect the home once the person who has been diagnosed with COVID-19 is no longer shedding replication-competent virus (*i.e.*, when no longer infectious). According to the CDC this is 10 days after symptom onset for persons with mild to moderate illness, and 20 days for persons with severe to critical illness or are severely immunocompromised.

IF A CLIENT OR PATIENT HAS TESTED POSITIVE

- Notify direct care workers who cared for the client or patient following the local health department guidance. In the absence of such guidance, use a time frame of 48 hours before symptom onset (or 48 hours before a positive test if the client or patient is asymptomatic).
- Notify the direct care workers of the last date they may have been in contact with the client or patient
- Do not disclose the client's or patient's name without permission
- For direct care workers who were in close contact of less than 6 feet of the client or patient for at least 15 minutes or more within 48 hours of the client or patient's symptom onset (or within 48 hours of a positive test in the case of an asymptomatic client or patient):
 - Remove the worker from the schedule if he/she cared for the client or patient without wearing at least a face mask or respirator and instruct him/her to self-quarantine for 14 days following the exposure
 - Remove the worker from the schedule if the direct care worker performed an aerosol-generating procedure and was not wearing a gown, gloves, eye protection, and a respirator at the time the procedure was performed, and instruct him/her to self-quarantine for 14 days following the exposure

- If the direct care worker wore at least a face mask or respirator and eye protection, and the patient or client with COVID-19 was not wearing a cloth face covering or face mask, the worker may continue to work but should monitor their health as noted above, and wear a face mask. He/she should discontinue working, as noted above, if he/she becomes sick.
- If possible, postpone the visit for a time when the client or patient has recovered
- If postponing is not possible, and the agency has decided that it can continue to provide care, prepare to manage the client or patient with the most appropriate PPE available (see above) and in accordance with the agency's COVID-19 protocols. See also the above section on client/patient training and instructions for additional steps.

STEPS TO TAKE IF A DIRECT CARE WORKER FINDS, AFTER ENTERING THE RESIDENCE, THAT THERE IS SOMEONE (OTHER THAN THE CLIENT OR PATIENT) WHO HAS A COVID-19-LIKE ILLNESS

- Notify their supervisor
- Follow the agency's protocol as to whether the direct care worker should exit the residence or continue providing care
- The direct care worker should be wearing at least a cloth face covering when making a visit (regardless of COVID-19 status), unless state-mandated. If the direct care worker is wearing a cloth face covering and a face mask is available, then the direct care worker should switch to a face mask and perform hand hygiene.
- If the agency still plans to care for a client or patient who lives in a home where a household member has possible or confirmed COVID-19, then:
 - Verify that a direct care worker is willing to care for the client or patient that has tested positive or is exhibiting symptoms
 - The ill person who is not the client or patient should be isolated in a separate room from the client or patient. This room should have a private restroom for the ill person's use.
 - The direct care worker should maintain a distance of six feet or more from such person and practice standard precautions as noted above
- Make sure the client's or patient's healthcare provider is aware that the client or patient lives in such an environment and develop a care plan that reflects the necessary safety precautions

STEPS TO TAKE IF A DIRECT CARE WORKER IS DIAGNOSED WITH COVID-19

- The direct care worker should call the agency immediately to report the diagnosis
- The direct care worker should **NOT** report the diagnosis directly to the client or patient. The agency should communicate that message
- The direct care worker should be taken off the schedule, and reminded to follow the health department's guidance in regards to self-quarantine and/or self-monitoring.

- Determining when a direct care worker may return to work, the CDC recommends employers use a “symptom-based method,” which depends on the severity of the illness and the nature of the person’s immune system:
 - Direct care workers who **are not** severely immunocompromised, and remained **asymptomatic** throughout their infection may return to work after at least 10 days have passed since the date of the first positive viral diagnostic test.
 - Direct care workers who **are not** severely immunocompromised, test positive and experience **mild to moderate** illness may return to work after:
 - At least 24 hours have passed since last fever without the use of fever-reducing medications; and
 - Improvement in symptoms (e.g., cough, shortness of breath); and
 - At least 10 days have passed since symptoms first appeared.
 - Direct care workers with **severe to critical** illness or who **are** severely immunocompromised may return to work after:
 - At least 24 hours have passed since last fever without the use of fever-reducing medications; and
 - Improvement in symptoms (e.g., cough, shortness of breath); and
 - At least 20 days have passed since symptoms first appeared.
 - Definitions for the above:
 - **Mild Illness:** Individuals who have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
 - **Moderate Illness:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO₂) ≥94% on room air at sea level.
 - **Severe Illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO₂ <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO₂/FiO₂) <300 mmHg, or lung infiltrates >50%.
 - **Critical Illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
 - **Severely Immunocompromised:** Determined by the individual’s health care provider.
- The CDC [provides](#) that in some instances, a test-based strategy could be considered to allow a health care worker to return to work earlier than if the symptom-based strategy described above

were used. The CDC warns that many individuals will have prolonged viral shedding, limiting the utility of this approach. CDC criteria for the test-based strategy are:

- Direct care workers who **are not** severely immunocompromised, test positive and experience **mild** to **moderate** illness may return to work after:
 - He/she no longer has a fever (without the use of medicine that reduces fevers), and
 - Improvement in symptoms (e.g., cough or shortness of breath), and
 - He/she received two negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimen tests in a row, collected at least 24 hours apart. All test results should be final before returning to work.
- Direct care workers who **are not** severely immunocompromised, and remained **asymptomatic** throughout their infection may return to work after receiving two negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimen tests in a row, collected at least 24 hours apart. All test results should be final before returning to work.
- Or, once released to return to work by their health care provider, provided the release is consistent with CDC guidelines in effect at the time of the release
- When the direct care worker returns to work, he or she should:
 - Follow health department guidance
 - Wear a face mask at all times while on duty
 - Wear gloves, if state-mandated
 - Be restricted from contact with severely immunocompromised clients or patients until 14 days after illness onset
 - Adhere to hand hygiene, respiratory hygiene, and cough etiquette in [CDC's interim infection control guidance](#) (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
 - Self-monitor for symptoms, and seek re-evaluation if fever returns or if respiratory symptoms recur or worsen
- The agency should ask the direct care worker for validation regarding the positive COVID-19 test result and confirm when the symptoms first began
- The agency also should ask the direct care worker for validation regarding the negative COVID-19 test results, when available

- The agency should notify all clients or patients for whom the direct care worker provided services during the 48 hours preceding symptom onset (or positive test in the case of a direct care worker who is asymptomatic)
 - The notice should not disclose the direct care worker's name
 - The notice should tell the client or patient the date the direct care worker last provided services to the client or patient
 - The notice should state that the direct care worker has been removed from the schedule
 - The client or patient should be reminded to self-quarantine and seek advice from their medical provider
 - The notice should indicate whether the agency will continue to provide care to the client or patient during the self-quarantine period
- Assign a new direct care worker when a new direct care worker was requested by the client or patient and the family will monitor the client or patient for signs or symptoms
- Ensure the new direct care worker continues to use standard precautions and infection control protocols to protect themselves and their clients or patients
- The client or patient should notify the agency immediately if they present symptoms
- Look to the direct care worker's healthcare professional confirming the direct care worker's diagnosis to report to the health department
- If the agency still plans to care for a client or patient while on self-quarantine, then the guidelines outlined in the section regarding care for a suspected or confirmed COVID-19 client or patient should be followed during the self-quarantine period

WAYS TO PRESERVE PPE SUPPLIES, AND HAVE CONTINGENCY PLANS IF SUPPLIES ARE SHORT

- Masks may be available from the following alternative sources:
 - The farm section of large stores like Menards, Farm & Fleet, etc.; cabinet supply makers; nail salons; insulation and other HVAC contractors; and construction firms
- Other types of NIOSH-approved respirators may be used
- Consideration can be made to use N95 respirators beyond the manufacturer-designated shelf life for care of patients or clients with COVID-19
 - Note, performance may be impaired - components such as the straps and nose bridge material may degrade, which can affect the quality of the fit and seal
 - It is particularly important that direct care worker perform the expected seal check, after donning and prior to entering a patient or client care area

- Consider extended use and limited reuse of respirators
 - Note, it is unknown what the potential contribution of contact transmission is for COVID-19, and caution should be used
 - Re-use should be implemented according to [CDC guidance](#)
- As noted above, the CDC and OSHA have endorsed the use of select non-NIOSH-approved respirators that are approved for use in other countries.
- Cloth face coverings may be homemade. Cloth face covering should only be worn in lieu of an N95 respirator or face mask when no other respiratory protection is available and respirator protection is indicated and only as a last resort. When a cloth face covering is worn as a last resort, it is best to pair it with a face shield that covers the entire front and sides of the face (see the CDC [website](#) for additional information).
 - Certain materials filter better than others and the fit of a cloth face covering determines its protectiveness
 - Any face covering is better than nothing
 - Medical grade or at least proper dust mask is likely to be superior to using a bandana or other homemade face mask
 - The Joint Commission has recognized that homemade masks are an extreme measure and should be used only when standard PPE of proven protective value is unavailable
- Cloth gowns may be obtained from a healthcare linen service or homemade and worn as a last resort pursuant to [CDC optimization strategies](#) for when traditional isolation gowns are unavailable
 - Note, homemade PPE should be used only when standard PPE of proven protective value is unavailable
- Agency should document its efforts to obtain proven protective PPE if it decides to deploy homemade PPE.

CONTINGENCY PLAN CONSIDERATIONS FOR CONTINUING CLIENT OR PATIENT CARE SHOULD A LARGE PROPORTION OF STAFF BECOME SICK OR NEED TO BE ABSENT FOR COVID-19 RELATED REASONS

- Prioritize critical and non-essential services based on the client's or patient's health status, functional limitations, disabilities, and essential needs
- Use level of support as part of triaging clients:
 - Lives alone
 - Lives with family members

- Lives in an assisted living or similar facility
- Identify minimum staffing needs based on the above triaging of clients or patients

OSHA RECORDING/REPORTING OBLIGATIONS

- Understand Occupational Health and Safety recording and reporting obligations based on applicable federal and/or state law (note, 22 states have their own OSH agency).
 - Record a COVID-19 case on your OSHA 300 log if:
 - The employee tested-positive for COVID-19; and
 - The case is work-related (note, some states have enacted legislation regarding presumptions on this issue for Workers' Compensation purposes for healthcare workers); **and**
 - The case involves death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, loss of consciousness, and/or a significant injury or illness diagnosed by a physician or other licensed healthcare professional.
 - Report a COVID-19 case to OSHA when:
 - An employee with a confirmed case of COVID-19 that is work-related dies within 30 days of the event that resulted in contracting COVID-19, or
 - An employee with a confirmed case of COVID-19 that is work-related is hospitalized on an in-patient basis within 24 hours of the event that resulted in contracting COVID-19.

PREPARING TO RESPOND TO OSHA COMPLAINT

- The Agency should consider retaining counsel when responding to an OSHA complaint. Additionally, the Agency should consider taking some or all of the following steps:
 - Document the due date for a response.
 - Catalogue all COVID-19 efforts (including review of Exposure Report Forms and Exposure Logs for relevant information).
 - Investigate the allegations.
 - Consider program improvements.
 - Draft a comprehensive response.
 - Consider attaching documentation, such as written protocols for handling the outbreak, personal protective equipment ("PPE") requirements and protocols, procedures for

reporting signs and symptoms of COVID-19, and photographic evidence of supplies of equipment.

- And remember the cardinal rule: **do not retaliate**. The Agency will not be informed of the identity of the complainant. Even if the Agency believes it knows the identity of the complainant, that belief should not be divulged in the Agency's response. Furthermore, employees are protected from retaliation when exercising their rights under the Occupational Safety and Health Act of 1970, one of which is to raise safety and health complaints with OSHA. The anti-retaliation rule should apply regardless of whether or not the concern raised with OSHA was valid.

WAYS TO COPE WITH THE EMOTIONAL REACTIONS TO STRESSFUL SITUATIONS, SUCH AS COVID-19

- Constant communication with direct care workers is critical during these stressful unprecedented times and be sure to give them the opportunity to discuss their concerns as often as possible
- Remind staff and clients or patients that feeling sad, anxious, overwhelmed, or having trouble sleeping or other symptoms of distress is normal
- If symptoms become worse, last longer than a month, or a person struggles to participate in their usual daily activities, encourage them to reach out for support and help
- The direct care worker is on the front lines and their health and well-being is critical to ensure the best outcomes for the care of our clients and patients

Contributors:



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Appendix D to Sec. 1910.134 (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged, even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirators limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998]

Acknowledgment of Receipt:

Employee Signature

Date