

COVID-19 Exposure Control Plan

1.0 Purpose and Applicability

COVID-19 is a contagious illness caused by a novel coronavirus. First detected in Wuhan, China in January 2020, the virus has since been detected in 60 locations internationally, including the United States. While coronaviruses are common in people and in many different species of animals, rarely do coronaviruses that infect animals spread to humans; however, research indicates that this novel coronavirus most likely had its origin in bats.

COVID-19 is a new disease, and there is still much to be learned about it. It is spread between people who are in close contact with one another (within 6 feet) for a prolonged period of time through respiratory droplets when an infected person coughs or sneezes. It is also possible that the virus may be contracted when a person touches a surface that has the virus on it and then touches their own mucus membranes, but that is not thought to be the main avenue of transmission. Reported illnesses have ranged from mild symptoms to severe illness and death for confirmed COVID-19 cases. Symptoms may appear 2-14 days after exposure and include fever, cough, and shortness of breath.

The purpose of this COVID-19 Exposure Control Plan is to establish, implement and maintain safe work practices and controls to reduce the risk of transmission of COVID-19 for Capital Caring patients, families, staff, and volunteers.

2.0 Scope

This COVID-19 Exposure Control Plan applies to all Capital Caring Health employees, volunteers, patients and families.



3.0 Responsibilities

- 3.1 The **Infection Control Practitioner** is responsible for implementation of the COVID-19 Exposure Control Plan. He/she will maintain, review, and update the plan whenever necessary to include new or modified tasks and procedures and in accordance with federal, state, and local guidelines.
- 3.2 The **COVID-19 Incident Command Team** is responsible for ensuring the operations of Capital Caring Health continue. The Incident Command Team will also lead create, revise as necessary, and communicate to all Capital Caring Health staff changes to work practices and controls
- 3.3 The **Leadership Team** for each neighborhood or IPU will ensure that employees adhere to the protocols outlined in this plan. When needed, they will ensure the availability of all necessary personal protective equipment (PPE.) The Leadership Team will assist the clinical staff with the identification and screening of high-risk patients and will notify the Infection Control Practitioner of any concerns.
- 3.4 **Employees** who may be at risk of exposure to COVID-19 must comply with the procedures and work practices outlined in this exposure control plan. **All Capital Caring Health Staff** must be alert to admitting diagnoses, to signs and symptoms of SARS CoV-19, reporting this information immediately to physicians, managers, and the Infection Control Practitioner for investigation and follow-up, and to collaborate in an appropriate plan of care.
- 3.4 The **Employee Health Nurse** and the **Workers Compensation Coordinator** are responsible for maintaining employee health records as they pertain to COVID-19 and for ensuring that all medical actions are performed in the event that an employee is exposed to the virus. The Employee Health Nurse is responsible for notifying the appropriate government agencies and/or health department as required.
- 3.6 The **Education Department** will be responsible for training and for maintaining the documentation of training.

4.0 Facility Readiness

- 4.1 All in-patient units must position a respiratory hygiene station at the entrances of the facility. The respiratory hygiene station must include face masks, tissues, hand sanitizer, and a hands-free waste receptacle.
- 4.2 All in-patient units must post visual alerts (e.g. signs, posters) in appropriate languages at the entrance and in strategic locations to provide patients and visitors with instructions about hand hygiene, respiratory hygiene and cough etiquette. Instructions should include how to use facemasks or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how to perform hand hygiene.
- 4.3 An additional sign must be posted at the entrance of all in-patient units that instructs any person who meets the CDC criteria of a Person Under Investigation (see table in section 7.1.2) to contact a member of the clinical team before entering the unit. The appropriate contact information must be included on the sign.
- 4.4 Hand hygiene supplies must be readily available at all times.



5.0 Employee Risk Assessment

- 5.1 CDC Guidelines are observed in determining staff risk for exposure to COVID-19 and to determine the assignment of the risk category for home care operations and for the in-patient units.
- 5.2 The Infection Control Practitioner will review official updates on the spread of COVID-19 as they are published to determine the current risk to staff. Any change to the risk level will be made in conjunction with the Chief Medical Officer and Chief Clinical Officer and communicated immediately to staff.

6.0 Patient Risk Assessment

- 6.1 Anyone can contract COVID-19 if exposed to the COVID-19 virus.
- 6.2 Older persons and persons with pre-existing medical conditions (such as cardiopulmonary disease or weakened immune systems) are more likely to develop serious illness more often than others.

7.0 Managing Patients with Suspected or Confirmed COVID-19

7.1 Screening Patients for COVID-19 Prior to Admission

7.1.1 Recognizing persons at risk for COVID-19 is a critical component of identifying cases and preventing further transmission.

- Initial Screening will consist of a scripted message and will be documented in the patient's medical record labelled "Progress Note COVID-19 Screen"
 - Script and recommended documentation for a negative screening result: "I have confirmed that all persons expected to be in the home of (patient's name) at the time of (type of visit) have not had international travel within the last 14 days, do not have a fever, cough, or sore throat, have not had contact with someone under investigation for Coronavirus (COVID-19) in the last 14 days
 - If screening for COVID-19 is positive, arrange for admission visit, Immediately notify Infection Control and Clinical Supervisor, Utilize personal protective equipment (PPE) as directed in accordance with CDC guidelines, CDC currently recommends facemask OR N95 (if Fit Testing is complete), gown, gloves, and eye protection, Document in the patient's medical record: "COVID-19 Screen Positive"

7.1.2 Screening Patients for COVID-19 after Admission

- With the exception of the Inpatient Units, prior to any Capital Caring Health staff visits in any care location, an over-the-phone COVID-19 screening will be completed. Post-admission screening will consist of a scripted message and will be documented in the patient’s medical record labelled “Progress Note COVID-19 Screen.” Script and Recommended documentation for a negative COVID-19 screening: “I have confirmed that the COVID-19 screen remains negative”
- If screening for COVID-19 is positive: Arrange for visit, immediately notify Infection Control and Clinical Supervisor, utilize personal protective equipment (PPE) as directed in accordance with CDC guidelines. CDC currently recommends facemask OR N95 (if Fit Testing is complete), gown, gloves, and eye protection. Document in the patient’s medical record: “COVID-19 Screen Positive”

Clinical Features		Epidemiologic Risk
Fever or signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	AND	Any person, including healthcare personnel, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	AND	A history of travel from affected geographic areas, within 14 days of symptom onset
Fever with severe acute lower respiratory illness (e.g., pneumonia, ARDS (acute respiratory distress syndrome) requiring hospitalization and without an alternative explanatory diagnosis (e.g., influenza).	AND	No identified source of exposure

Current CDC recommendations as on 3/3/2020

7.2 While the patient remains in the home setting, he/she should wear a surgical mask, if possible, and be instructed to observe strict respiratory hygiene and cough etiquette procedures.

7.3 If the patient is in an IPU, he/she must be placed in a separate room (airborne infection isolation room, if available) with the door closed, apart from other patients and away from common areas until transfer to the nearest emergency room. An isolation precautions sign must be placed on the door. The patient should also wear a surgical mask, if possible, and observe strict respiratory hygiene and cough etiquette procedures.

7.4 Visitors and family members should be instructed to minimize their movement within the facility.

7.4.1 The number of staff and visitors who are in contact with the patient must be minimized, and only essential people should enter the room.

- If appropriate and depending on the condition of the patient, staff should ask the patient and/or family for their cell phone number as a means of communication until the patient can be transferred to the nearest hospital for evaluation.

7.1.2 A log listing which staff and visitors have been in contact with the patient must be maintained. This log will be initiated by the patient’s nurse and should be maintained in a separate folder at the reception desk. Once the patient has been discharged to the emergency room, the log must be sent to the Infection Control Practitioner and the Employee Health Nurse.

7.1.3 Staff who are in contact with a patient suspected of having COVID-19 should follow standard, contact, and droplet precautions, including the use of eye protection. Only staff who have been trained and fit tested may don an N95 respirator mask.

8.0 Staff Surveillance

8.1 Any staff member or volunteer who has recently traveled to an area of outbreak or has been in contact with a patient, family member, or person in the community with known or suspected COVID-19 must notify their Clinical Supervisor or Volunteer Coordinator as well as the Infection Control Practitioner and Employee Health Nurse immediately.

8.2 Any work restrictions following an exposure of a staff member will follow current CDC Guidelines.

Epidemiologic Risk Factors	Exposure Category	Recommended Monitoring for COVID-19 (until 14 days after last potential exposure)	Work Restrictions for Asymptomatic Health Care Providers (HCP)
HCP (with unprotected eyes, nose, or mouth) who perform <u>or</u> are present in the room for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction).	High	Active	Exclude from work for 14 days after last exposure

<p>HCP who perform or are present in the room for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) and not using a gown and gloves.</p> <p>Note: If the HCP's eyes, nose, <u>or</u> mouth were also unprotected they would fall into the high-risk category above.</p>	Medium	Active	Exclude from work for 14 days after last exposure
<p>HCP (with unprotected eyes, nose, <u>or</u> mouth) who have prolonged close contact with a patient <i>who was not wearing a facemask</i>.</p> <p>Note: An N95 mask confers a higher level of protection than a facemask. However, they are grouped together in this scenario because (even if an N95 or facemask was worn) the eyes remain uncovered while having prolonged close contact with a patient <i>who was not wearing a facemask</i>.</p>	Medium	Active	Exclude from work for 14 days after last exposure
<p>HCP (with unprotected eye, nose, and mouth) who have prolonged close contact with a patient <i>who was wearing a facemask</i>.</p>	Medium	Active	Exclude from work for 14 days after last exposure
<p>HCP (not wearing gloves) who have direct contact with the secretions/excretions of a patient and the HCP failed to perform immediate hand hygiene</p> <p>Note: If the HCP performed hand hygiene immediately after contact, this would be considered low risk.</p>	Medium	Active	Exclude from work for 14 days after last exposure
<p>HCP wearing a facemask or N95 only who have prolonged close contact with a patient <i>who was wearing a facemask</i></p> <p>Note: An N95 confers a higher level of protection than a facemask. However, they are grouped together in this scenario and classified as <i>low-risk</i> because the patient was wearing a facemask for source control.</p>	Low	Self with delegated supervision	None
<p>HCP using all recommended PPE (i.e., an N95, eye protection, gloves and a gown) while caring for or having contact with the secretions/excretions of a patient</p>	Low	Self with delegated supervision	None
<p>HCP (not using all recommended PPE) who have brief interactions with a or patient regardless of whether patient was wearing a facemask (e.g.,</p>	Low	Self with delegated supervision	None

brief conversation at a triage desk; briefly entering a patient room but not having direct contact with the patient or their secretions/excretions; entering the patient room immediately after they have been discharged)			
HCP who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room	No identifiable risk	None	None

Current CDC Recommendations 3/3/2020

9.0 Cleaning and Disinfection

- 9.1 Any staff who enter the room soon after the patient leaves should adhere to isolation precautions until the room has been terminally cleaned.
- 9.2 Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings. Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
- 9.3 Disinfecting cleaners must be used according to the manufacturers' recommendations including adherence to the appropriate contact times.
- 9.4 Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.

10.0 Employee Training

- 10.1 Employees will be educated regarding COVID-19 with current CDC guidelines for personal protective equipment (PPE) as needed depending upon the current risk. The education will include but will not be limited to:
- Basic concepts of transmission, pathogenesis, and diagnosis
 - Risk factors, signs and symptoms of COVID-19 and the importance of screening patients for COVID-19
 - Potential for occupational exposure including the prevalence in the community
 - Principles of treatment for COVID-19
 - Principles of PPE
 - Principles and practices of infection control that reduce the risk of exposure including the plan in place at Capital Caring

11.0 Recordkeeping

- 11.1 Medical Records
- 11.1.1 Medical records are maintained for each employee, including any records related to an occupational exposure, in accordance with 29 CFR 1910.1020, "Access to Employee Exposure and Medical Records."
- 11.1.2 The Employee Health department is responsible for maintenance of the required medical records. These confidential records are kept in the Employee Health office for at least the duration of employment plus 30 years.



11.1.3 Employee medical records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days. Such requests should be sent to the Employee Health Nurse.

11.2 Training Records

11.2.1 Training records, including N95 Fit Testing, are completed for each employee upon completion of training.

11.2.2 The Education Department maintains the training records for at least 3 years from the date on which the training occurred.

11.2.3 The training records will include:

- The date of the training session
- The contents and summary of the training session
- The name(s) and qualifications of the person(s) conducting the training

11.2.4 Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to the Education Department.