Washington State Department of HEALTH

SARS-CoV-2 Infection Prevention and Control in Healthcare Settings Toolkit

DOH 420-474 June 2025

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Table of Contents

Abbreviations

ABHS: alcohol-based hand sanitizer

ACH: air changes per hour

AGP: aerosol generating procedure

AIIR: airborne infection isolation room

ASHRAE: American Society of Heating, Refrigerating and Air-Conditioning Engineers

CDC: [United States] Centers for Disease Control and Prevention

CMS: [United States] Centers for Medicare and Medicaid Services

DOH: [Washington State] Department of Health

DOSH: [Washington State Labor & Industries] Division of Occupational Safety and Health

DSHS: [Washington State] Department of Social and Health Services

EPA: [United States] Environmental Protection Agency

EVS: environmental services

HCP: healthcare personnel

HSQA: [Washington State Department of Health] Health Systems Quality Assurance

LHJ: local health jurisdiction

LTCF: long-term care facility

L&I: [Washington State Department of] Labor and Industries

NAAT: nucleic acid amplification test

NIOSH: National Institute of Occupational Health and Safety

PCR: polymerase chain reaction

PPE: personal protective equipment

OSHA: [United States] Occupational Safety and Health Administration

TBP: transmission-based precautions

SARS-CoV-2: severe acute respiratory syndrome coronavirus 2

SNF: skilled nursing facility (nursing home)

WHO: World Health Organization

Background and Purpose

The Washington State Department of Health (DOH) developed this toolkit for healthcare settings to use to prevent transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease 2019 (COVID-19).

Healthcare settings may use this toolkit to create flexible policies specific to their facility based on their individual risk assessment following CDC Infection Control Guidance: SARS-CoV-2.

The WA DOH is in full alignment with CDC's guidance as it pertains to healthcare and COVID-19.

In general, healthcare settings should follow Center for Disease Control and Prevention (CDC) guidance to prevent transmission of SARS-CoV-2:

- CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- Overview of Testing for SARS-CoV-2, the virus that causes COVID-19
- Strategies to Mitigate HCP Staffing Shortages
- Conserving Supplies of Personal Protective Equipment in Healthcare Facilities during Shortages

Note: The resources in this document are not regulatory in nature except when required by a regulatory agency such as Washington State Department of Labor & Industries (L&I), Washington State Department of Social and Health Services (DSHS), DOH-Health Systems Quality Assurance (HSQA), and Centers for Medicaid and Medicare Services (CMS). When creating policy and procedures, healthcare settings should ensure they meet regulatory requirements.

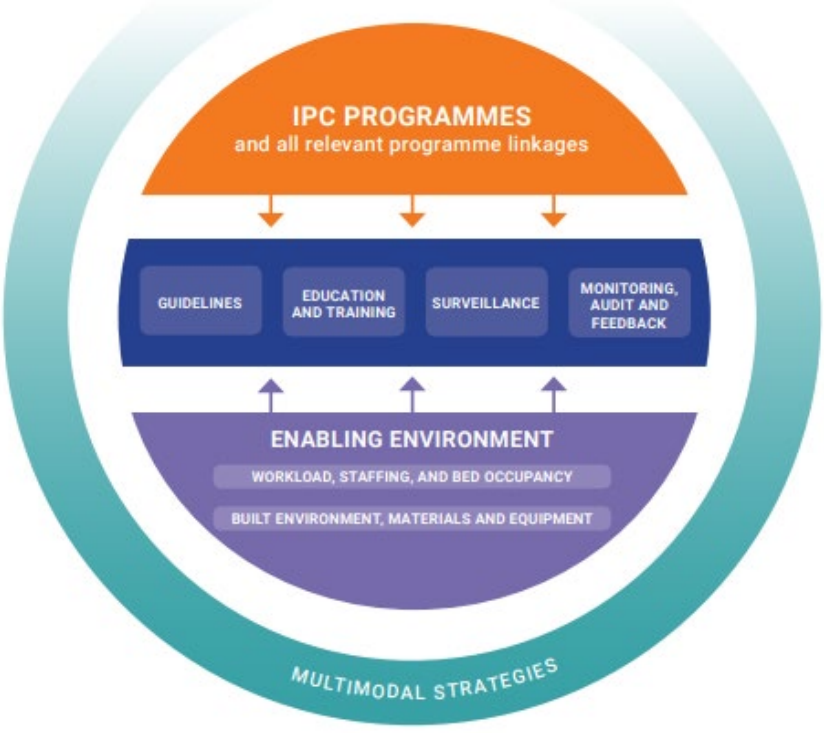
The resources in this document are tools your facility can use as a guide to stay in line with state and national standards. This is an interim document, and we will update it with changes in national and state guidance and most recent evidence and data.

Infection Prevention and Control Program and Plan

Healthcare facilities should have a person dedicated to infection prevention and control and a plan to mitigate the risk of infection transmission. Some healthcare settings have specific regulatory requirements for infection prevention and control. Please refer to regulatory agencies (L&I, DSHS, HSQA, and CMS) for regulatory requirements.

At minimum, an infection prevention and control program should include:

1) Guidelines, policies, and procedures.
2) Education and training.
3) Surveillance.
4) Monitoring, auditing, and feedback.



From: WHO Core Components of Infection Prevention and Control Program

Elements of COVID-19 Prevention in All Healthcare Settings

Screening

Follow CDC recommendations to ensure that everyone entering the facility is aware of infection prevention and control practices, including, but not limited to the following:

- Post visual alerts and signs at the entrance and strategic places. Include a publication or posting date to alert people that signs reflect current recommendations.
- Provide instructions when scheduling appointments.

Establish a process for everyone entering the facility. Regardless of vaccination status, people entering the facility should be screened and report any of the following:

- A positive viral test for SARS-CoV-2
- Symptoms of COVID-19
- Close contact with someone with SARS-CoV-2 infection (for patients and visitors)
- A higher-risk exposure (for HCP)

HCP should report any of the criteria above to occupational health or the person the facility designated, so they can be managed properly. See CDC's HCP Exposure and Exclusion from Work and CDC Mitigating Healthcare Worker Staffing Shortage for guidance managing HCP with SARs-Cov-2 infection or exposure.

Visitors with a positive viral test for SARS-CoV-2 or symptoms of COVID-19 should postpone non-urgent in-person visits until they meet the criteria for ending isolation in Section 2 of CDC recommendations.

Visitors who had close contact with someone with SARS-CoV-2 should postpone non-urgent, in-person visits until 10 days after their close contact if they meet any of the criteria in Section 2 of CDC recommendations (e.g., cannot wear source control).

For additional information about visitation from the Centers for Medicare & Medicaid Services (CMS), see Policy & Memos to States and Regions | CMS

Hand Hygiene

Follow CDC recommendations for hand hygiene. HCP should use an alcohol-based hand rub containing at least 60% alcohol or wash with soap and water for the following clinical indications:

- Immediately before touching a patient.
- Before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices.
- Before moving from work on a soiled body site to a clean body site on the same patient.
- After touching a patient or the patient's immediate environment.
- After contact with blood, body fluids, or contaminated surfaces.
- Immediately after glove removal.

Handwashing with soap and water is most important after using the restroom and when hands are visibly soiled. Most other times, an alcohol-based hand rub is preferred over soap and water due to evidence of better compliance compared to soap and water.

Environmental Infection Control – Cleaning and Disinfection

Follow CDC recommendations for environmental cleaning and disinfection: CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 and CDC Environmental Infection Control Guidelines.

- Dedicated medical equipment should be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection.
- All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including areas where aerosol generating procedures (AGPs) are performed. For example, using cleaners and water to pre-clean surfaces before applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label.
- Refer to List N on the U.S. Environmental Protection Agency's (EPA) website for EPA-registered disinfectants that kill SARS-CoV-2.
- Use routine procedures for laundry, food service utensils, and medical waste.
- After a patient with confirmed or suspected COVID-19 is discharged or transferred, HCP, including environmental services personnel (EVS), should

refrain from entering the vacated room until sufficient time passes for enough air changes to remove potentially infectious particles. After that time passes, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use. See CDC Recommendations for Disinfection and Sterilization in Healthcare Facilities including important footnotes.

Ventilation

Ensure ventilation is working properly and make improvements as needed in patient rooms and all shared spaces. Reduce or eliminate exposures from infected individuals by using engineering controls. For example, use physical barriers at reception and triage locations, and dedicated pathways to guide symptomatic patients through waiting rooms and triage areas.

Resources for guidance on ensuring that ventilation systems are operating properly:

- CDC Environmental Infection Control Guidelines
- American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities, which also provides COVID-19 technical resources for healthcare facilities
- CDC About Ventilation and Respiratory Viruses

DOH provides additional information on improving ventilation in:

- Ventilation and Air Quality for Reducing Transmission of Airborne Illnesses
- Cooling indoor spaces without air conditioning (wa.gov)

Personal Protective Equipment (PPE) and Transmission-Based Precautions (TBP)

This section:

- Provides tools to quickly determine appropriate PPE in different circumstances.
- These tools provide general references and do not cover all possible scenarios.

HCP should adhere to Standard Precautions and follow PPE requirements according to Transmission-Based Precautions (TBP). When caring for patients with confirmed or suspected COVID-19, HCP must wear appropriate PPE according to their setting:

- DOH COVID-19 PPE Recommendations for Healthcare Personnel
- CDC Infection Control Guidance: SARS-CoV-2

For more information about PPE use, please refer to:

- L&I Rules by Chapter (wa.gov)
- L&I Standards for Standard Precautions

- Conserving Supplies of Personal Protective Equipment in Healthcare Facilities during Shortages
- CDC Isolation Precautions
- WSHA/DOH Isolation Precautions Signs
- How to Tell if your N95 Respirator is NIOSH Approved (cdc.gov)

Source Control

This section:

- Provides guidance on when source control should be worn in healthcare settings and what is considered appropriate source control for HCP, patients, and visitors.
- Describes source control and the difference between source control and PPE, considering that some devices under certain circumstances may function as both.*
- Provides guidance on how to improve the fit of source control in healthcare settings, which is different than community settings.

Note: There is overlap of devices used for source control and PPE. Fitted respirators (such as N95s) and well-fitting medical facemasks when worn as PPE also act as source control. There are times in healthcare settings, however, when PPE is not indicated, and source control is still required.

The guidance in this section is not comprehensive with respect to PPE and should not be used to determine whether a device worn for source control meets or exceeds requirements for PPE. For information on when PPE should be used refer to:

- CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- L&I's Requirements and Guidance for Preventing COVID-19
- DOH's Donning and Doffing PPE

Source Control Versus PPE

Source control:

- Well-fitting cloth face coverings, facemasks, or respirators that cover a person's mouth and nose to prevent spread of potentially infectious respiratory secretions when they are breathing, talking, sneezing, or coughing.
- Some devices used for source control may not protect the wearer from infection with SARS-CoV-2(the virus that causes COVID-19). Source control should be used in addition to other options used to control the spread of SARS-Cov-2.

- Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are encouraged for everyone in a healthcare facility, even if they do not have symptoms of COVID-19.
- Healthcare facilities should follow CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, in addition to any current Washington DOH or LHJ masking guidance and requirements.

PPE

- Worn to reduce exposure to hazards that cause serious workplace injuries and illnesses, see the Occupational Safety and Health Administration (OSHA) page on Personal Protective Equipment
- A proper fit is important to improve the function of both source control and PPE. Transmission from asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection can occur in healthcare settings.

Aerosol-generating Procedures (AGP)

AGPs are procedures that might pose higher risk for transmission if the patient were to have COVID-19. They may include procedures that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, or respiratory tract.

Facilities should evaluate what procedures have the potential to generate aerosols. They should include those procedures in their respiratory protection plan and facility risk assessment. For more information see:

- CDC: Implementing universal use of PPE for HCP
- L&I Chapter 296-841, WAC, Airborne Contaminants

Note: It hasn't been possible to develop a comprehensive list of AGPs for healthcare settings due to limited data on which procedures may produce potentially infectious aerosols, and whether reported transmissions during AGPs are due to aerosols or other exposures.

Patient Isolation and Quarantine

Follow CDC Isolation Precautions Guideline

Patients with an exposure to SARS-CoV-2 need to be placed in TBP for quarantine if they meet one of the following criteria:

- Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure
- Patient is moderately to severely immunocompromised
- Patient resides on a unit with others who are moderately to severely immunocompromised
- Patient resides on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

Guidelines for managing patients with suspected or confirmed SARS-CoV-2:

- Communicate information about patients with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility (for example, radiology) and to other healthcare facilities
- Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). The patient should have a dedicated bathroom
- Limit transport and movement of the patient outside of the room to medically essential purposes

Implement Cohorting**:**

- Cohorting is an infection prevention and control measure that groups together patients with the same infectious condition and no other infection
- It limits the risk of spreading COVID-19 by using dedicated staff to care for only COVID-19 positive patients
- It allows for conservation of PPE resources and extended use of PPE such as respirators, face masks and eye protection when supplies are limited
- While intended for long-term care facilities, healthcare personnel can adapt strategies for cohorting in many in-patient healthcare settings

Asymptomatic Patients with Exposure to SARS-CoV-2:

- Asymptomatic patients with an exposure to SARS-CoV-2 generally do not require TBP. Exposed patients should wear source control for 10 days post-exposure.
- If a patient has not recovered from a SARS-Cov-2 infection in the last 30 days, they should be tested immediately on post exposure day 1 (but not before 24 hours from exposure) day 3 and day 5.

Isolation Versus Quarantine

Quarantine:

TBP used to keep someone who might have been exposed to COVID-19 away from all others to prevent potential transmission of COVID-19.

Isolation:

TBP used to keep someone who has confirmed COVID-19, away from others to prevent transmission to others.

Table 1: Summary of SARS-CoV-2 Isolation and Quarantine

	Quarantine	Isolation
Days	For a patient that meets the criteria for quarantine, quarantine ends after one of the following: 10 day quarantine OR 7-day quarantine with negative tests on day 1, 3 and 5.	Isolation ends for patients who are not severely immunocompromised when: At least 10 days have passed since symptoms first appeared. AND At least 24 hours have passed since last fever without the use of fever-reducing medications. AND Symptoms (for example cough, shortness of breath) have improved.
Reason for TBP	The incubation period for COVID-19 is thought to extend to 14 days, with a median of 4–5 days from exposure to symptom onset. Most people with COVID-19 who have symptoms will do so within about 11 days of SARS-CoV-2 infection. If exposed to COVID-19, perform post-exposure testing.	It takes about 10 days for someone to stop being infectious after they become ill with COVID-19, which is why it is recommended that someone who tests positive for COVID-19 isolates for 10 days.

Considerations for Healthcare Personnel

Mitigating Healthcare Worker Staffing Shortage

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. In times of COVID-19 surge, healthcare facilities may experience HCP shortages due to employee illness, exclusion from work due to higher-risk exposure, the need to care for ill family members, fear of illness, and burnout.

This guidance is for COVID-19 contingency capacity staffing and crisis capacity staffing strategies,* which are defined as:

Contingency Capacity Staffing

- Healthcare facilities and employers should work with human resources and occupational health services to carry out contingency capacity strategies that plan and prepare for staffing shortages.

Crisis Capacity Staffing

- When staffing shortages occur, healthcare facilities and employers should work with human resources and occupational health services to carry out crisis capacity staffing strategies that ensure safe patient care.

**Note: These strategies are independent of "contingency standards of care" and "crisis standards of care" based on the framework the National Academies of Medicine developed. Unlike implementation of crisis standards of care, which in Washington requires a formal statewide declaration, healthcare facilities and employers may choose to implement contingency capacity staffing and crisis capacity staffing independently.*

The following are considerations for managing healthcare personnel in your facility with infection or exposure to SARS-CoV-2:

Staffing shortages

CDC's Strategies to Mitigate HCP Staffing Shortages offers a continuum of options for addressing staffing shortages. Contingency and then crisis capacity staffing strategies supplement conventional strategies. Contingency strategies should be used before crisis strategies. Facilities experiencing staffing shortages should reach out to their local health jurisdiction, local emergency management and regional health care coalition.

- Strategies to Mitigate Healthcare Personnel Staffing Shortages
- CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- DOH Standards of Care
- WA State Regional healthcare Coalition.

High-Risk Exposures and Isolation:

- CDC Infection Control Guidance: SARS-CoV-2.
- L&I Requirements and Guidance for Preventing COVID-19

Testing

A robust testing program can identify cases earlier, allowing early isolation, identification of people exposed and early source control interventions when indicated.

- HCP and patients should be tested immediately if symptomatic, regardless of vaccination status.
- Skilled nursing facilities should also consider testing upon admission if an individual is at risk for COVID-19.
- Pre-procedure or other pre-admission viral testing is at the discretion of the facility.

  Note: The yield of this testing for identifying asymptomatic infection is likely low when performed on vaccinated individuals. However, these results might continue to be useful in some situations:

  - *When performing higher risk procedures or for HCP caring for patients who are moderately to severely immunocompromised*
  - *To inform the type of infection control precautions used (for example, room assignment, cohorting, or PPE) and*
  - *To prevent unprotected exposures.*
- Expanded screening testing of asymptomatic HCP without known exposures is at the discretion of the facility.
- Follow CDC Testing for COVID-19 if implementing a screening process.
- For testing HCP to return to work following SARS-CoV-2 infection or exposure, see CDC recommendations in CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

Considerations for Immunocompromised People

People who are immunocompromised have an increased and varying susceptibility to severe COVID-19 disease.

Immunocompromising conditions can include, but are not limited to:

- Active cancer treatment
- Hematologic malignancy
- Recipients of solid organ transplants
- Advanced or untreated HIV infection
- Prolonged use of drugs that suppress the immune system
- People born with immunodeficiencies

Individuals with an increased risk for severe disease or who have someone in their household with an increased risk, should consider wearing well-fitting masks or respirators even if source control is not required by a facility.

CDC and NIH also provide additional prevention recommendations, including vaccination and prophylaxis strategies, in the following resources.

- National Cancer Institute COVID-19: What People with Cancer Should Know
- COVID-19 Real-Time Learning Network: Immunocompromised Populations
- CDC COVID-19 Vaccination guidance for people who are moderately or severely immunocompromised
- CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- CDC Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care
- COVID-19 Related Infection Prevention for the Immunocompromised Host - ISID
- Information for Persons Who Are Immunocompromised Regarding Prevention and Treatment of SARS-CoV-2 Infection in the Context of Currently Circulating Omicron Sublineages — United States, January 2023 | MMWR (cdc.gov)

Setting Specific Checklists

Long Term Care Facilities

Residents and staff of LTCFs are disproportionately affected by COVID-19, with more outbreaks, cases, and deaths compared to acute care facilities.

What to do if you identify a COVID-19 case in your Long-term Care Facility:

This checklist provides a framework for responding to COVID-19 in a LTCF and may be used to guide response actions. Consult with your local health jurisdiction (LHJ) when managing outbreaks.

Contain and Prepare

- ☐ **COVID-19 positive resident:** Place in aerosol contact precautions and post precautions sign on door.
- ☐ **COVID-19 positive HCP:** Exclude from work (see CDC Return to Work Criteria). Notify LHJ and follow LHJ direction.

  LHJ Contact _____

  Phone # _____

- ☐ Consider opening a COVID-19 unit and quarantine unit (if not already open):
- ☐ If possible, dedicate separate staff (staff that do not care for residents outside of the COVID-19 unit during their shift) to care of residents with COVID-19.
- ☐ Refer to CDC guidance for mitigating staffing shortages and PPE optimizing strategies if needed. Contact LHJ if experiencing PPE shortages.
- ☐ Ensure adequate specimen collection supplies for point-of-care or laboratory nucleic acid amplification test (NAAT)/polymerase chain reaction (PCR) tests. Identify where you can get additional supplies.
- ☐ Implement universal source control on the unit or area experiencing the outbreak until no new cases are identified for 14 days.
- ☐ Consider placing a hold on admissions to the facility until you can clarify the extent of transmission and implement interventions. Follow guidance from your LHJ.
- ☐ Limit outside-contracted staff entering the building to acutely necessary medical treatments and therapies, and critical building and infrastructure maintenance or repair.
- ☐ Notify all HCP, residents, and families of the outbreak. Reinforce basic infection control practices.

Identify Additional Cases

- ☐ Prepare to conduct unit-wide testing.
- ☐ Identify staff who can assist with specimen collection.
- ☐ Designate a point person to receive and track results.
- ☐ Obtain orders for testing from a licensed provider (DOH, LHJ or Other)
- ☐ With assistance from your LHJ, begin unit-wide testing including all residents and staff present in the facility two days prior to onset of the identified case.
- ☐ Aim for the shortest turnaround time for tests as possible, ideally within 2 days.
- ☐ If using point-of-care antigen tests, report all positive cases to your LHJ.
- ☐ Continue testing all residents and staff on affected unit who previously tested negative every 3–7 days for a minimum of 14 days from most recent positive result, or according to LHJ direction.

Identify Potential Exposures

- ☐ With assistance from your LHJ, identify HCP, residents, and visitors who may have been exposed to COVID-19. Place any resident identified as potentially exposed in quarantine, if they meet criteria per CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
- ☐ If possible, place them in private rooms.
- ☐ If private rooms are unavailable, avoid placing residents with high probability of exposure with residents at high risk for severe disease).
- ☐ HCP with who are asymptomatic generally do not need to be restricted from work following their exposure unless they meet criteria described in CDC guidance. It includes working on a unit that is experiencing ongoing SARS-Cov-2 transmission that is not controlled with initial interventions.

Managing Additional Cases

- ☐ Place all residents who test positive in the COVID-19 unit. Provide care using dedicated staff using aerosol contact precautions.
- ☐ Exclude all staff from work who test positive according to CDC guidance.
- ☐ Maintain adherence to cohorting guidelines, testing frequency, and proper PPE use to minimize your outbreak.

Returning to Normal Operations

- ☐ Follow the CDC's time and symptom-based strategy for returning recovered residents to the general unit. Note that immunocompromised residents may require a prolonged

recovery time.

- ☐ Work with your LHJ on resuming normal operations in line with state and national guidance.

Considerations for Memory Care

This section contains suggested best practices based on memory care facility experiences during the COVID-19 pandemic.

Note: Some suggested practices may not be regulatory requirements. For questions about regulatory requirements, contact your DSHS Field Manager. To find your field member on the Residential Care Services Offices webpage, click on HQ or region 1,2,3 Some recommendations may not apply to all circumstances or all facility types. Please contact your LHJ if you have questions about implementing any of these recommendations.

Memory care poses unique challenges for infection-prevention best practices for the following reasons:

- Residents in memory care may have difficulty understanding or remembering the need to wear masks and follow other infection prevention protocols.
- Residents in memory care may gather closely, touch surfaces, staff, and/or each other frequently. They may become distressed with changes in routine made in response to COVID-19, such as fewer visits, relocation within the facility or unit, change in schedule, and cancellation of group activities.

Proactive Cohorting

- Separate buildings or cottages can be used to house residents with confirmed or suspected COVID-19. If separate buildings are not available, separate wings or hallways could be used.
- If possible, consider keeping a set of adjacent rooms open for immediate quarantine and isolation if an exposure or new case occurs.
- In consultation with DSHS, fire safety officials, and your LHJ, consider closing fire doors to create physically separate spaces for units.

Outbreak Mitigation

- Encourage and remind residents to wear source control if tolerated.
- Consider introducing activities or using TVs and other distractions away from the boundaries between units to discourage residents from attempting to leave their unit.
- Increase staffing during outbreak periods to have extra help monitoring residents and keeping them in their designated units.
- Consider using agency staff if necessary.

- Consider using sitters to help keep residents calm and comfortable in their unit.
- If not in a designated memory care unit, consider placing quarantined or isolated residents who wander in rooms or areas that minimize contact with negative residents. Ensure staff wear fit-tested N95 respirators in quarantined areas or where isolated residents may wander. When moving residents, bring personal comfort items to help them acclimate to new rooms.

Symptoms in Memory Care Residents

COVID-19 may present differently among those with dementia due to their inability to describe symptoms. Follow CDC Infection Control Guidance: SARS-CoV-2 for frequency of evaluating residents for COVID-19.

Common symptoms in the dementia population may include:

Changes in behavior

- Increased agitation
- Increased confusion
- Refusal to eat
- Unexplained falls
- Sudden sadness

Physical Symptoms

- Coughing
- Difficulty breathing
- Fever
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell

PPE Considerations

PPE Guidance is the same for memory care units as it is for other healthcare facility types.

The following list addresses special considerations for use of PPE in Memory Care:

- If residents are having difficulty understanding information related to PPE, staff may consider other PPE options that meet the same level of protection. For

example, goggles instead of face shields, and/or transparent masks approved for use in healthcare settings.

- Use of gowns and gloves in common spaces when PPE is not indicated may increase the risk of transmission among residents and staff. If direct resident care needs to occur outside of a room for a COVID positive/suspected resident, don and doff PPE and perform hand hygiene after care.
- Loose gowns may drape over and touch contaminated surfaces.
- Constant use of PPE can give staff a false sense of security leading to less frequent hand hygiene.
- Isolation carts that contain transmission-based precautions should be placed outside the door of a resident in quarantine or isolation.

To deter residents from touching and contaminating PPE in the cart, consider using:

- A piece of furniture that matches facility décor
- Carts that can be secured. Locks are not recommended as PPE should be easily accessible for staff to don at the door
- Trash bins with lids to reduce resident interest in waste in the bin
- If you determine resident-accessible hand sanitizer stations are a hazard in your facility, consider giving HCP individual hand sanitizers to keep on their person.

Hospitals

What to do if you identify a COVID-19 case in your hospital

This checklist provides a suggested framework for responding to COVID-19 in a hospital and may be used to guide response actions. Consult with your LHJ when managing outbreaks in healthcare settings.

Contain and prepare

- ☐ COVID-19 positive patient: Use appropriate precautions in a negative airflow room, if available. We encourage hospitals to use WSHA/DOH precautions sign.
- ☐ COVID-19 positive HCP: Exclude from work if the newly identified case is a HCP (see CDC Return to Work Criteria). Notify and follow LHJ directions.

  LHJ Contact _____

  Phone # _____
- ☐ Prepare to open your COVID-19 unit (if unable to isolate or have dedicated COVID-19 staff spaces on a regular unit):
- ☐ Ensure adequate staffing to dedicate to care for COVID-19 patients.

- ☐ Prepare for potential staff shortages and identify resources for additional staff. Refer to CDC guidance for mitigating healthcare personnel staffing shortages
- ☐ Ensure adequate PPE, identifying resources if additional PPE is needed. Refer to CDC NIOSH Conserving PPE in Health Care Facilities During Shortages if needed.
- ☐ Implement universal source control on the unit or area experiencing outbreak until no new cases are identified for 14 days.
- ☐ Ensure adequate specimen collection supplies and identify where additional supplies may be obtained.
- ☐ Consider limiting visitation on the unit where a positive case is identified.
- ☐ Notify family or designated power of attorney as appropriate.

Identify potential exposures and additional cases

- ☐ In coordination with your LHJ, and following CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, begin expanded testing of identified possible exposures. This could be a staff department such as IT, a specific hallway where a positive patient resides, or an entire unit.
- ☐ Exposed patients generally do not require quarantine. If a patient requires quarantine per CDC Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic, use the same precautions used for patients who have COVID-19. Patients in quarantine and patients known to have COVID-19 should not be roomed together.
- ☐ Exposed HCP with higher-risk exposures who are asymptomatic generally do not need to be restricted from work for 10 days or 7 days with a negative test following their exposure.
- ☐ Place any potentially exposed patient that requires quarantine in a private room, if possible.
- ☐ If private rooms are unavailable, consider the probability of exposure and risk to the roommate. For example, avoid placing patients with high probability of exposure with patients at high risk for severe disease.
- ☐ Aim for the shortest turnaround time for tests as possible.
- ☐ Report all results to the hospital infection prevention/control and to the LHJ.
- ☐ Complete post-exposure testing for those with identified exposures.

Managing additional cases

- ☐ Place all patients who test positive in the COVID-19 unit (or isolation room on regular unit) and care for using dedicated staff (staff cares for only COVID-19 positive patients or only general patients during their shift).

- ☐ Exclude from work all staff who test positive according to CDC's Return to Work.
- ☐ Maintain strict adherence to cohorting guidelines, frequent testing, and proper PPE use to minimize your outbreak.
- ☐ Refer to CDC guidance for mitigating Healthcare Personnel Staffing Shortages if needed.
- ☐ Refer to CDC's NIOSH Conserving Supplies of Personal Protective Equipment in Healthcare Facilities during Shortages if needed.

Returning to normal operations

- ☐ Follow for returning recovered patients to the general unit. Note that immunocompromised patients may require a prolonged recovery time.
- ☐ Work with your LHJ on resuming normal operations in line with state and national guidance.

Other Setting Specific Resources

Considerations for Assisted Living, Group Homes, and Other Residential Care Facilities

- CDC Infection Control Guidance: SARS-CoV-2
- DOH Respiratory Illness Dashboard
- DOH What to do When you are Sick with COVID-19 or Other Respiratory Virus
- Communal Setting Guidance: How to Protect Yourself and Others
- CDC Respiratory Virus Guidance

Note: Healthcare services delivered in these settings should be informed by CDC Infection Control Guidance: SARS-CoV-2.

Additional Resources

Healthcare Associated Infections and Antimicrobial Resistance Contact Information

Email	Description	Monitored By
HAI@doh.wa.gov	General healthcare associated infection questions	HAI&AR Team
HAIEpiOutbreakTeam@doh.wa.gov	Epidemiological outbreak assistance and healthcare associated infection questions	Epidemiology Team
HAI-FieldTeam@doh.wa.gov	Schedule an ICAR for your facility	ICAR Coordinators
HAI-FITTest@doh.wa.gov	Schedule a respirator (N95) Fit test or training for your facility	Occupational Health Team
MDRO-AR@doh.wa.gov	Multidrug-resistant organisms (MDRO) coordination and guidance	MDRO Team
ProjectFirstline@doh.wa.gov	HAI training program for frontline healthcare workers	Strategic Partners Team

Webinars and Information Sessions

- **Long-Term Care Infection Prevention Empower Hour –** A monthly infection prevention education call for LTC settings such as nursing homes and SNFs. Enhance infection prevention knowledge and stay ahead in protecting residents and staff with the latest infection prevention strategies. Register for Empower Hour.
- **Critical Access Hospital (CAH) Coffee Hour** – A monthly networking opportunity for Critical Access Hospital Infection Preventionists to form connections, seek advice, and discuss current topics in a supportive, non-regulatory platform. To join, please contact HAI@doh.wa.gov.
- **DOH HAI/AR Newsletter –** Subscribe to our monthly newsletter.

Additional Resource Links

Infection Control and Response (ICAR)

- Infection Control and Response (ICAR) Program | HAI-AR | WA DOH
- Infection Control Assessment Tools | HAI | CDC

Multi-Drug Resistant Organisms (MDRO)

- Interim Guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms (MDROs): Updated December 2022 (cdc.gov)
- MDRO Management | Guidelines Library | Infection Control | CDC
- CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings

Signage and Video Demonstrations

- Videos About Infection Control | Project Firstline | CDC

Isolation Precautions

- Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) (cdc.gov) (updated May 2022)
- Isolation Precautions | Guidelines Library | Infection Control | CDC
- Precautions | Appendix A | Isolation Precautions | Guidelines Library | Infection Control | CDC
- Transmission Precautions | Appendix A | Isolation Precautions | Guidelines Library | Infection Control | CDC

Disinfection and Environmental Cleaning

- Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (cdc.gov) (updated May 2019)
- Guidelines for Environmental Infection Control in Health-Care Facilities (cdc.gov)
- CDC Environmental Cleaning in Global Healthcare Settings
- List N Tool: COVID-19 Disinfectants | US EPA

Immunizations

- COVID-19 Vaccines for Long-term Care Residents | CDC
- Resources for Long-Term Care Facilities | Washington State Department of Health

- Long-Term Care COVID-19 Immunization Champion Award | Washington State Department of Health
- Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC
- Subscribe to Immunization Training for Washington State Department of Health
- Subscribe to WA DOH Updates on Long Term Care and Adult Immunizations

Injection Safety

- Considerations for Blood Glucose Monitoring and Insulin Administration | CDC
- Injection Safety | CDC

Fit Testing

- DOH Fit Testing Webpage
- To schedule facility fit testing for your facility, or to speak with an occupational health nurse, please contact: HAI-FitTest@doh.wa.gov

Personal Protective Equipment (PPE)

- Respirator Donning and Doffing Instructions | The University of Texas Medical Branch

COVID Data Tracker

- COVID-19 Vaccinations by County

Ventilation

- DOH Ventilation and Air Quality resource

Laboratory Testing and Cohorting

- Testing and Management for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV2 and Influenza Viruses are Co-Circulating | CDC

Other

- Subscribe to the DSHS Dear Provider Letter
- Medical Test Site Waiver (MTSW)/ Clinical Laboratory Improvement Amendments (CLIA): If you plan to do influenza or RSV antigen testing, you can add these tests to your waiver using this Waiver Change Form.