STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

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Commissioner

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HEALTHCARE QUALITY AND SAFETY BRANCH

BLAST FAX 2020-55

TO: All Nursing Homes

FROM: Commissioner Renée D. Coleman-Mitchell, MPH RDCM

CC: Deputy Commissioner Heather Aaron, MPH, LNHA
Barbara Cass, RN., Branch Chief, Healthcare Quality and Safety Branch
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DATE: May 11, 2020

SUBJECT: **Interim Guidance and Example COVID-19 Cleaning Protocol**

The attached information is specific to:

1. COVID-19 Point Prevalence Survey Testing and Cohorting in Nursing Homes (Interim Guidance – May 11, 2020).
2. Example COVID-19 Cleaning Protocol for Long-Term Care.

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COVID-19 Point Prevalence Survey Testing and Cohorting in Nursing Homes
[Interim Guidance – May 11, 2020]

If done effectively, cohorting can control the spread of COVID-19 in Nursing Homes (NHs). Cohorting physically separates residents potentially capable of transmitting SARS-CoV-2 from those potentially naïve to it. Knowing the COVID-19 status (positive or negative) of all residents within a NH at a given point in time can help inform a cohorting strategy. CDC recommends testing in NHs when results will lead to specific infection control interventions such as cohorting.[1]

With Connecticut's increasing supply of nasopharyngeal (NP) swabs and capacity for laboratories to provide COVID-19 results rapidly, NHs are being prioritized for Point Prevalence Surveys (PPSs) to inform effective resident cohorting. During the month of May, the Connecticut Department of Public Health (DPH) will reach out to every NH to assess if a PPS has been completed, and if not, readiness to conduct one. We strive to test all Connecticut NH residents.

Point Prevalence Survey Testing

A PPS involves testing broadly to determine the COVID-19 status of all residents on the same day. To effectively limit the spread of COVID-19, **cohorting must be done as soon as PPS test results are received**, limiting potential time for change in COVID-19 status from negative to positive before cohorting is completed. To minimize the lag time between PPS testing and cohorting, the servicing laboratory must have a rapid turn-around-time.

PPS specimens should not be submitted to the CT State Public Health Laboratory, as rapid turn-around-times for a high volume of specimens cannot be guaranteed. The Connecticut National Guard is assisting with coordination of specimen submission to laboratories that can commit to providing test results for all specimens within 24 hours of collection.

DPH staff will initiate discussions about PPS with NHs; when a facility is ready, DPH will provide the National Guard with information needed to deliver specimen collection kits and coordinate specimen submission to a designated laboratory.

Important Planning Considerations Before Scheduling a PPS

Before scheduling a PPS, make plans and any preparations that can be made ahead of time to implement cohorting as soon as all resident results are received. A delay between PPS specimen collection and cohorting actions (designating separate areas and moving residents) can potentially extend exposure of COVID-naïve residents to COVID-positive ones.

While some decisions cannot be made until results are available, some decisions need to be made before the PPS.

- Assess physical space, equipment (e.g., boxes, dollys) staffing, and PPE needs for resident movement.
- Decide if residents who have already tested positive will be included in the PPS. See **Considerations for Discontinuation of Transmission-Based Precautions** (page 3).

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- Obtain permission/consent for testing per facility policy.
- Plan for adequate PPE and staffing to collect NP specimens on the day of PPS. Gowns and gloves should be changed between each resident's specimen collection. Facemask/respirator and eye protection may stay on (extended use) between specimen collections. Specimen collector should be trained in donning/doffing PPE.
- Plan for adequate staff and supplies for environmental cleaning/disinfection of rooms after residents are moved out (terminal cleaning) during cohorting. See attached **Example Environmental Checklist.**
- Please review CDC websites with guidance for **Testing[1] and Response[2] to COVID-19 in Nursing Homes** and see **Considerations for Cohorting** (below).

Considerations for Testing Nursing Home Staff

Cohorting *residents* is the priority for this PPS and cohorting initiative, as they are a high-risk population residing in a congregate living setting. As testing resources allow, staff testing should be considered. A resident PPS should not be delayed while planning for staff testing. If a NH is ready to test staff on the PPS date, please discuss with DPH.

DPH has previously recommended that symptomatic NH staff should seek testing. Considerations for testing asymptomatic staff (as part of a staff PPS) include:

- If asymptomatic staff are tested and are COVID-positive, CDC recommends the staff member not return to work until 10 days after their positive COVID-19 test OR two consecutive COVID-19 tests collected ≥24 hours apart.[3] **Facilities should consider staffing contingency plans before testing asymptomatic staff.**[4]
- If asymptomatic staff are tested and are COVID-negative, that is their status for only the point in time of specimen collection. There is no guarantee that they will not later develop illness or the potential to transmit the virus.
- Nonetheless, asymptomatic transmission can be controlled by "universal source control" (which means ALL staff ALWAYS have a mask covering the nose and mouth while in the NH). In addition:
  - Staff should be screened for fever and symptoms before entering NHs.
  - Symptomatic staff should not be allowed into the facility and should be referred for testing.

Considerations for Cohorting: DPH recommends cohorting residents into 3 separate units/areas.

1. **Positive**: residents confirmed to have COVID-19 due to a positive PCR test.
2. **"Negative"**: asymptomatic residents with no known exposures who test negative for COVID-19.
3. **"Exposed"**: roommates of COVID-positive residents undergoing a 14-day quarantine OR symptomatic resident with high clinical suspicion for COVID-19 awaiting test results (also known as Persons Under Investigations or PUIs)

- Each cohort should ideally have dedicated staff and equipment, minimizing movement across cohorts. When movement across cohorts is necessary, staff and equipment should move from "Negative" to "Exposed" to "Positive" where possible.
- Room sharing priorities if single-occupancy rooms are not available:
  - Prioritize private rooms for "Exposed" cohort, where residents could potentially be positive or negative
  - COVID-positive residents can share a room with other COVID-positive residents; COVID-negative residents can share a room with other COVID-negative residents.
- Refusal/declination of testing:
  - If a resident refuses testing AND has a COVID-19 positive roommate OR direct contact with a COVID-positive staff member, consider placing the resident in the "Exposed" cohort.
  - If a resident refuses testing AND has no known exposure AND is asymptomatic, consider placing the resident in the "Negative" cohort.
- Cohorting can help preserve Personal Protective Equipment (PPE):[5]
  - In the Positive cohort, due to current gown shortages, when laundered cloth gowns are unavailable, consider extended use of single use gowns (keeping gown on when moving directly between care for COVID-positive residents). Extended use of facemask/respirator and eye protection should also be considered for the Positive cohort. Change gloves and perform hand hygiene between residents.

- In the Exposed cohort, gown and gloves must be changed between residents, extended use of facemask/respirator and eye protection is acceptable.
- Conserve PPE in the "Negative" cohort. Use only facemask and other transmission-based precautions indicated by patient condition.

Considerations for Discontinuation of Transmission-Based Precautions[6]

- **If the symptom-based strategy is used, residents who previously tested positive by PCR should not be tested during the PPS.**
  - Preliminary viral culture studies suggest that though PCR testing (detection of RNA) can remain positive for over 14 days, transmission (measured by isolation of live virus) is not likely possible 10 days after symptom onset.[7]
  - Previously-positive residents can move from the Positive cohort to the "Negative" cohort when they are at least 72 hours fever-free, symptoms are improved, and it has been at least 10 days since symptom onset.
- **If the test-based strategy is used**, be aware that retesting residents who previously tested positive potentially lengthens the time spent in the Positive cohort beyond the length of transmissibility. If the test-based strategy is used for a resident that was previously positive:
  - Two negative PCR tests (collected ≥24 hours apart), in addition to improvement in symptoms and resolution of fever are required before lifting precautions or transfer to the "Negative" cohort.
  - A persistently positive but asymptomatic resident will need to continue transmission-based precautions until 10 days after the most recent positive result, then can move to the "Negative" cohort.
  - Due to persistence of RNA detection by PCR, DPH does not recommend retesting unless residents are ≥14 days after symptom onset, afebrile for ≥72 hours, and respiratory symptoms are improved.

Testing after PPS and Cohorting: Extra collection kits will be provided. Testing is recommended for:

- Testing all newly symptomatic residents and staff
- PPS of staff and/or a repeat PPS of residents if there is evidence for ongoing transmission within the facility.

Safe Specimen Collection Procedure

Collection of COVID-19 test specimens from patients is safest using a "buddy system": The "Collector" collects the NP specimen, and the "Assistant" performs a clean hand-off to the courier transporting to the processing laboratory.

1. Collector dons appropriate PPE.[8] Assistant is wearing gloves.
2. Collector opens pre-packaged vial and swab kit.
3. Collector verifies and handwrites patient name and DOB on specimen label on Transport Media tube.
4. Collector enters patient's room with pre-labeled vial and swab and closes door to minimize risk of droplet spread.
5. Collector collects NP specimen per protocol,[9] breaking off swab shaft and threading on vial cap completely.
6. Assistant stands outside patient room entrance, verbally checks with Collector that specimen cap is secured, and holds open biohazard bag for Collector.
7. Collector carefully drops specimen vial into biohazard bag, taking care to not touch sides of open bag.
8. Assistant seals bag and wipes it down with sanitizing cloth.
9. Collector doffs PPE as appropriate and performs hand hygiene.
10. Assistant packages specimen with cold packs.
11. Assistant sends the specimen to the processing laboratory with corresponding test requisition.

References: Note that COVID-19 websites are updated regularly.

1. CDC. Testing for Coronavirus (COVID-19) in Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
2. CDC. Responding to Coronavirus (COVID-19) in Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html
3. Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

4. CDC. Strategies to Mitigate Healthcare Personnel Staffing Shortages: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
5. CDC. Strategies to Optimize the Supply of PPE and Equipment: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
6. CDC. Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
7. CDC. Symptom-Based Strategy to Discontinue Isolation for Persons with COVID-19, Decision Memo: https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html
8. CDC. Using Personal Protective Equipment (PPE): https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
9. CDC. Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html

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EXAMPLE COVID-19 CLEANING PROTOCOL FOR LONG-TERM CARE

These checklists can be used by nursing and/or environmental services (EVS) personnel when cleaning and/or auditing cleaning in areas where people with suspected or laboratory-confirmed COVID-19 have been. They can also be used for residents under a 14-day quarantine. In general, cleaning should be performed in the order listed on the checklist.

CDC recommends that only essential personnel enter rooms of residents with suspected or confirmed COVID-19. Consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who already enter these rooms to provide care.[1] This will also help conserve PPE.

If EVS is to conduct daily cleaning for rooms with COVID-19, they should wear all recommended PPE (gown, facemask, eye protection, and gloves) in the room and remove all PPE components upon leaving the room, immediately followed by hand hygiene. Shoe covers are not recommended for rooms with COVID-19.

EVS personnel should not routinely enter rooms where residents with suspected or confirmed COVID-19 might undergo procedures resulting in aerosolization (e.g. BiPAP, CPAP, nebulization, open suctioning).[1] EVS personnel should delay entry into these rooms to perform terminal cleaning until a sufficient time has elapsed for potentially infectious particles to be removed from the air. A minimum of 30–60 minutes may be required, depending on the air changes per hour.[2] Consult with Infection Prevention and Control Department for guidance.

Shared equipment and frequently touched surfaces in resident rooms and common areas should be included in the schedule for regular cleaning.[3] For equipment, use manufacturer's directions on disinfection. Ensure adequate supplies of disinfectants on EPA List N: Disinfectants for Use Against SARS-CoV-2.[4]

References

1. CDC. Healthcare Infection Prevention and Control FAQs for COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html
2. CDC. Guidelines for Environmental Infection Control in Health-Care Facilities (2003), Appendix B. Air. Table B.1. Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency. https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1
3. CDC. Preparing for COVID-19: Long-term Care Facilities, Nursing Homes. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
4. EPA. List N: Disinfectants for Use Against SARS-CoV-2. https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

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I. Equipment

Ensure all necessary equipment is available prior to entering a resident room.

Equipment	Notes	Completed: Y/N
Standard Environmental Cleaning Cart Setup	Example: Disposable wipes/ cloths and mops. Use and change per usual facility protocol	
Personal Protective Equipment (PPE)*	Examples: Isolation Gowns, Gloves, Goggles or face shield, mask (or fit tested N-95 respirator as required for rooms with potential aerosols), liquid impervious gowns	
Waste can liners	Plastic liners (do not need to be marked "biohazard")	
Linen hamper liners		
Approved disinfectants per CDC guidelines	Examples: Virex 256, Virex Plus, Purple top Saniwipes For COVID-19, refer to EPA List N (Reference #4 above)	
Clean bed linen	For discharge cleaning only	
Clean privacy curtains and shower curtains	Cloth or plastic, washable or disposable, as indicated by facility policies	

*Follow facility guidelines for extended use and reuse of PPE, if applicable. Gowns are not to be worn outside the room. Hand hygiene with Alcohol-Based Hand Rub (ABHR) or soap and water should be performed if there is any reason to leave the room.

II. Discharge Cleaning

When a patient has been discharged from a room, a deep clean, also referred to as "terminal cleaning" should be performed before the room is reoccupied. If aerosol-generating procedures were performed in the room, entry into the room for terminal cleaning should be delayed until sufficient time has elapsed for potentially infectious particles to be removed from the air.[2] The actions below are ordered for efficiency and reduced risk of cross-contamination.

Initial Actions

Actions Performed	Notes	Completed: Y/N
Don Proper PPE according to isolation protocol.	Example: Gown, Mask/N95 (fit tested), Goggles/Face Shield, and gloves	
Open all dispensers and remove and dispose of all paper towels and toilet tissue exposed to the open environment.		
Collect and remove all trash and soiled linen from around the room. Empty waste and linen hampers.	Do not replace plastic liners in trashcans or hampers until the room has been totally cleaned	
Properly remove and discard any linen that may be in linen closets inside room that may have been exposed to the open environment.	These should be placed in a soiled linen bag.	
Remove any cloth privacy curtains or shower curtains placing them in bags according to facility policies.	Do not replace with clean curtains until room is cleaned.	

Using approved disinfectant, carefully wipe down all high-touch horizontal surfaces that may have been in contact with patients, visitors, and healthcare workers.

- Always work from high to low when cleaning and dusting
- Always follow recommended manufacturer guidelines for the proper surface contact time and approved square feet the wipe is registered for use and discard wipes and use additional wipes for multiple surfaces.

- Make sure to wipe down bedside table with approved disinfectant, sink area, computer keyboards, workstation areas, and IV poles or any medical equipment per facility guidelines.
- Ensure disinfectant is approved to clean equipment and touch screens before using them on those items.

High-touch surfaces: Begin inside the room and clean the high-touch surfaces in the restroom last, ending with disinfection of the toilet.

High-touch surfaces in the room	Completed: Y/N
Room light switch and room inner door knobs	
Bedside tables and table handles	
Bed rails/controls	
IV poles (grab areas)	
Tray tables	
Call box and button/telephone and buttons	
Chairs- arms and seats	
Room sink fixtures	

High-touch surfaces in the restroom	Completed: Y/N
Bathroom mirror, inner door knob/plate	
Shower handles	
Bathroom handrails by toilet	
Bathroom light switch and sink fixtures	
Toilet flush handle	
Toilet seat- top and bottom	
Toilet bed pan cleaner	
Wipe the rest of the toilet last	
Bedside commodes should be cleaned last and marked according to facility policy to identify it has been disinfected and ready for use by the next patient.	

CHANGE GLOVES here, and any occasion where moving from dirty to clean areas.

Damp dust, then wipe down the rest of the room

Action Performed	Completed: Y/N
Damp dust TV and stands.	
Damp dust over bed lights.	
Damp dust high surfaces around the room beginning at entrance to the room and moving around the room in a circle.	
Damp dust high dust surfaces in the restroom last.	
Dust mop the floor.	

Wiping down patient bed:

Action Performed	Completed: Y/N
Inspect mattress prior to cleaning for rips, tears, leaks. Report any of these to the supervisor (These beds should still be cleaned but not reused until repaired).	
Apply cleaner/disinfectant on the mattress and allow it to remain wet for the appropriate dwell time per manufacturer guidelines. Clean mattress on all surfaces: top, sides, bottom.	
Wipe down the under-bed frame, below the mattress cover, and all surfaces of the bed including springs, wheels, and discard cloths whenever visibly soiled and use a clean cloth.	
Wipe down all reusable pillows	

Last steps

Action Performed	Completed: Y/N
Inspect the walls and all other vertical surfaces, wiping down any spots or stains with a separate clean cloth.	
Remove cleaning supplies and throw away disposable wipes and place cleaning cloths in the laundry as appropriate per facility guidelines.	
Replace trash and linen liners.	
Wet mop the floor using cleaner disinfectant (Do not re use mops for additional rooms).	
Allow floor to dry.	
Place "Yellow Caution sign" in doorway while floor dries.	
Properly remove your PPE. Gowns and gloves should be discarded. Mask can be used for multiple patient rooms throughout shift. Face shields can be cleaned and reused.	
Perform hand hygiene with appropriate product; Alcohol- Based Hand Rub (ABHR) or antimicrobial soap and water.	
Clean and remove Isolation door sign.	
Replace clean bed linen, cloth privacy and shower curtains to replace and prepare room for next patient's use.	
Replace hand sanitizers and paper towels in the room and restroom. Make sure the expiration date is visible when replacing hand sanitizers.	

III. Occupied Room Cleaning

Initial Actions

Action Performed	Notes	Completed: Y/N
Don Proper PPE according to isolation protocol. Be sure to perform hand hygiene before donning proper PPE.	Example: Gown, Mask/N95 (fit tested), Goggles/Face Shield, and gloves	
Collect and remove all trash and soiled linen from around the room. Empty waste and linen hampers. Replace liners.		
Inspect any cloth privacy curtains or shower curtains for visible soiling and replace as needed	Do not replace until room is cleaned.	

Using approved disinfectant, carefully wipe down all high-touch horizontal surfaces that may have been in contact with patients, visitors, and healthcare workers.

- Always work from high to low when cleaning and dusting
- Always follow recommended manufacturer guidelines for the proper surface contact time and approved square feet the wipe is registered for use and discard wipes and use additional wipes for multiple surfaces.
- Make sure to wipe down bedside table with approved disinfectant, sink area, computer keyboards, workstation areas, and IV poles or any medical equipment per facility guidelines.
- Ensure disinfectant is approved to clean equipment and touch screens before cleaning.

High-touch surfaces: Begin inside the room with high-touch surfaces in the restroom last, ending with toilet disinfection.

High-touch surfaces in the room	Completed: Y/N
Room light switch and Room inner door knobs	
Bedside tables and table handles	
Bed rails/controls	
IV poles (grab areas)	
Tray tables	
Call box and button/telephone and buttons	
Chairs- arms and seats	
Room sink fixtures	

High-touch surfaces in the restroom	Completed: Y/N
Bathroom mirror, inner door knob/plate	
Shower handles	
Bathroom handrails by toilet	
Bathroom light switch and sink fixtures	
Toilet flush handle	
Toilet seat- top and bottom	
Toilet bed pan cleaner	
Wipe the rest of the toilet last	
Bedside commodes should be cleaned last and marked according to facility policy to identify it has been disinfected and ready for use by the next patient.	

CHANGE GLOVES here, and any occasion where moving from dirty to clean areas.

Damp dust, then wipe down the rest of the room

Action Performed	Completed: Y/N
Damp dust TV and stands.	
Damp dust over bed lights.	
Damp dust high surfaces around the room beginning at entrance to the room and moving around the room in a circle.	
Damp dust high dust surfaces in the restroom last.	
Dust mop the floor.	

IV. Common Areas

This checklist can be modified to track all the common areas in your facility/unit.

Locations	Completed: Y/N
Hallways and alcoves	
Nurses' Stations	
On-unit Staff Lounges and Restrooms	
Staff Locker rooms (including locker room showers and bathrooms)	
Dirty supply areas	
Clean supply areas	
Offices	
Conference rooms	
Other	

High-touch areas should be wiped down using disposable disinfectant wipes.

High-Touch Areas	Completed: Y/N
Door or drawer handles/knobs/strike plates	
Hand rails and light switches	
Soap and Hand Hygiene dispensers	
Sinks, faucets, and toilets	
Counters, tables, and chairs	
Glass, keyboard/touch screens (if cleanable)	
Phones, Isolation carts, and Linen carts	

Credit: Crothall Healthcare and Eastern Connecticut Health Network