

*Department of Mental Health
Inpatient Licensing Division
Bulletin #20-05R
Revised for Implementation 9/1/2020*

***Clinical Competencies/Operational Standards Related to Infection Control In
Response to the COVID-19 Pandemic***

Tier 1 (All Facilities)

All Psychiatric units in free standing hospitals or units within general hospitals are expected to have the capability to provide necessary infection control for patients requiring inpatient psychiatric hospitalization in response to the COVID-19 pandemic.

A. Facility Requirements:

A Tier 1 inpatient psychiatric facility shall:

1. Follow current visitor guidelines located at: [Visitor Access Information and Visitation Policies and Guidelines](#)
 - a. All visitors should be screened for symptoms and other risk factors for COVID-19, and have their temperature taken prior to entry into the facility. If unable to visit, the hospital/unit should provide a device to facilitate virtual visiting, or allow patients to use their own electronic devices for this purpose, unless a clinical assessment deems them unable to safely use devices.
2. Educate staff about preventing the transmission of respiratory pathogens such as COVID-19 and ensure they can demonstrate competency.
3. Promote social distancing and avoiding congregating of patients and staff, maintaining 6-foot distance at all times, as able.
4. Promote frequent hand hygiene and covering coughs and sneezes. Post visual alerts (e.g., signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette.
5. Minimize patient sharing or simultaneous use of bathrooms.
6. Conduct, at minimum, screening of patients for COVID-19 signs and symptoms once per day shift and once per evening shift. These checks should consist of taking and recording vital signs, inclusive of temperature and oxygen saturation. Night shift checks should be done based on clinical judgement or when ordered by a licensed independent provider.
7. Conduct, at minimum, screening of staff for COVID-19 symptoms at the beginning of each shift. Ensure that staff are aware of sick leave policies. Staff should be encouraged to stay home if they are not feeling well.
8. Test all patients who have a temperature >100.4 F for COVID-19, even if they have had prior negative COVID-19 test.

9. Conduct facility and unit cleaning via a standardized protocol for housekeeping, with an emphasis on high touch areas such as door handles. Full description is provided of CDC recommended cleaning and disinfecting procedures:
<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html>
 - a. Increased attention should be paid to cleaning of patient bathrooms and staff restrooms. Shared bathrooms should receive even more frequent cleaning and may require monitoring of use to determine the frequency of cleanings.
 - b. If a patient who is presumed or confirmed to be infected with COVID-19 is transferred, the vacated room is vacated for the appropriate time per CDC guidance and then must be terminally cleaned prior to allowing access to the room by hospital staff or reassignment of the room to another patient.
10. Ensure all staff, regardless of unit, always wear face masks. At all times, when staff are in a quarantine COVID-19 area, full personal protective equipment (PPE) must be worn. Staff should be able to demonstrate proper donning, doffing, and disposal of any PPE.
 - a. Full description is provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings:
<https://www.cdc.gov/infectioncontrol/guidelines/isolation/>
 - b. Using Personal Protective Equipment (PPE):
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>
11. Determine the best estimate for the amount of needed PPE, monitor PPE supplies, and have a procedure for obtaining additional PPE when needed. If the facility's standard orders for PPE are not being filled and emergency supplies are required, orders for PPE can be placed by completing a DPH order form and sending it through the Department of Mental Health (DMH) contact person for submission.
 - a. The CDC provides a PPE burn rate calculator to assist with more accurately determining ongoing PPE needs: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html>
12. Ensure all patients are clinically assessed for safety in wearing masks. Patients who are safely able to do so should wear face masks when they are outside of their rooms and if necessary, have adjustment made for safety such as removing metal clips if self-injury is likely.
13. Establish presumed negative COVID-19 and quarantine spaces within the facility with clear criteria for entry into that space and for movement between spaces, as described in **Section C**.
14. Establish a procedure for COVID-19 testing, including if necessary, an established relationship with a provider for sample collection, testing, and provision of results. Testing should be completed in the following situations:
 - a. For all patients upon admission, unless initiated or completed by the referral source (e.g., emergency department);
 - b. For any patient or staff who displays symptoms;
 - c. For any patients and staff who were exposed to any patient or staff confirmed to be infected with COVID-19, consulting with the DPH epidemiologist line or the internal

infection control specialist to determine the level of exposure and corresponding appropriate testing of staff and patients; and

- d. Otherwise when deemed medically appropriate.
15. Test all patients prior to or upon admission to an inpatient psychiatric facility for COVID-19, to the extent possible. After accepting a referral, a Tier 1 inpatient facility must admit an asymptomatic patient with no known exposure to COVID-19 upon receipt of COVID-19 test results or within six hours, whichever is first. Upon acceptance of a referral, admission may not be delayed for an asymptomatic patient with no known exposure to COVID-19 by more than six hours due to pending COVID-19 test results; provided however, that a child/adolescent or geriatric unit may require no more than 1 negative test result prior to admission.
 - a. It is recommended that patients with known exposure to, with symptoms of, or confirmed to be infected with COVID-19 who do not require acute levels of medical care but do require inpatient psychiatric care be admitted to a Tier 2 inpatient psychiatric facility.
 - b. Patients awaiting test results must be quarantined.
 - i. If the test results are negative for COVID-19, the patient may enter the presumed negative COVID-19 area, beginning symptom checks, at least once per shift.
 - ii. If the test results are positive for COVID-19, the patient should remain in the quarantine area. The facility should refer to the guidelines outlined in **Section D.1** below.
 - c. Patients unwilling or unable to be tested for COVID-19 should be treated as presumed to be infected with COVID-19, while continuing efforts to encourage patients to allow testing for their own and others' safety. DMH COVID Bulletin 20-03 provides guidance on isolation of patients confirmed or presumed to be positive for COVID-19.
 - d. Tier 1 inpatient psychiatric facilities with populations at higher risk of adverse outcomes for COVID-19 may consult with DMH to determine if the individual facility is in a situation where COVID-19 test results should be required for all admissions.
 16. Establish a relationship with a medical hospital for consultation, coordination of care, and to facilitate transfer of patients requiring more intensive medical care. a. Consultation should include the ability to discuss cases, provide the latest guidance, and triage transfer requests with the medical hospital, thereby increasing appropriate transfers and minimizing unnecessary transfers. Recommended consultation would also include psychiatric consult liaison work with the medical facility via telehealth, providing clinical support and psychiatric specialty services to the patient while in the medical setting.
 17. Ensure ongoing consultation with an infection control specialist and/or epidemiologist, either through the consultative medical hospital or through a separate source.
 18. Coordinate care with Tier 2 inpatient psychiatric facilities to facilitate the transfer, when necessary, of patients presumed or confirmed to be infected with COVID-19 who do not require an acute level of medical care but do require inpatient psychiatric care.
 - a. When a patient is transferred to a medical hospital for evaluation and care of any condition, including but not limited to COVID-19, accept the patient's return when

medical hospital level of care is no longer required and once that patient tests negative for COVID-19, assuming they continue to meet hospital level of care psychiatrically. If the patient tests positive for COVID-19, transfer to a Tier 2 inpatient psychiatric facility from the medical hospital is recommended unless the Tier 1 facility can demonstrate the capacity to provide Tier 2 level of infection control for the patient within a small portion of the unit or hospital, even though it may be insufficient for direct admissions purposes. Tier 1 inpatient psychiatric facilities should coordinate with medical hospitals to facilitate transition to Tier 2 inpatient psychiatric facilities. If an emergency department is unable to directly transfer a patient who is medically stable but confirmed to be infected with COVID-19 to a Tier 2 facility or hold them any longer, a Tier 1 facility should accept the patient back and keep them in the quarantine area, away from other patients, and focus on expedient transition to a Tier 2 facility.

19. If any staff member or patient tests positive for COVID-19, consult with DPH Epidemiologist line (617) 983-6800 to determine best course of action, including admissions. Consultation with additional infection control specialists may also be required.
 - a. Patients who are ready for discharge home may do so with instructions for self-quarantine at home.

B. Frontline Staffing:

Unless otherwise specified “staff” in this section refers to frontline clinical staff. A Tier 1 inpatient psychiatric facility shall:

1. Create a back-up plan for staff shortages in the event that multiple staff members need to quarantine as a result of testing positive for or becoming symptomatic for COVID-19.
2. Ensure all staff can recognize the signs and symptoms of COVID-19 and that there is a procedure in place for alerting the nurse responsible for the patient’s care if such are identified.
3. To the maximum extent possible, create two distinct and consistent staffing teams designated to the presumed negative COVID-19 and quarantine areas. To the maximum extent possible, do not inter-mix staff between areas during an assigned shift. In the event that staffing is not adequate to field completely separate teams, maximal efforts must be made to keep as many staff as possible on a team. Strict use of and changing of recommended PPE, in line with the most recent DPH PPE guidance, must be enforced when staff are needed to cross between the quarantine area and the presumed negative COVID-19 area.
 - a. This Staff Cohort practice can help with detection of emerging patient condition changes and limit cross contamination. Whenever possible, staff should not move to a different unit but remain with their cohorted staffing team each shift.
 - b. To the maximum and appropriate extent possible, minimize the number of staff caring for each patient.
 - c. If full separation of staffing teams is not feasible for a facility, the maximum execution of this is still expected (i.e., an approach that minimizes overlapping staff must be conscientiously implemented).
4. Limit all workforce, not just frontline clinical staff, interactions with patients presumed or confirmed to be infected with COVID-19 to the extent possible.

C. Dedicated Quarantine Area

A Tier 1 inpatient psychiatric facility shall:

1. Create a dedicated quarantine area in a separate area or unit within the facility. a. If a psychiatric unit in an acute general hospital has rapid testing, the ability to transfer patients confirmed to be infected with COVID-19 to an internal medical partner as needed, and the ability to safely isolate any patient who becomes suspected, presumed, or confirmed to be infected with COVID-19 at any time, they may not be required to have an area permanently and solely dedicated to quarantine. Any facility believing they meet these requirements should consult with DMH to discuss adjusted guidance.
2. Encourage all patients in quarantine area to wear masks at all times. Patients in quarantine area must wear masks when out of their room.
 - a. All patients should be clinically assessed for safety in wearing masks and if necessary, have adjustment made for safety such as removing metal clips if self-injury is likely.
3. Encourage patients to stay in room with door closed, maintaining the ordered level of patient safety checks or observation.
4. Minimize staff coming on and off the dedicated quarantine area.
5. Have no face-to-face group treatment in the quarantine area, due to the uncertainty of COVID-19 diagnosis in the quarantine area.
6. Encourage telemedicine for provision of care to the extent possible.
7. Provide patient meals in rooms, using disposable supplies, in the quarantine area. Each patient needs to be assessed to determine if they are safe to use disposable utensils.
8. Ensure supplemental oxygen available if needed to maintain saturation above 92% for any patient confirmed to be infected with COVID-19 awaiting transfer to a medical service for worsening shortness of breath with a medical order.

D. Clinical Management:

1. Suspected, Presumed, or Confirmed Cases of COVID-19

For suspected, presumed, or confirmed cases of COVID-19, a Tier 1 inpatient psychiatric facility shall:

- a. Immediately move any patient who develops signs or symptoms of COVID-19, is otherwise suspected to be infected with COVID-19, or is known to be infected with COVID-19 to the quarantine area. The patient should wear a mask.
- b. Keep the door to the room closed, as able. If a patient refuses to remain in the room, locked door/staff secure seclusion should occur to maintain safety of patient and unit. Extreme caution must be exercised during locked door seclusion, especially if the door does not have a window, as the patient must be able to be visualized by staff at all times. See separate document regarding DMH regulations that apply to this behavioral seclusion:
<https://www.mass.gov/doc/dmh-licensing-bulletin-20-03-admission-and-treatment/download>

- c. Ensure all direct care of such patients at this juncture occur with staff in PPE per CDC and DPH guidance.
 - i. CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>
 - ii. DPH Guidance on Optimization of PPE in the Commonwealth of Massachusetts: <https://www.mass.gov/doc/guidance-for-prioritization-of-personal-protective-equipment-ppe-in-massachusetts/download>
- d. If unable to safely isolate a patient confirmed to be infected with COVID-19, unable to provide the appropriate level of medical care required by patient, or unable to transfer patients to an internal medical partner as needed: immediately initiate a transfer to either a medical facility or a Tier 2 inpatient psychiatric facility, depending on clinical symptoms and the level of care required by the patient.
 - i. Tier 1 inpatient psychiatric facility must obtain COVID-19 test results, even after transfer.
- e. If able to safely isolate a patient confirmed to be infected with COVID-19, provide the appropriate level of medical care required by patient, and transfer patients to an internal medical partner as needed: initiate testing and have patient remain in quarantine space.
 - i. A patient may be transferred to the presumed negative COVID-19 area after 14 days since symptoms first appeared (or when positive swab was taken) and 72 hours with no symptoms, including afebrile without antipyretic use. Patients who need added staffing supports post-recovery are likely better served by closer staffing in a quarantine area.

2. COVID-19 Recovery

Individuals who tested previously positive for COVID-19 and were either symptomatic or asymptomatic and have recovered per symptoms and time course will be considered in recovery (and not infectious) and no longer require transmission-based precautions using a symptom-based strategy (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html> : Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings).

Symptomatic COVID-19 Infection:

- a. Will be considered clear based on severity of COVID-19 illness and the following criteria:
 - i. At least 10 days and in some cases, up to 20 days (based on CDC-based severe cases) have passed since symptoms first appeared AND
 - ii. At least 24 hours have passed since last fever without the use of fever-reducing medications AND
 - iii. Symptoms (e.g. cough, shortness of breath) have improved

- iv. Regarding even more severe COVID-19 infections with persisting symptoms, the referring center should obtain consultation with an infection disease expert for guidance on clearance for transfer.
- b. Immunocompromised individuals—consultation with infection disease expert should be obtained for clearance for transfer, or refer to DPH Epidemiology line: 617-983-6800.
- c. No repeat COVID-19 testing should be required for transfer after having met the criteria above, for 90 days from the start of index infection or first known test positive for COVID-19
 - i. Should new onset of symptoms occur during this timeframe, the referring center should be able to present an alternate cause for symptoms, or have obtain consultation with an infection disease expert for guidance on clearance for transfer
 - ii. If the individual remains recovered but shows positivity on a Covid swab taken >90 days after recovery while remaining recovered, the referring center should obtain consultation with an infection disease expert for guidance on clearance for transfer

Asymptomatic with COVID-19 Positive test result

- a. At least 10 days have passed since the first COVID-19 positive test
- b. Individual remains asymptomatic throughout the time since first positive COVID-19 test
- c. Should person develop symptoms at any time, treat as a Person Under Investigation (PUI) and assume COVID-19 infection
- d. No repeat COVID-19 testing should be required for transfer after having met the criteria above, for 90 days from the date of the first known test positive for COVID-19
 - i. Should new onset of symptoms occur during this timeframe, the referring center should be able to present an alternate cause for symptoms, or have obtain consultation with an infection disease expert for guidance on clearance for transfer
 - ii. If the individual remains recovered but shows positivity on Covid swab taken >90 days after recovery while remaining recovered, the referring center should obtain consultation with an infection disease expert for guidance on clearance for transfer

Each facility shall ensure that all staff designated to provide the listed services receive education and demonstrate competencies (i.e., upon hire, as needed, and/ or annually) that are consistent with their role in patient care regarding the above competencies. Each facility shall further ensure that medical and nursing care staff are trained in and can demonstrate knowledge of the facility's policy or plan for securing the resources necessary to provide the listed services and to provide just-in-time training to all staff who will provide care to the patient being admitted.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See Bulletin 18-01]

All inpatient psychiatric facilities should monitor the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), Department of Mental Health (DMH), Department of Public Health (DPH) and MassHealth websites for up-to-date information and resources:

CMS website: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

CDC website: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

DMH LICENSED FACILITY BULLETIN 20-03 MAY 1, 2020: Admission and Treatment of Patients with COVID-19: <https://www.mass.gov/doc/dmh-licensing-bulletin-20-03-admission-and-treatment/download>

DPH's website provides up-to-date information on COVID-19 in Massachusetts:
<https://www.mass.gov/2019coronavirus>.

MassHealth's website provides COVID-19 related information for MassHealth providers:
<https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers>

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.
Effective September 1, 2020