Department of Mental Health
Inpatient Licensing Division
Bulletin #22-01R
January 10, 2022
Revised November 3, 2022

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

This DMH Licensing Bulletin replaces DMH Licensing Bulletin #20-05R and all attachments related to Tier 1 and Tier 2 Facilities

The Massachusetts Department of Mental Health (DMH) continues to work with our state and local partners to address Coronavirus Disease 2019 (COVID-19), caused by the virus SARS-CoV-2, and we continue to appreciate the essential role you have in responding to this evolving situation. We recognize that providing care for individuals seeking inpatient psychiatric treatment who test positive for COVID-19 may prove to be especially challenging for mental health care practitioners and facilities. In consideration of continued increasing indicators of community transmission including variants of SARS-CoV2, DMH is issuing this revised bulletin to licensed facilities for admitting and caring for patients with confirmed COVID-19 to help mitigate the spread of COVID-19. The information in this bulletin is intended to complement each hospital's internal infection control expertise. This update replaces the January 10, 2022 version and incorporates new isolation and exposure guidance.

A. Screening of all Individuals:
    1. Hospitals should screen all individuals entering the facility for symptoms but may utilize posted signage as a means to do so. Hospitals should have all individuals entering the facility (including healthcare personnel and visitors) self-assess for symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, runny nose, headache, myalgia, chills, fatigue, gastrointestinal symptoms, new onset loss of smell or taste and a fever). Hospitals should post signage at facility entrance(s) explaining self-screening to visitors and staff. If a visitor self-screens positively for symptoms or a diagnosis of SARS-CoV2 infection in the past 10 days, then they should not be allowed to enter the facility. Any healthcare personnel who had a diagnosis of SARS-CoV-2 infection in the prior 10 days must meet the return to work criteria outlined here: Guidance for Health Care Personnel with SARS-CoV2 Infection or Exposure | Mass.gov

2. Visitors must be provided a facility-issued mask upon entry to the hospital. Visitors are required to wear a mask at all times while in the hospital and to perform hand hygiene when visiting a patient. Follow current visitor guidelines located at: hospital-visitation-guidance_10.13.22.doc (live.com)
3. To augment in-person visitation, the hospital/unit should also offer 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.

B. Facility Requirements:
   1. Encourage patients, healthcare personnel and visitors to remain up to date with all recommended COVID-19 vaccine doses.
   2. Ensure all staff always wear well-fitting face masks while they are in the facility unless they are in well-defined areas that are restricted from patient access (e.g. staff meeting rooms, staff break rooms).
   3. Full PPE, including fit tested NIOSH-approved particulate respirators with N95 filters or higher or alternative, eye protection, (i.e., goggles or a face shield that covers the front and sides of the face) gloves, and gown, should be worn per DPH and CDC guidelines for the care of any patient with known or suspected COVID-19. Department of Public Health Comprehensive PPE guidance may be found here: https://www.mass.gov/info-details/ppe-testing-and-vaccine-supply-resources-during-covid-19#personal-protective-equipment-(ppe)-during-covid-19-
   4. Staff should demonstrate competency in donning, doffing, and disposal of PPE. Competency should be routinely assessed by designated infection prevention leads by performing audits and using audit results to promote improvement. See https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
   5. Ensure all staff can recognize the signs and symptoms of COVID-19 and that a procedure is in place for alerting the nurse responsible for the patient's care.
   6. Promote physical distancing and avoid congregating of patients and staff.
   7. Promote frequent hand hygiene and respiratory cough etiquette. Post visual alerts (e.g., signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette.
   8. Minimize patient sharing or simultaneous use of bathrooms/shower areas.
   9. 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. Hospitals can purchase facemasks that are appropriate for patients with self-injury behaviors.
   10. Exceptions for wearing masks include situations that may inhibit an individual from wearing a facemask safely. These may include, but are not limited to:
       a. Those with a certain mental health or other medical or disabling condition; or for whom wearing a mask would affect the person's ability to breathe safely.
       b. Those communicating with a person who has a hearing impairment or other disability.
       c. The person depends on supplemental oxygen to breathe.

    d. Those in specific circumstances, such as receiving medical or dental care.
11. Patients should be asked about COVID-19 symptoms and must have their temperatures checked a minimum of one time per day. On unit(s) conducting outbreak testing, a hospital/unit should assess patients for symptoms of COVID-19 during each shift. Additional checks should be done based on clinical judgement or when ordered by a licensed independent provider.
12. Transfers of patients from one acute psychiatric inpatient unit to another is allowed in limited instances in accordance with consultation from the hospital's internal infection control team and/or DPH epidemiology department. DMH should be notified when this occurs but approval is not required.
13. Isolate any patients who have new signs of COVID-19 and test them, regardless of vaccination status even if they have had a prior negative COVID-19 test.
14. Conduct routine facility and unit cleaning and disinfection using an EPA-registered, hospital grade disinfectant and a standardized protocol for housekeeping, with an emphasis on frequently touched surfaces or objects for appropriate contact time as indicated on the product's label. Full description is provided of CDC recommended cleaning and disinfecting procedures: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
    a. Refer to List N on the EPA website for EPA-registered disinfectants that kill SARS-CoV-2 when used according to manufacturer's instructions. It is also recommended that facilities consult List P: Antimicrobial Products Registered with EPA for Claims Against Candida Auris | US EPA, due to increasing incidence of these infections in the population.
    b. Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles [see https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1]
    c. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.
    d. Facility and unit cleaning should also include 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.
15. Determine the best estimate for the amount of needed PPE, monitor PPE supplies, and have a procedure for obtaining additional PPE when needed. 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
16. Establish a procedure for COVID-19 testing, including if necessary, an established relationship with a provider for sample collection, testing, and provision of results. Facilities may use any FDA EUA-authorized rapid antigen test to perform testing. Positive FDA EUA-approved rapid antigen test results no longer need to be confirmed with a molecular test.

17. Testing should be completed in the following situations:
    a. Testing all newly admitted patients for COVID-19 regardless of vaccination status is recommended unless the patient is recovered in the last 30 days. Waiting for test results should not delay a person's admission to the facility. Patients who test negative test on day 0 (i.e., upon admission) should be retested on day 2, and day 5 or later and should wear a mask around others through day 10, as they are able. For any patient or staff who displays COVID-19 symptoms.

       For any patients and staff who were exposed to any patient or staff confirmed to be infected with COVID-19 and not recovered from COVID-19 in the last 30 days should be tested as soon as possible, but not sooner than 24 hours following exposure, on day 3 and day 5, and should wear a mask around others through day 10. , see guidelines for staff: Guidance for Health Care Personnel with SARS-CoV2 Infection or Exposure | Mass.gov

       For patients: COVID-19 Isolation and Exposure Guidance for the General Public

    b. Otherwise, testing should be done when deemed clinically appropriate.
       i. If the test results are negative for COVID-19, the patient may enter the general population, beginning symptom checks, at least once per day.
       ii. If the test results are positive for COVID-19, the patient should be managed with isolation precautions until they meet criteria for discontinuation of isolation. The facility should refer to the guidelines outlined in Section E.1 below.
18. Patients unwilling or unable to be tested for COVID-19 should be assessed for signs and symptoms of COVID-19 and for any exposure while continuing efforts to encourage patients to allow testing for their own and others' safety. If the patient does not have any signs or symptoms of COVID-19 and no known exposure, then they can remain in the general population.
19. DMH COVID Bulletin 20-03R provides guidance on isolation of patients confirmed to be positive for COVID-19.
20. Establish a relationship with a medical hospital for consultation, coordination of care, and to facilitate transfer of patients requiring more intensive medical care. 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.

21. Ensure ongoing consultation with an internal infection control specialist and/or epidemiologist. If the hospital does not have access internally, arrange this through the consultative medical hospital or through a separate source.
22. When a patient is transferred to a medical hospital for evaluation and care of any condition, including but not limited to COVID-19, the inpatient psychiatric facility must accept the patient's return when medical hospital level of care is no longer required.
23. If any staff member or patient tests positive for COVID-19, and the hospital does not have an internal infection control specialist consult with DPH Epidemiologist line 617-983-6800, or the local Board of Health (depending upon hospital location to determine best course of action, including how to manage admissions.) Consultation with additional infection control specialists may also be required.
24. Patients who are exposed and are ready for discharge home may do so with instructions for care at home. COVID-19 Isolation and Exposure Guidance for the General Public

C. Frontline Staffing:

Unless otherwise specified, "staff" in this section refers to frontline clinical staff. All inpatient psychiatric facilities shall:

1. Create a back-up plan for staff shortages in the event that multiple staff members need to isolate and remain out of work as a result of testing positive for or becoming symptomatic for COVID-19.
2. Whenever possible, create separate staffing teams that are dedicated for patients that are COVID-19-positive within the same shift. Exercise consistent assignments of staff to patients regardless of symptoms or COVID-19 status. This practice can help with detection of emerging condition changes. 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. If staff need to care for patients across care areas then inpatient psychiatric facilities must require that staff change recommended PPE between caring for different patients, in line with the most recent DPH PPE guidance and perform hand hygiene.
    a. 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).
3. Limit all workforce, not just frontline clinical staff, interactions with patients who are exposed or confirmed to be infected with COVID-19 to the extent possible.
4. All HCP who have either tested positive for SARS-CoV2 or who are exhibiting symptoms of COVID-19 and have been told by a provider that they have, or probably have, COVID-19, even in the absence of a test, should isolate. An isolating HCP who had COVID-19 symptoms may return to work: after 5 days have passed since the first positive test was taken; AND symptoms have substantially improved, including being fever-free, for 24 hours; AND the HCP received a negative test (antigen) on Day 5 or later.
5. An isolating HCP who has been asymptomatic and is isolating may return to work after 5 days once: the HCP received a negative test (antigen) on Day 5 or later.

6. Any HCP who returns to work prior to 10 days since their first positive test was taken should avoid caring for patients who are moderately to severely immunocompromised until after 10 days has passed since their positive test.
7. HCP who have been exposed to someone who has COVID-19 but are not themselves exhibiting any symptoms and have not tested positive, do not need to be restricted from work provided they remain asymptomatic.
8. Exposed asymptomatic HCP who have a community exposure should have a negative test prior to returning to work.
9. Please see the following link: Guidance for Health Care Personnel with SARS-CoV2 Infection or Exposure | Mass.gov

D. Isolation

All inpatient psychiatric facilities shall:

1. Identify an isolation space(s) where COVID-19 positive patients can be separated from patients who do not have COVID-19 or who have unknown COVID-19 status. This area may be a specific room on the unit or section of the unit, or it may be the patient's own bedroom.
2. If tolerated, patients in isolation should wear facemasks issued by the facility when staff are providing care to them and especially when out of their room.
3. Encourage patients to stay in room, maintaining the ordered level of patient safety checks or observation.
4. Minimize staff coming into and out of the isolation area.
5. Encourage and facilitate video-conferencing for provision of care to the extent possible.
6. Provide patient's in isolation with meals in rooms. Each patient needs to be assessed to determine if they are safe to use utensils.
7. Ensure supplemental oxygen is available if needed to maintain saturation above 92% unless otherwise medically indicated for any patient while awaiting transfer to a medical service for a change in respiratory status.

E. Clinical Management:

1. Confirmed Cases of COVID-19

   For confirmed cases of COVID-19, an inpatient psychiatric facility shall:

   a. Place a patient with confirmed COVID-19 infection in a single person room if available and not share a bathroom with others who are not COVID-19 positive. The door should be kept closed (if safe to do so).
   b. Patients who are confirmed to be infected with COVID-19 may be cohorted together. Multi drug resistant organization (MDRO) colonization status and/or presence of other communicable disease should also be taken into consideration when making cohorting decisions.
   c. For patients who are confirmed to be infected with COVID-19, keep the door to the room closed, as able. If a patient refuses to remain in the room, locked door/staff secure seclusion may be considered in a manner consistent with (DMH Bulletin 20-03R).

d. If unable to provide the appropriate level of medical care required by patient, immediately initiate a transfer to a medical facility for evaluation.
e. If able to provide the appropriate level of medical care required by patient, initiate testing if patient has not already tested positive and have patient remain in isolation if the test result is positive.
f. A patient infected with COVID-19 may be released from isolation and transferred back to a general unit after 5 days since symptoms first appeared (or when positive swab was obtained) and 24 hours with no or improving symptoms, including being afebrile without antipyretic use; and a negative antigen test result collected on day 5 or later. The patient should continue to wear a face mask while near to others through Day 10. If the patient cannot wear a face mask, then they should remain in isolation for an additional 5 days.

2. COVID-19 Clearance from Isolation and Transmission-Based Precautions
Patients with COVID-19 may be released from isolation after five days from symptom onset, if afebrile for at least 24 hours, any symptoms have improved and they have a negative viral test collected on day 5 or later or, if asymptomatic, after five days from specimen collection date of the positive COVID-19 test and have a negative viral test collected on day 5 or later. These residents must wear a mask around others through day 10.

Individuals who previously tested positive for COVID-19 and were either symptomatic or asymptomatic and have recovered per symptoms and time course are considered to not be 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).

a. Symptomatic COVID-19 Infection:
   i. Will be considered clear based on severity of COVID-19 illness and the following criteria:
      - At least 5 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 (e.g. cough, shortness of breath) have significantly improved.
      - Negative antigen test collected on day 5 or later.
      - These patients must wear a mask around others through day 10.
   ii. Regarding severe COVID-19 infections with persisting symptoms, the referring center should obtain an internal medicine consultation for guidance on clearance to release from transmission-based precautions.
   iii. No repeat COVID-19 testing should be required for transfer after having met the criteria above, for 30 days from the start of infection or first known test positive for COVID-19.

iv. Should new onset of symptoms occur during this timeframe, the inpatient psychiatric facility should perform a COVID-19 antigen test and obtain consultation with an infection disease expert for guidance.

b. Asymptomatic with COVID-19 Positive test results.
   i. At least 5 days have passed since the first COVID-19 positive test.
   ii. Individual remains asymptomatic throughout the time since first positive COVID-19 test and have a negative viral test collected on day 5 or later. These patients must wear a mask around others through day 10.
   iii. No repeat COVID-19 testing should be required for transfer after having met the criteria above, for 30 days from the date of the first known test positive for COVID-19.
   iv. Should new onset of symptoms occur during this timeframe, the inpatient psychiatric facility should obtain a COVID-19 test and obtain consultation with an infection disease expert for guidance
c. Immunocompromised individuals—consultation with infection disease expert should be obtained for clearance to release from transmission-based precautions.
d. Patients with severe to critical illness and who are not moderately to severely immunocompromised may be released from isolation if at least 10 days and up to 20 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 (e.g., cough, shortness of breath) have improved.

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 or APRN 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 DMH 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/hcp/infection-control-recommendations.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

DMH LICENSED FACILITY BULLETIN 20-03R 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.