Contents

[Screening 1](#_Toc41653711)

[PPE and Community Spread 1](#_Toc41653712)

[Staffing and Cohorting 6](#_Toc41653713)

[Congregate and Communal Spaces 8](#_Toc41653714)

[Other Infection Control Policies 9](#_Toc41653715)

# Screening

1. **One of the audit items requires that anyone coming into the facility to have their temperature taken every time they enter. Does this include short trips outside (e.g. taking out the trash, smoke break, etc.)?**

Yes, these staff should be re-screened. A facility can refer to their previous screen form for their symptoms (if confirmed unchanged from prior in the day), and expedite re-entry, but a rescreen is expected, including a rechecking of temperature. No one should skip the queue entirely.

On initial screening and re-screening, staff cannot take their own temperatures or self-attest to their own temperatures. Someone other than the person whose temperature is taken must take and attest to the temperature.

# PPE and Community Spread

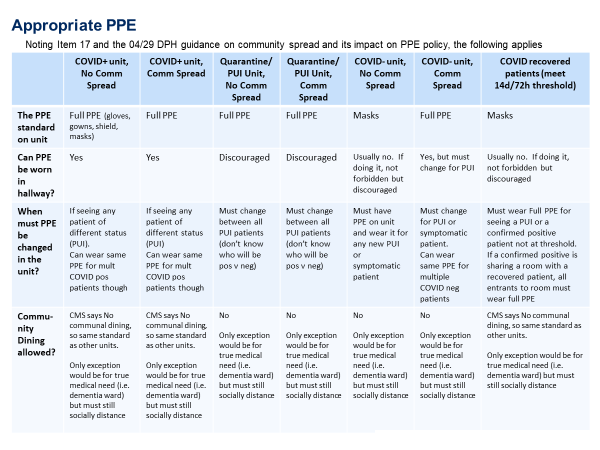
1. **It’s not clear how staff should be using PPE in different units to be in adherence with the Infection Control Checklist. Is there guidance for us to follow?**

Noting Infection Control Competency #17 on the Infection Control checklist, as well as the DPH guidance published on April 29, 2020 regarding community spread (aka facility transmission in the NF) and its impact on PPE policy, this section gives further detail on community spread and resulting PPE policies.

Community spread is defined as spread within the facility, not spread from outside of the facility. Facilities with community spread have higher level PPE requirements, particularly for COVID-19 negative units, than facilities with no community spread for the duration of the period of possible infection. A facility will be considered to have community spread if *any* of the following are true:

* The facility suspects there has been community spread within the facility (even if not yet proven); and/or
* A single resident within the facility who has been there prior to diagnosis has developed COVID-19 (i.e., a facility only needs to have one single resident become COVID-19 positive while residing in the facility to have met the threshold of community spread).

If all of the positive residents in the facility are new admittances placed into a COVID-19 positive unit and are specifically not residents who went out from the facility and came back from the hospital or other outside location, these do not count towards community spread. However, even one single resident becoming positive when either condition described in the bulleted items, above, is met puts the facility into community spread.

With community spread defined, the chart below provides additional guidance on appropriate PPE in different scenarios.

**For further clarification on PPE requirements when staff and residents are in hallways**, in order to meet the PPE competencies of the infection control competency checklist:

Staff wearing PPE in hallways of units is not expressly required. However, there are also many situations where it makes sense to wear PPE in hallways. For instance, it is allowed in a fully COVID-19 positive unit, and may conserve PPE supply to do so, with staff only changing PPE if they encounter a patient of different status (PUI – patient under investigation) or if the PPE becomes soiled. In a dementia unit (whether that is COVID-19 positive or negative) it may also make sense to wear PPE in the hallways given the inevitable amount of patient interactions that happen in the hallways.  
  
Given that the PPE supply is limited, auditors are not judging facilities universally on whether or not they wear or do not wear PPE in the hallways, but instead on if patient care is happening with the appropriate PPE in the hallways. As different sites have different degrees of PPE availability, this is the minimum threshold for the checklist audit. It is indeed preferable to change gowns between all patients (or use the same dedicated gown 1:1 per patient throughout a single shift) if a facility has enough PPE in order to be able to do so (and some facilities may elect to do so), but this is not minimum threshold that the audit is specifically evaluating all facilities for.

If a facility elects to expect that clinical staff should wear PPE in the hallways of particular units, the expectation will be the same for non-clinical staff going into and through the unit. In these cases, auditors are assessing for concordance of execution on a facility’s own practices.   
  
In these ways, auditors are judging based on a true infection control deficiency that they have seen, rather than a single universal standard that interplays with limited PPE supplies. EOHHS staff go over auditor submissions and clarify even after audits are completed to make sure that this was the standard used by the auditor; this review is in addition to giving the same guidance presented here to auditors.

1. What does "no PPE is used across shifts" mean? Can staff wear the same PPE if working a double shift on the same unit?

In a double shift on the same unit where the same PPE standard is applied for all patients, one could continue wearing that PPE across both shifts. But whether across a continuous double shift, or on an individual shift, other PPE rules apply (particularly to gloves and gowns below; face shields should be wiped as often as examples below; and for N95s or other masks, facilities may stretch those but should have a uniform policy for how they do so):

* PPE should be changed between care of patients of different status (positive versus quarantine or negative versus quarantine). This includes that if two layers of gown or gown-equivalent are worn over each other, both must be changed to go see a patient of a different status.
* PPE should be changed if soiled.
* PPE should be changed when leaving a patient care area.
* PPE that is substituted for gowns (such as lab coats, coveralls, jump suits, johnnies, etc.) should be changed as often as gowns (changed each shift at minimum; do not reuse the same lab coat on a different day without washing it).
* No PPE should be used across multiple shifts that cross into another day (i.e., do not reuse yesterday's gloves, gowns, or gown-equivalent without cleaning them if cleanable, if disposable should be disposed of at this point; do not re-use face shield without cleaning it).
* No PPE should be shared by two individuals (e.g., staff cannot share a lab coat).

1. If facilities do not have enough gowns, is it acceptable to wear lab coats or johnnies?

It is allowed. But these should be changed as often as any other gown (i.e., do not wear across shifts or share a johnny with another staff person, must be cleaned before reuse on a new shift, etc).

1. Can staff wear cloth masks over or under medical grade masks (i.e. surgical masks, N95s, etc.)?

No cloth masks of any kind should be used for staff in the facility. This includes no cloth masks under or over other masks (a surgical mask may be worn over an N95 or its equivalent however). All staff (clinical or non-clinical) should be using medical grade masks (surgical or N95, etc.) without cloth masks over or under them.

Surgical masks are recommended for residents as well, but residents may wear cloth masks.

1. Is a hair cover needed, i.e., bonnet?

The checklist does not differentiate between wearing or not wearing hair bonnets.

1. Can a staff member take off their mask in their own office?

A staff member should not be interacting with any other staff without a mask, and should not put themselves at risk of such an interaction easily occurring. Auditors will assess for if any and allstaff are failing to wear their face mask. A staff member could be in their own personal office, with the door closed, and take off their mask. But if they do so, they would not be seen by the auditor. If the auditor however sees any person in a room without their face mask (i.e. the door was open), they will deem this insufficient.

Per the May 21st, 2020 DPH Comprehensive PPE Guidance, that particular guidance is directed widely across the care continuum. In further clarification to NFs, it is still expected particular to all NFs that face masks are worn by all staff in all areas of the facility (i.e. this standard did not change with the May 21st guidance).

1. If clinical staff are required to wear full PPE in a room or hallway, are non-clinical staff required to do so as well?

Auditors are not assessing for a particular minimal standard of PPE when it comes to hallways across all facilities.

However, for facilities that do require clinical staff to wear PPE in hallways, the same is expected of non-clinical staff.

Non-front-line staff such as maintenance staff, central supply, housekeeping, etc. are expected to wear the same PPE standard in rooms as other front-line staff on the various units, and the same PPE standard in hallways as other front-line staff on the various units. Auditors will assess for concordance of exercised standards within a given facility.

1. Are KN95 masks allowed as a replacement for N95 masks? How long can both type of masks be stretched in usage?

The checklist does not differentiate between N95 or KN95 masks. Checklist item number 24 states that facilities’ “infection control policies that outline the recommended transition-based precautions… should accommodate for DPH and CDC guidance on PPE conservation methods.” In other words, facilities may stretch use of such N95 or KN95 masks, but they should have a uniform policy for how they do so.

1. Is it appropriate for a facility to have one precaution cart for more than one room or for a group of rooms with COVID-19 residents within the same area?

This is appropriate. However, staff should be able to access this PPE without crossing into any resident area or hallway area that involves residents of another cohort (e.g., quarantine).

Furthermore, PPE should be available for replacement if needed by staff, such as if PPE becomes soiled. A facility that, for instance, kept PPE centrally stored within the facility and only gave 1 gown for a shift to staff on a unit, would fail on the checklist as no replacement PPE is available without staff having to completely leave the care area and cross into another area to get the needed replacement during care.

1. Can staff bring PPE to their shift such as their designated face mask in a proper storage container such as a paper bag or plastic container?

It is inadvisable for staff to bring PPE such as gowns or gloves to a shift (as these need to be disposed of or cleaned between shifts).

For face shields and masks, if staff wear the PPE outside of the unit or facility that it is meant to be worn within, this would be a violation of PPE policy. These staff should doff and store such PPE before leaving the room, unit, or facility for which it is meant. Auditors do not use a universal standard for where face shields are required in a facility, they will instead evaluate for consistency within the facility per its own practices. Masks should be worn through the facility.

Staff may however carry their PPE outside of the facility within a designated receptacle meant to allow its travel and preserve its longevity. The facility should utilize a uniform method for how staff carry such PPE outside of care areas.

1. If you have multiple patients on one unit that are being tested for COVID-19 or whose COVID-19 status is unknown (PUI), can they share an isolation cart or does it have to be separate?

Staff may get PPE from the same isolation cart and should wash hands before accessing PPE for these quarantine-status patients. But different PPE should be worn between patients, given it is unknown which patients will turn out to be positive, negative, etc.

1. To conserve PPE, can a face shield be left in the room on a hook with the isolation gown for the dedicated staff to use for the next encounter?

For the next encounter in the same shift, this would be acceptable as long as it was not used across shifts. Staff should not share these PPE with other staff in the same shift. In addition, the face shield must be wiped down between shifts or before crossing into different cohort areas or units. If a face shield is wiped down and cleaned after a shift, a different staff member may use the face shield on a subsequent shift.

1. Staff is wearing jump suits (coveralls) throughout the building then applying a gown or johnny over them to go into residents’ rooms. Is this acceptable?

Staff should be changing PPE when seeing patients of different statuses, which includes jump suits. They should not wear a jump suit that is used in a COVID-19 positive room or unit into a COVID-19 negative or PUI room or unit. It is the facility’s responsibility to make sure these residents are segregated accordingly and that PPE is being changed, inclusive of the jump suits.

With that said, if staff are caring for residents of the same status (e.g., all COVID-19 positive patients on a unit), they are allowed to wear the jump suits room to room, as they also could for gowns.

1. If a facility is part of a multi-facility organization, can some of the two-week PPE supply required to be available be centrally coordinated for deployment (e.g., one week available on-site, and one week available centrally to deploy to a facility)?

This is acceptable, but storage of two-week supplies centrally should not overlap with other facilities (i.e., cumulatively, each part of the organization should have an accountable two-week supply locally plus what is at the central location).

If a facility ends up requiring state assistance for PPE that is discordant with the answer supplied to the auditor of having two weeks of PPE (using a central supply as part of it), it will be noted by the state and subject to penalties.

1. We have gotten guidance from DPH that nursing stations should not have PPE worn at them, but auditors have asked about why we are not wearing PPE at them.

See previous responses for standards on hallways. This applies to nursing stations as well, clarifying the DPH guidance.

For example, if a nursing station is fully enclosed in a single unit, and that unit has only one type of resident (positives for example), and no staff from other units use the station, and the facility does not otherwise consider it to be a clean zone - if all of those are met, than staff could wear PPE at that station. But if any of those are not met (i.e. station is shared with other staff, etc.), then staff should not wear PPE at the station.

1. ****When a facility has had its COVID-19 positive residents subsequently recover or no longer reside at the facility (i.e., the facility has no further actively COVID positive residents and all have fallen into recovery status), when can it return to a mask only PPE level for its general population? In other words, what is the checkpoint at which the facility is no longer in community spread status (aka facility transmission for an NF)?****   
      
   The facility must wait a minimum of 14 days after the most recent specimen was collected that was resulted as COVID-19 positive and all COVID-19 positive residents must be at least 72 hours since last exhibiting symptoms or requiring anti-fever medications, without new cases and with no current PUIs (i.e., all PUIs must be confirmed negatives). The facility should also not have had any known COVID positive staff working shifts during that interim period, and no newly tested positive staff in the last 14 days or staff that remain with tests pending.

In addition to the above, a facility will continue to be considered in community spread status until DPH has announced that there is not ongoing transmission within the larger community (i.e. outside of the facility's walls) in the geography that the facility is located.

Both requirements above must be met before a facility can step down from a community spread status (aka facility transmission for an NF). This provision is subjective to change based on future MA DPH and CDC guidance. For further reference, facilities can discuss with the DPH epidemiologist line.

# Staffing and Cohorting

1. Can staff on a dedicated COVID-19 positive unit work on a non-COVID-19 positive unit or a quarantine unit on another day, and vice versa?

Only in extreme conditions. If working a double shift in such a scenario, staff should move from negative to positive units across double shifts, not positive to negative units. Facilities should separate staff so that separate staff consistently work with the separate cohorts of patients (i.e., different staff for negative units and positive units, etc.)

In most cases, facilities should have entirely separate frontline staff for a shift (RNs, CNAs, etc.) for known positive and negative patients, and these staff should not care for residents across these two cohorts on a shift.

1. Is it acceptable to have the same nurse care for COVID-19 test-pending residents and either known negative or known positive residents? Is it acceptable to allow test-pending residents to be cohorted with other residents?

Ideally, residents awaiting test results or who are showing symptoms but who have not been able to be tested should be moved to a quarantine unit meant to house persons under investigation (PUIs). If that is not possible, the resident should be moved, at the very least, to a dedicated quarantine room with its own bathroom and no sharing of that space with other residents, whether positive, negative or whose status is also unknown.

If the site has a quarantine unit, it should have its own dedicated staffing to the maximal degree possible. If a quarantine room is on a different type of unit (within a larger positive or negative unit), then the staff can work with other residents on that unit but absolutely must change PPE between different types of residents and between any residents whose status is unknown.

1. How should facilities cohort rehabilitation staff or other specialized staff that might have to see residents on multiple units in the course of a day?

Ideally, facilities should separate such staff so that different staff work with the different cohorts of residents (i.e., different staff for negative units and positive units, etc.)

If this is not possible, rehabilitation staff must wear appropriate PPE per the unit they are in. Per shift, rehabilitation staff should first work in negative units, and work later in positive units.

1. Do we need signs outside of residents’ rooms if we have signs outside of the entire COVID-19 positive unit? Or the opposite, if we have signs on every residents' door in a COVID-19 unit, do we need a sign on the entrance door to the unit?

If all residents are uniformly of the same status (e.g., no PUIs; this is a dedicated COVID-19 positive or negative unit), a universal sign at the entrance to the unit is sufficient, which is interchangeable with room by room signs. Signs must be clearly visible.

1. Please explain why you need a sign on a COVID-19 negative resident door and what specifically that sign should say?

Checklist item number 13 from MassHealth Nursing Facility Bulletin 145 is as follows:   
"13. Signs are posted immediately outside of resident rooms indicating appropriate infection control and prevention precautions and required PPE per Department of Public Health guidance."

If there are not COVID-19 positive residents in the unit, and there are no PUIs, and there is no community spread standard, then the PPE requirement is at status quo for the unit other than the requirement that all staff must wear masks. In such a case, the facility does not need to put up additional signage in that unit.

For other cases, the PPE requirement is higher, and appropriate signage should be used.

Where signs are required, they are required to meet the infection control and prevention precautions required of the checklist item. A sign that states something akin to “See Nurse before entering room” would itself be insufficient for the checklist item.

1. Do facilities need to put up barriers/walls on units to separate COVID-19 positive spaces from COVID-19 negative spaces?

There is not a requirement for a specific barrier or wall, though an iteration for that could be an option. The auditors are agnostic to having a specific type, and any specific type described in formal or informal guidance is provided as an example, rather than the sole option or exhaustive list.

However, there does need to be a clear and visually apparent demarcation that communicates to staff that a certain zone is COVID-19 positive and a certain zone is COVID-19 negative. A form of physical barrier is best but not always possible, hence at least a visually clear demarcation is needed. Facilities should request guidance from DPH Life Safety staff on barriers that may otherwise be inconsistent with existing federal regulations but that may be permitted through other means such as a federal waiver permitted by CMS.

Facilities should not intermix resident rooms with different COVID-19 statuses, whether COVID-19 positive, COVID-19 negative, or residents whose status is unknown, with rooms of residents of a different status. Rooms should not be intermixed with mixed types of patients throughout a unit geographically, and such statuses should be grouped together on a unit. Staff working a shift with either positive or negative resident cohorts should not cross that demarcation and should not interact with staff or residents in the other zone.

1. Does a resident who tested positive for COVID-19 need a re-test in order to no longer be considered COVID-19 positive?

Either the CDC test-based criteria (subsequent negative tests on different days) or the DPH standard of recovery after 14 days from first symptoms plus 72 asymptomatic hours without fever-reducing medications are sufficient for a resident to be considered recovered. Once either of these standards are met (and one of them must be met before doing so), the patient can leave the dedicated positive unit and full PPE for them is no longer required.

1. How do we determine when an asymptomatic COVID-19 positive resident becomes COVID-19 negative or recovered if we do not test?

If an asymptomatic resident is found to be COVID-19 positive, such as when the facility is conducting facility-wide testing, the resident should immediately be moved to the dedicated COVID-19 positive unit/area until they have met the 14 day/72 hour criteria or re-test criteria described in question 32, above. The clock starts from the day of the initial swab that found them to be positive. Facilities are expected to test all persons under investigation (PUI) and isolate them until test results are back. If a negative result is yielded on a PUI and there remains high suspicion, a second test is encouraged while continuing to keep the patient isolated.

1. Per previous guidance, for patients who have recovered from COVID-19, staff are no longer required to use full PPE when caring for this population. Given I am already establishing space for COVID-19 positive patients, negative patients, and a quarantine space for PUIs, where do I put the recovered?

Once a COVID-19 positive resident has met the 14-day and 72-hour timeframes for recovery or met the subsequent negative test requirement for recovery, such resident is considered recovered and may be moved to a Quarantine/PUI or COVID-19 negative unit because they are not considered to be infectious based on known trends so far. Many of these patients tend to require higher levels of care after illness however, so while it is encouraged for them to remain on positive or quarantine wings for the purpose of fulfilling their enhanced care needs, they could go to the negative unit as well.

# **Congregate and Communal Spaces**

1. Infection control competency number 6 in the checklist, which is a core competency, requires ALL congregate spaces to be closed. What about a dementia unit where the residents’ safety is in jeopardy if we cannot use the sitting room?

Auditors know to make appropriate allowances for dementia units (such as allowing trash cans to be directly outside of a resident’s room instead of in the room at the entrance) and per difficulty in conducting individual dining with this population.

Auditors will monitor that the facility is trying to maintain 6+ foot social distancing and that staff are monitoring these patients to make sure that is maintained to the best of their ability (infection control competency number 6 will be failed if the facility does not monitor or is lax about maintaining social distancing).

Per CMS guidance, even if a dementia unit is all COVID-19 positive patients, social distancing is required. Also per previous guidance, if a non-dementia unit is all COVID-19 positive patients, communal dining is not allowed.

1. Does the requirement to close congregate spaces in infection control competency number 6 also apply in COVID-19 negative environments?

Yes.

1. If a dementia resident is COVID-19 positive, and it is safe to do so, is congregate dining allowed with social distancing?

Particularly for dementia residents, if they are within their own dedicated space that must be either a COVID-19 positive or negative space, *not a mixed space*, they can dine in that space at the same time as other dementia residents with the same COVID-19 status, if supervised social distancing is implemented.

1. Can the facility still have smoking groups at scheduled times outside using social distancing? The residents wear masks until they are outside.

Social distancing is required of any activity. Non-medical activities should be minimized. Facilities should provide all other tobacco alternatives first. If the alternative options would otherwise cause residents to be non-compliant, the facility can facilitate a socially distanced, continuously monitored version of smoking groups as noted. If these activities are not continuously monitored, the facility will not pass core competency, infection control competency number 6.

1. Are residents allowed to go outside or come out of their rooms and walk the halls if they are COVID-19 negative?

Residents can be in halls or go outside if they are COVID-19 negative and not on PUI status, but this should be minimized. Any movement outside of rooms by residents should be monitored to maintain social distancing and ensure face masks are worn (and staff should continuously encourage face mask use by residents). Group activities should not be occurring, except in the limited circumstances described in questions 29-32, above.

# Other Infection Control Policies

1. ****If a resident is COVID-19 positive and has a status such as DNH (Do not hospitalize), hospice, end-of-life, or comfort care measures only, are we still required to do vital signs at least every 4 hours during the day and evening shifts?****

**These checks may be deferred for certain patients at end of life care, hospice, or comfort measures only care. For DNH or other such patients who would otherwise still receive treatment at the facility such as oxygen or antibiotics for a UTI, vitals monitoring is expected to continue in order to guide that care. If the same level of care is provided for those in some modified version of end of life, hospice, or comfort measures; then vitals should continue as well in order to guide that care. Additionally, the given status (DNH, CMO, etc.) must be documented in the clinical record.**

1. Facilities are required on the 28-point checklist established in MassHealth Nursing Facility Bulletin 145 to do vital sign checks two times daily for negative residents. If the facility has no COVID-19 residents, must the process continue?

Yes, close monitoring for possible spread of COVID-19 even in currently totally negative facilities is paramount. There are no exceptions to this requirement.

1. Do residents who have recovered still need two times daily vital sign checks?

Yes. Given the unclear nature of long-term outcomes and subsequent adverse susceptibilities from COVID-19, these patients should continue to get at least twice a day vital sign checks, and may require more frequent checks, per provider discretion.

1. Are the facilities to perform vital sign checks every 4 hours on daytime and evening shifts for all residents or just COVID-19 positive residents/units?

COVID-19 positive and those isolated as persons under investigation must be checked at least every 4 hours on these shifts. Though a vital sign check is not required for this population during the overnight shift, vital sign checks should still be reasonably close together otherwise (i.e. it is unacceptable to allow a 12 hour gap between vital sign checks between evening and daytime). This may return to two times a day vital sign checks for those who have recovered (i.e. they have met the 14 day/72 hour criteria or the consecutive negative test criteria. Facilities may not stop vital sign checks pre-emptively prior to meeting these criteria).

1. ****For checklist Item #25, if the facility does not have a documented clinical criteria for emergency transfer to a higher level of care, other than a general change of condition policy, how is this graded?****

**This item asks facilities to have a *documented* clinical criteria. That criteria can within itself include an MD or RN assessment as part of its decision tree, but the criteria itself cannot be only a change of condition criteria with nothing else. A clinical criteria is recommended to include guiding vital signs, other signs, and symptoms to assist front-line staff in decision making. The criteria can be inclusive of front-line staff using a decision support tool such as an SBAR (Situation-Background-Assessment-Recommendation tool) to help decide elevation of concern to a clinician.**

1. ****Which items on the checklist require a facility to have a documented policy available for review?****

**Even if a facility has no COVID-19 cases, they need to have policies in place so they know how to respond to potential cases, PUIs, and outbreaks. That standard does not change per policies that are required.**

**Items 5, 21, 23, 24, and 25 require documented policies that are available for review. These may be part of other documents or policies rather than independently named documents. These must be available for review during an audit (having a policy but not having it available during an audit will result as failure on the item). Being able to verbalize a policy but not present a reviewable version will also result as failure on the item. The version of the policy reviewed locally by the auditor will be the standard upon which the checklist item is evaluated (having a more comprehensive company policy created but not available for auditor review at the time of audit will not lead to a change in an audit score).**

**Item 9 requires maintaining a regularly updated document available for review. This document must be up to date.**

**Items 11, 12, and 22 do not require specific written policies in place. For item 11, the facility must still be able to show verifiable proof of their contingency plan for supply shortages (can include order forms, etc.). For item 12, the facility should have a uniform guidance on how they are using PPE. This guidance does not need to be a home-grown document and a facility can reference documents from other sources such as CDC or DPH. For item 22, the facility does not need a document speaking to daily assessments of staffing needs, but the facility should be able to show materials for how they execute that function.**

1. Who can serve as “an infection control lead”? Can the lead be the Director of Nursing (DON)?

Auditors evaluate the Infection Leads (IL) based on their ability to adequately and competently do the role. We have seen facilities where the IL exclusively does that role, where they have one single other role, and where the IL has five separate roles (is the DoN, and the scheduler, the IL, a charge nurse, and PPE coach, etc.).

The auditor will evaluate if the IL is able to do the role competently and adequately and is not struggling to balance this with other roles. In addition, the IL needs exclusive time to do the IL role during work hours (i.e., not juggling multiple tasks during that exclusive IL time). The IL role needs to be fulfilled as well during off days by a designee when the otherwise regular IL has a day off.

We understand that facilities may have staff who leave or get ill, so facilities may need to quickly replace or appoint a new IL, on occasion. This situation will not be penalized, so long as the the new IL is adequately fulfilling the roll. It is a requirement that this role needs to be done well.

1. If a facility feels that they have received guidance from their DPH epidemiologist that would put them in conflict with the checklist requirements, how should they proceed?

DPH epidemiologist guidance is specific to facility-specific situations and needs. Auditors will take this guidance into account, when it is presented to them during an audit, in assessing facilities for compliance with the checklist items.

Facilities should be ready to present written documentation of such guidance that they have received. This can include email or notes taken from a phone call with DPH epidemiologist (phone call notes should note who was spoken with).

Based on review and verification of these, auditors will make adjustments to evaluation accordingly.

1. Please clarify what is expected in a sick leave policy.

The sick leave policy does not need to be a COVID-19 specific policy. But the policy, if it is a general policy, should reflect that it has been updated in light of the COVID-19 situation (or if no changes were necessary, that it was reviewed in light of the COVID-19 situation). However, the policy must include the specific elements noted in the checklist to pass the checklist item.

1. Please define “PPE Coaches”.  What are their responsibilities.  Must this be a free-floating position for an entire shift dedicated to this task only? Can they have other responsibilities? Can it be the Nurse Manager or Nursing Supervisor?  Can it be the Charge Nurse or a Staff Nurse who has other duties such as Medication Administration but are able to visualize other staff during this time?

The PPE coach is the one person accountable on each shift for supporting proper PPE use at each unit.

The PPE coach can have other duties. PPE coaches can be assigned for the whole facility per shift or be assigned per unit per shift. However, if assigned as one single coach per facility, then the Coach must have visualized PPE practices of other staff across the various units on that shift. The checklist established by MassHealth Nursing Facility Bulletin 145 does not specify a specific training level or other role required of a PPE coach. A PPE coach must be assigned for every shift, including the overnight shift.