COVID-19 Resources for Nurses

The nursing workforce is on the frontlines of treating and preventing the spread of the coronavirus disease (COVID-19) outbreak. Hart Health Strategies Inc. has compiled the following list of frequently asked questions to aid nurses in responding to this public health crisis. Unless otherwise noted, the recommendations contained below are from the Centers for Disease Control and Prevention (CDC).

What changes should be made to patient scheduling?

When scheduling appointments for routine medical care, instruct patients to call ahead and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection on the day they are scheduled to be seen.

When scheduling appointments for patients requesting evaluation for a respiratory infection**,** use nurse-directed triage protocols to determine if an appointment is necessary or if the patient can be managed from home. If the patient must come in for an appointment, instruct them to call beforehand to inform triage personnel that they have symptoms of a respiratory infection and to take appropriate preventive actions.

What steps should be taken to cohort patients?

Health care providers should consider limiting points of entry to the facility. Physical barriers should be installed at reception areas to limit close contact between triage personnel and potentially infectious patients. You could also consider establishing triage stations outside the facility to screen patients before they enter.

The ***triage of patients with respiratory symptoms*** **should be prioritized**.

- These patients should be isolated in an examination room with the door closed. If an examination room is not readily available, ensure the patient is not allowed to wait among other patients seeking care. A separate, well-ventilated space should be identified that allows waiting patients to be separated by 6 or more feet. Patients might opt to wait in a personal vehicle or outside the health care facility where they can be contacted by mobile phone when it is their turn to be evaluated.
- **Designate an area at the facility to be a "respiratory virus evaluation center"** where patients with fever or respiratory symptoms can seek evaluation and care. For patients with COVID-19 or other respiratory infections, evaluate the need for hospitalization. If hospitalization is not medically necessary, home care is preferable if the individual's situation allows.

Admitted patients with known or suspected COVID-19 cases should be placed in a single-person room with the door closed. The patient should have a dedicated bathroom. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients who will be undergoing aerosol-generating procedures. **Facilities could consider designating entire units, with dedicated personnel, to care for known or suspected COVID-19 patients**.

- Dedicated means that providers are assigned to care only for these patients during their shift.
- Determine how staffing needs will be met as the number of patients with known or suspected COVID-19 increases and providers become ill and are excluded from work.
- It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will likely be housed on the same unit. However, only patients with the same respiratory pathogen should be housed in the same room.

To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay. Limit transport and movement of patients outside of the room to medically essential purposes. Whenever possible, perform procedures/tests in the patient's room. Consider providing portable x-ray equipment in patient cohort areas to reduce the need for patient transport.

For *all admitted patients,* incorporate questions about new onset of respiratory symptoms into daily assessments. Monitor for and evaluate all new fevers and respiratory illnesses.

How can telehealth be used to support infection prevention and control?

The CDC strongly encourages health care providers to explore alternatives to face-to-face triage and visits, and to use telemedicine when possible. Hart Health Strategies Inc. has prepared a separate document outlining the steps that have been taken to expand the availability of telehealth services during the COVID-19 pandemic.

What type of health care visits should be postponed?

The CDC, Surgeon General, and Centers for Medicare and Medicaid Services (CMS) are urging that all non-essential planned surgeries, elective procedures, and non-urgent outpatient visits be postponed until further notice. The CDC also recommends that all group health care activities (e.g., group therapy, recreational activities, etc.) be cancelled.

How can nurses help conserve personal protective equipment?

Hart Health Strategies Inc. has prepared a separate document detailing how the government is working to ensure an adequate supply of personal protective equipment (PPE), and the CDC is encouraging providers to follow its strategies to optimize the use of PPE and equipment.

The CDC's suggestions include that facilities consider having personnel remove only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis while continuing to wear the same eye protection and respirator or facemask. Risk of transmission from eye protection and facemasks during extended use is expected to be very low.

How should visitation policies be amended?

As previously stated, health care providers should consider limiting points of entry to the facility. Visitors to the most vulnerable patient populations should be limited, and visitors should be screened for symptoms prior to entry to the unit.

Visitors to patients with known or suspected COVID-19 should also be limited. Nurses can encourage the use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets. If visitation must occur, visits should be scheduled and controlled to allow for the following:

- Evaluating the risk to the health of the visitor (e.g., underlying illness putting them at higher risk for COVID-19).
- Instruction on hand hygiene, limiting surfaces touched, and use of PPE according to facility policy.
- Instruction to only visit the patient room; they should not go to other locations in the facility.
- Active assessment for fever and respiratory symptoms upon entry to the facility; if symptoms are present, visitor should not be allowed entry.

Visitors should not be present during specimen collection procedures.

If restriction of all visitors is implemented, facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's emotional well-being and care.

What should be done when personnel are exposed to COVID-19?

The following table contains the CDC's epidemiological risk classification for asymptomatic health care personnel following exposure to patients with COVID-19, and their associated monitoring and work restriction recommendations.

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic Personnel
Prolonged close contact with a COVID-19 patient who was wearing a facemask			
Personnel PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
Personnel PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
Personnel PPE: Not wearing eye protection	Low	Self with delegated supervision	None
Personnel PPE: Not wearing gown or gloves	Low	Self with delegated supervision	None
Personnel PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None
Prolonged close contact with a COVID-19 patient who was not wearing a facemask			
Personnel PPE: None	High	Active	Exclude from work for 14 days after last exposure
Personnel PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days after last exposure
Personnel PPE: Not wearing eye protection	Medium	Active	Exclude from work for 14 days after last exposure
Personnel PPE: Not wearing gown or gloves	Low	Self with delegated supervision	None
Personnel PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None

Definitions

The following definitions should be used when implementing the CDC's recommendations.

- ***Self-monitoring*** means personnel should monitor themselves for fever by taking their temperature twice a day and remain alert for respiratory symptoms.
- ***Active monitoring*** means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever or respiratory symptoms. For personnel with high- or medium-risk exposures, CDC recommends this communication occurs at least once each day**.** Active monitoring can be delegated by the health department to the personnel's health care facility occupational health or infection control program.
- ***Self-Monitoring with delegated supervision*** in a health care setting means personnel perform self-monitoring with oversight by their health care facility's occupational health or infection control program in coordination with the health department of jurisdiction. On days personnel are scheduled to work, health care facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, a facility may consider having personnel report temperature and absence of symptoms to occupational health prior to starting work.
- ***Close contact*** for health care exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with COVID-19 for a prolonged period of time; or b) having unprotected direct contact with infectious secretions or excretions of the patient.
- ***High*-risk *exposures*** refer to personnel who have had prolonged close contact with patients with COVID-19 who were not wearing a facemask while personnel's nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled on patients with COVID-19 when the health care providers' eyes, nose, or mouth were not protected is also considered high-risk.
- ***Medium-risk exposures*** generally include personnel who had prolonged close contact with patients with COVID-19 who were wearing a facemask while personnel's nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Some low-risk exposures are considered medium-risk depending on the type of care activity performed.
- ***Low-risk exposures*** generally refer to brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while personnel were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure.

What changes have been made in regard to nursing licensure?

The National Council of State Boards of Nursing (NCSBN) has created a resource to track state responses to COVID-19. Be sure to refresh your browser to see the most up-to-date version of the document.