SUBJECT: C3B COVID TREAMTMEN UNIT ADMISSION AND DISCHARGE CRITERIA

ORIGINAL DATE: AUGUST 2020

Purpose:

To provide guidance to staff regarding admission and discharge criteria for the C3B COVID Treatment Unit

Background:

C3B is established as a unit to care for patients with COVID-19.

Staffing is a complex process with the goal of matching the needs of patients throughout their injury/illness with competencies of nurses. Because the condition of patients rapidly and continuously fluctuate, flexibility of nurse staffing that goes beyond the fixed nurse-to-patient ratios is imperative.

C3B is a unit with eight single occupancy beds and one negative pressure room that provides ward level care with a surge capacity up to 20 beds. The negative pressure room may be reserved for a patient requiring alternative ventilator or oxygen support e.g. CPAP, high flow nasal cannula, or at high risk for requiring intubation.

All staffing models will be a collaboration amongst inpatient unit charge nurses and the Nurse of the Day (NOD). Nurse to patient ratios are based on patient acuity and minimum staffing requirements. The Charge Nurse will be staffed by a Critical Care Department staff member (e.g. Progressive Care or Intensive Care) and will be deemed clean and not provide direct patient care/contact unless during an emergency and may be supported by a senior Hospital Corpsman familiar with the C3B unit and access to clean patient supply area. Nurse-to-patient ratio is 1:4 dependent on patient acuity, and workload. Ancillary support (i.e., HM/LPN) may be used to assist the nurse with patient care as defined by scope of practice and competency level.

Admissions:

The unit will accept adult patients admitted or transferred by the COVID provider teams. If in the event of a shortage of beds or staff, the Charge Nurse will notify the NOD to prioritize admissions. Patients will overflow to the modified Ambulatory Infusion Center (AIC)

1. Admissions and transfers will be facilitated through Bed Management/Admissions Department (953-1515), with the coordination of the admitting provider/service and Charge Nurse as outlined in the Patient Admissions and Disposition Program (NAVMEDCENPTSVA INSTRUCTION 6320.93) and Medical Staff Policy and Procedures (NAVMEDCENPTSVA INSTRUCTION 610.23E).

2. During in-house transfers to the unit, transport personnel will don appropriate PPE and the patient will wear a surgical face mask over their nose and mouth and have clean sheet covering them from the neck to their feet. Written admission orders are required prior to patient transfer.

C3B Unit Discharge Criteria:

Patients will be reviewed daily to identify those appropriate for discharge, transfer to other units, and/or de-escalation of care.

> COVID-19 patients can be discharged from a healthcare facility whenever clinically indicated. Factors to consider include: use of supplemental oxygen, fever curve, timeline of illness, comorbid conditions and risk for decompensation, and ability to quarantine or self-isolate as required.

Any patient discharged from the unit will wear a surgical mask until they have left the facility.

POLICY:

1. Patients with suspected or confirmed COVID-19 are subject to the hospital's Infection Control Isolation policy reference Infection Control Manual Chapter 1 Standard Precautions and Isolation Precautions.

2. All nursing staff assigned to care for suspected patients will be properly trained in proper personal protective equipment (PPE) practices and aware of command protocols prior to assuming care.

3. Staff will ensure adherence to the following Isolation Precautions:
    a. Airborne + Contact + Eye Protection (goggles or face shield).
    b. Clinicians must wear a respirator (fit-tested N95 mask), gown, gloves and eye protection (goggles or wrapped eye glasses)

4. Limit staff in the room, especially for any aerosol-generating procedures.

5. When feasible, nursing care will be bundled to limit excessive exposure time.

6. One staff member will be designated as a "monitor/observer or runner" to assist with monitoring adherence to infection control guidelines, retrieving medications, and/or supplies.

PROCEDURE:

A. Hand Hygiene

HAND HYGIENE IS THE SINGLE MOST IMPORTANT MEANS OF PREVENTING THE SPREAD OF INFECTION.

Hands must be disinfected with an alcohol-based hand rub before and after providing care that involves touching the patient or the patient's environment. Hands must also be disinfected after removing gloves, gowns, or respiratory protection devices and after touching inanimate objects in the immediate vicinity of the patient, or touching contaminated items or surfaces. If hands are visibly soiled, wash hands with soap and water, dry hands, and apply an alcohol-based hand rub.

B. Patient Placement – Airborne Infection Isolation Rooms (AII)

Doors into the room must be kept closed at all times.

For the single negative pressure patient room that requires activation of negative pressure airflow, the panel must be activated to "negative". Negative pressure must be validated every shift when in use and documented. Methods of validation include use of a visual indicator e.g. tissue test or the negative pressure panel.

C. Personal Protective Equipment (PPE)

Correct use of PPE is critical to preventing staff exposure. Monitors will be assigned to the unit to review correct donning and doffing procedures with staff when this protocol is initiated and will periodically monitor staff to ensure compliance with donning and doffing protocols.

1. Donning (putting on) PPE: These requirements apply to ALL staff entering the room of a patient. The following PPE is required to be donned prior to entry into the patient room. Donning in the following order is recommended.
    a. Gown - A clean, nonsterile, disposable, isolation gown must be worn. Ensure that gown is tied in back and provides full coverage.
    b. N-95 respirator
        i. All staff must wear approved respiratory protection (N-95 respirator).
        ii. Before using an N-95 respirator, staff must be medically cleared and trained in how to wear/use each device.
        iii. For N-95 respirators, staff must have been fit-tested within the past year to ensure proper size and fit.
        iv. A "fit-check," also known as a "seal check," should be performed before each N-95 respirator use.
        v. The N-95 respirator must be discarded after each use upon leaving contaminated room.
        vi. Surgical masks may be substituted for N-95 respirators as long as aerosol-generating procedures are not being performed, and based on updates to institution policy.
    c. Goggles/Face shield
        i. All staff must wear goggles or face shield to protect mucous membranes from exposure due to splash or potential for hand contamination of eyes, nose or mouth. Goggles and face shields will be reused per protocol.
    d. Gloves

i. All staff must wear clean, nonsterile gloves. Gloves must be pulled over the cuffs of gown.

2. Doffing (removing) PPE: When removing protective equipment; remove in the following order and then perform hand hygiene. Use the doffing checklist provided and dispose in appropriate bin.
    a. Gloves and Gown in a single step
    b. Goggles/Face shield, reuse per protocol.
    c. N-95/surgical Mask (outside of the room)

For the AII room with an anteroom and negative pressure:

Remove gown and gloves in the patient room and remove the N95 and eye protection in the anteroom. Ensure the door from the anteroom into the patient room is closed and negative airflow into patient room has been confirmed.

For AII room without anteroom and negative pressure

Except for respiratory protection and eye protection, remove and discard PPE (gloves gown) just inside the patient room before exiting to hall. Remove respiratory protection and eye protection (N-95 or PAPR) after leaving the patient room and closing door.

D. Patient Care Equipment/Supplies

1. Equipment (e.g., stethoscope, blood pressure cuff, thermometers) should be single-use or dedicated to use of the patient to avoid sharing with other patients. Reusable patient care equipment must be disinfected with a hospital-approved disinfectant before use for another patient.

2. Supplies in the room of a patient should be kept to a minimum. Disposable items (e.g. adhesive tape, gauze, gloves, etc.) must be discarded on discharge.

3. On-hand inventory of supplies needed will be monitored and updated by the designated unit Supply Technician. The unit Supply Technician will ensure areas will be stocked for daily use, weekends, and holidays and will coordinate efforts with MMD, Mr. Jesus Saenz jesus.m.saenz10.civ@mail.mil.

4. Material Management Department (MMD) will supply the following items:
    a. N95 Masks
    b. Gloves
    c. Gowns
    d. Surgical Masks
    e. Masks for hygiene stations
    f. Goggles

E. Patient Transport: Strict Isolation Requirements

1. Only patients who require essential diagnostic procedures (e.g. X-ray, Ultrasound, CT, etc.) will be transported off unit

2. Notify the receiving department that the patient is on Airborne Isolation + Contact Isolation + Eye Protection.
    a. **There must be a member of the transport team, who has clean hands to interact with the environment**.
    b. If transport or movement outside of an AII room is necessary, place a regular surgical mask on the patient for transport and a clean sheet covering them below the neck to their feet.
    c. All staff involved should wear appropriate PPE in the isolation room while preparing the patient for transport. PPE should be removed per doffing procedures above when leaving the room.
    d. Wounds must be covered, and body fluids contained. The patient should wash or disinfect his or her hands before leaving the room if possible. The patient should wear a clean gown or robe or be covered by a clean sheet or drape for transport to another department or area.
    e. The patient chart will be transported in a manner that prevents contact with the patient and/or contaminated linen.
    f. PPE should not be worn when transporting the patient. With the exception – If patient contact and/or contact with contaminated equipment will occur during transport (e.g. for ICU patients or patient transported in their bed) full PPE must be worn by those having direct contact with the patient and/or the bed or equipment during transport. PPE is removed per doffing procedure when contact with patient and/or contaminated equipment is completed. Every effort will be made not to touch clean surfaces (e.g., elevator buttons) with gloved or contaminated hands by team members in PPE.

F. Specimen Collection

1. Preparation
    a. Prepare appropriate tubes/containers, labels, and plastic specimen transport bags.
    b. Disinfect hands and don PPE, putting on a second pair of clean gloves.

2. Procedure for negative pressure rooms with an anteroom
    a. Place a chux pad in the “Clean” emesis basin and leave in the Anteroom. Bring supplies and unused specimen transport bags into the patient’s room.
    b. Follow standard procedures for patient identification and specimen collection.
    c. Label all specimens at patient bedside.
    d. Remove first pair of gloves and discard.
    e. With clean gloves, place labeled specimens into the unused specimen transport bag and seal the bag.

f. Wipe outside of bag with hospital-approved disinfectant wipes. At this time the bag is considered "Clean"
g. Place "clean" bagged specimens in the "clean" emesis basin (previously placed next to the door in the Anteroom).
h. Bagged specimens will be hand-delivered directly to the lab for processing. Staff should use a one hand gloving technique, by donning gloves on one hand to carry the specimen and keeping the other hand clean to open doors or operate elevators.
i. Remove gloves after drop-off and perform hand hygiene after removal of gloves. Please refer to the COVID-19 Laboratory SOP on the COVID-19 SharePoint Site.

3. Procedure for rooms without an Anteroom.
    a. Place a chux pad in the "Clean" emesis basin and leave directly outside the door.
    b. Bring supplies and unused specimen transport bags into the patient's room.
    c. Follow standard procedures for patient identification and specimen collection.
    d. Label all specimens at patient bedside.
    e. Remove first pair of gloves and discard.
    f. With clean gloves, place labeled specimens into the unused specimen transport bag and seal the bag.
    g. Wipe outside of bag with hospital-approved disinfectant wipes. At this time the bag is considered "Clean"
    h. Open patient door and place "clean" bagged specimens in the "clean" emesis basin (previously placed next to the patient door). Then close the patient door.
    i. Bagged specimens will be hand-delivered directly to the lab for processing. Staff should use a one hand gloving technique, by donning gloves on one hand to carry the specimen and keeping the other hand clean to open doors or operate elevators.
    j. Remove gloves after drop-off and perform hand hygiene after removal of gloves. Please refer to the COVID-19 Laboratory SOP on the COVID-19 SharePoint Site.

G. Visitors

1. Per command policy dated 22MAY2020, visitation for patients admitted with COVID-19 has been suspended.

H. Healthcare Worker (HCW) Monitoring

1. A list of healthcare workers caring for patients in C3B or entering room of a patient will be maintained.

2. Healthcare workers caring for a patient, and those that perform tasks associated with risk of exposure (e.g. staff involved in room cleaning) will be monitored for fever and other relevant symptoms for the length of the incubation period, specific to the infection, from their last date of potential exposure.

I. Healthcare Worker Exposure

1. HCWs who report an unprotected exposure (e.g., entering the room without appropriate PPE) or possible exposure should be assessed by healthcare team to determine if exposure had occurred. NOD will be paged for awareness.
2. If determined that an exposure occurred; post exposure follow-up will be conducted based on direction from Infectious Disease and Occupational Health.

J. Room Turnover Time and Discharge Cleaning

1. After a confirmed case patient vacates room or is discharged, the room must remain with the door closed for 60 minutes, before staff enter the room without PPE or another patient is admitted to the room. This is to enable appropriate exchange of air (four air exchanges occur with rooms without negative pressure and six air exchanges occur with negative pressure.)
2. Cleaning staff must wear respiratory protection and other PPE required for Strict Isolation when cleaning during this airing time. If cleaning is performed after the required airing time, respiratory protection is not required but gown, gloves and face protection are. Cleaning staff must follow correct doffing sequence when removing PPE.

References:

Centers for Disease Control and Prevention, www.cdc.gov/coronavirus/2019-ncov/index.html

World Health Organization, www.who.int/emergencies/diseases/novel-coronavirus-2019