

# Coronavirus Disease 2019 (COVID-19)

## FAQ on Infection Control



### Page Summary

This page was updated on March 10, 2020 to align with the revised [Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\) or Persons Under Investigation for COVID-19 in Healthcare Settings](#).

**Who is this for:** Healthcare personnel who may care for patients who are confirmed with or under investigation for COVID-19.

**What is it for:** This creates FAQs to support the existing [Healthcare Infection Prevention and Control Guidance for COVID-19](#).

**How is it used:** To assist healthcare facilities in preventing transmission of COVID-19 in healthcare settings.

1. What personal protective equipment (PPE) should be worn by individuals transporting patients who are confirmed with or under investigation for COVID-19 within a healthcare facility? For example, what PPE should be worn when transporting a patient to radiology for imaging that cannot be performed in the patient room?

In general, transport and movement of the patient outside of their room should be limited to medically essential purposes. If being transported outside of the room, such as to radiology, healthcare personnel (HCP) in the receiving area should be notified in advance of transporting the patient. For transport, the



facemask—if a respirator is not available—and eye protection [i.e., goggles or disposable face shield that covers the front and sides of the face]). This recommendation is needed because these interactions typically involve close, often face-to-face, contact with the patient in an enclosed space (e.g., patient room). Once the patient has been transferred to the wheelchair or gurney (and prior to exiting the room), transporters should remove their gown, gloves, and eye protection and perform hand hygiene.

If the patient is wearing a facemask, no recommendation for PPE is made typically for HCP transporting patients with a respiratory infection from the patient's room to the destination. However, given current limitations in knowledge regarding COVID-19 and following the currently cautious approach for [risk stratification and monitoring of healthcare personnel caring for patients with COVID-19](#), use of a facemask by the transporter is recommended for anything more than brief encounters with COVID-19 patients. Additional PPE should not be required unless there is an anticipated need to provide medical assistance during transport (e.g., helping the patient replace a dislodged facemask).

After arrival at their destination, receiving personnel (e.g., in radiology) and the transporter (if assisting with transfer) should perform hand hygiene and wear [all recommended PPE](#). If still wearing their original respirator or facemask, the transporter should take care to avoid self-contamination when donning the remainder of the recommended PPE. This cautious approach will be refined and updated as more information becomes available and as response needs change in the United States.

Interim guidance for EMS personnel transporting patients with confirmed or suspected COVID-19 is [available here](#). EMS personnel should wear all recommended PPE because they are providing direct medical care and in close contact with the patient for longer periods of time.

## **2. What PPE should be worn by HCP providing care to asymptomatic patients with a history of exposure to COVID-19 who are being evaluated for a non-infectious complaint (e.g., hypertension or hyperglycemia)?**

Standard Precautions should be followed when caring for any patient, regardless of suspected or confirmed COVID-19. If the patient is afebrile (temperature is less than 100.0°F) and otherwise without even mild symptoms\* that might be consistent with COVID-19 (e.g., cough, sore throat, shortness of breath), then precautions specific to COVID-19 are not required. However, until the patient is determined to be without such symptoms, HCP should wear all recommended PPE for the patient encounter. If the primary evaluation confirms the patient is without symptoms, management and need for any Transmission-Based Precautions should be based with the condition for which they are being evaluated (e.g., patient colonized with a drug-resistant organism), rather than potential exposure to COVID-19.

This public health response is an important opportunity to reinforce the importance of strict adherence to Standard Precautions during all patient encounters. Standard Precautions are based on the principles that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may

contain transmissible infectious agents. The application of Standard Precautions is determined by the nature of the HCP-patient interaction and the extent of anticipated blood, body fluids, and pathogen exposure. For example, a facemask and eye protection should be worn during the care of any patient if splashes, sprays, or coughs could occur during the patient encounter. Similarly, gloves should be worn if contact with body fluids, mucous membranes, or nonintact skin are anticipated.

\*Note: In addition to cough and shortness of breath, nonspecific symptoms such as sore throat, myalgia, fatigue, nausea, and diarrhea have been noted as initial symptoms in some cases of COVID-19. These symptoms can have several alternative explanations; however, failure to identify and implement proper precautions in a healthcare setting for persons infected with COVID-19 can contribute to widespread transmission in that facility due to the presence of susceptible patients and close interactions with healthcare personnel. For this reason, a lower temperature of 100.0°F and the inclusion of mild and non-specific symptoms should be used by healthcare settings evaluating these patients to increase the ability to detect even mild cases of COVID-19.

### **3. What personal protective equipment (PPE) should be worn by environmental services (EVS) personnel who clean and disinfect rooms of hospitalized patients with COVID-19?**

In general, only essential personnel should enter the room of patients with COVID-19. Healthcare facilities should consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who will already be in the room providing care to the patient. If this responsibility is assigned to EVS personnel, they should wear all recommended PPE when in the room. PPE should be removed upon leaving the room, immediately followed by performance of hand hygiene.

After discharge, terminal cleaning may be performed by EVS personnel. They should delay entry into the room until a [sufficient time has elapsed](#) for enough air changes to remove potentially infectious particles. We do not yet know how long SARS-CoV-2 remains infectious in the air. Regardless, EVS personnel should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on [clearance rates under differing ventilation conditions](#) is available). After this time has elapsed, EVS personnel may enter the room and should wear a gown and gloves when performing terminal cleaning. A facemask and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated or otherwise required based on the selected cleaning products. Shoe covers are not recommended at this time for personnel caring for patients with COVID-19.

### **4. Where should nasopharyngeal swabs be performed on a known or suspected COVID-19 patient, and with what PPE?**

The collection of nasopharyngeal (NP) swabs from patients with known or suspected COVID-19 can be performed in a regular examination room with the door closed. Use of an airborne infection isolation room for nasopharyngeal specimen collection is not required. HCP in the room should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown. If respirators are not readily available, they should be prioritized for other procedures at higher risk for producing infectious aerosols (e.g., intubation), instead of for collecting NP swabs.

## **5. Do all patients with confirmed or suspected COVID-19 need to be placed in airborne infection isolation rooms?**

No. Updated [CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#) recommends placing patients in a regular examination room with the door closed. Airborne infection isolation rooms should be reserved for patients undergoing aerosol generating procedures or for diagnoses such as active tuberculosis.

## **6. How long does an examination room need to remain vacant after being occupied by a patient with confirmed or suspected COVID-19?**

Although spread of SARS-CoV-2 is believed to be primarily via respiratory droplets, the contribution of small respirable particles to close proximity transmission is currently uncertain. Airborne transmission from person-to-person over long distances is unlikely.

The amount of time that the air inside an examination room remains potentially infectious is not known and may depend on a number of factors including the size of the room, the number of air changes per hour, how long the patient was in the room, if the patient was coughing or sneezing, and if an aerosol-generating procedure was performed. Facilities will need to consider these factors when deciding when the vacated room can be entered by someone who is not wearing PPE.

For a patient who was not coughing or sneezing, did not undergo an aerosol-generating procedure, and occupied the room for a short period of time (e.g., a few minutes), any risk to HCP and subsequent patients likely dissipates over a matter of minutes. However, for a patient who was coughing and remained in the room for a longer period of time or underwent an aerosol-generating procedure, the risk period is likely longer.

For these higher risk scenarios, it is reasonable to apply a similar time period as that used for pathogens spread by the airborne route (e.g., measles, tuberculosis) and to restrict HCP and patients without PPE from entering the room until sufficient time has elapsed for enough air changes to remove potentially infectious particles.

General guidance on [clearance rates under differing ventilation conditions](#) is available.

In addition to ensuring sufficient time for enough air changes to remove potentially infectious particles, HCP should clean and disinfect environmental surfaces and shared equipment before the room is used for another patient.

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