



Eric J. Holcomb
Governor

Lindsay M. Weaver, MD, FACEP
State Health Commissioner

Infectious Disease Epidemiology & Prevention Division's COVID-19 Infection Prevention Toolkit

Updated: Sept 1, 2023

This toolkit provides recommended resources for long-term care and assisted living facilities experiencing a COVID-19 outbreak.

Relevant information for nursing homes, not otherwise covered in Sections 1 and 2 of the **Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic**, have now been incorporated into Section 3: Setting-specific considerations. Guidance on how to **manage healthcare personnel with COVID-19 or exposure to COVID-19** and **strategies on how to mitigate staffing shortages** are available. **Vaccines** are still an important way to prevent the spread of COVID-19. Relevant CMS guidance **QSO 20-39-NH regarding visitation**.

Facilities will be encouraged to look beyond COVID-19 and make broader masking decisions based on facility-and-patient-level characteristics and local metrics that could reflect increasing respiratory virus transmission in the community to decide when to implement source control. For more infection prevention resources and guidance from the Indiana Department of Health's Infection Prevention team you can visit **the infection prevention team webpage**. It is also recommended facilities sign up to receive **The Long-term Care Newsletter**.

This toolkit includes **optional** **Core Principles of COVID-19 Infection Prevention job aides**:

1. **Hand Hygiene**
 - i. Hand Hygiene Checklist and Audit tool pgs. 3-5
2. **Source Control- masks and screening**
 - i. Facemasks Do's and Don'ts pg. 6
3. **Instructional Signage**
 - i. Cover your Cough Respiratory Etiquette Sign pg. 7

To **promote**, **protect**, and **improve** the health and safety of all Hoosiers.



- ii. Symptoms of Coronavirus (COVID-19) – Signage – English pg. 8
- iii. Symptoms of Coronavirus (COVID-19) – Signage – Spanish pg. 9
- 4. Cleaning & Disinfecting**
 - i. How to Read a Disinfectant Label pg. 10
 - ii. CDC High Touch Surfaces and Environmental Cleaning Checklist pg. 11
- 5. Appropriate Personal Protection Equipment (PPE) for staff**
 - i. Contact&Droplet+ Transmission Based Precautions Sign pg. 12
 - ii. Aerosol Generating Procedure Signage pg. 13
 - iii. CDC Transmission Base Precautions Signs pgs. 14-16
 - iv. CDC Donning and Doffing pgs. 17-19
 - v. Eye Protection Cleaning pg. 20
 - vi. CDC N-95 User Seal Check pgs. 21-22
- 6. Effective Cohorting**
 - i. Refer to setting-specific considerations for **Nursing Homes** from the CDC Infection Control Recommendations
 - ii. Respiratory Surveillance Line List & Outbreak Summary for LTC pgs. 23-29
- 7. Resident and staff testing**
 - i. Refer to CDC's **Overview of Testing for SARS-CoV-2**
- 8. Miscellaneous job aides**
 - i. APIC's 10 Ways to Protect Your Residents pg. 30
 - ii. Inter-facility infection control transfer form pg. 31-32

Hand Hygiene Checklist

Personnel															
HAND HYGIENE	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
Sink and soap available															
Paper towels available															
ABHR available															
Nails available															
Appropriate PPE available															
Appropriate handwashing															
Appropriate ABHR															
HH pre-resident contact															
HH post-resident contact															
HH after contact with body fluids															
HH after touching objects/surfaces															
HH after PPE removal															
Gloves worn															
Gloves appropriate															
Gown worn															
Gown appropriate															
Mask worn															
Mask appropriate															
WOUND CARE	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
Clean surface															
All supplies assembled															
HH performed															
Clean gloves donned															
Prevented cross contamination															
Contaminated glove changed															
HH performed															
Clean gloves donned															
Clean dressing applied															
Unused supplies discarded/dedicated															
Soiled surfaces disinfected															
Gloves removed															
HH performed															

POC GLUCOSE TESTING	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
HH performed															
Clean gloves donned															
Single use lancet used															
Equipment cleaned per policy															
Gloves removed															
HH performed															
ADMINISTERING MEDICATIONS	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
Cross contamination avoided															
HH performed on entering room															
Objects not contaminated															
HH performed on leaving room															

Instructions

Personnel	Note staff observed - RN, LPN, CNA, PT, RD, MD, CRNP, etc.
HAND HYGIENE	
Sink and soap available	Sink empty of supplies. Soap dispenser not blocked and contains soap.
Paper towels available	Paper towels accessible close to sink.
ABHR available	Sanitizer dispenser accessible or carried with personnel.
Nails available	No artificial nails. Nails short. Nail polish intact. No open wounds.
Appropriate PPE available	Gloves accessible. Gowns available for contact precautions. Masks for droplet. N95 and eye protection for airborne.
Appropriate handwashing	Includes all surfaces for at least 20 sec. Thoroughly dries hands. Turns off water with paper towel.
Appropriate ABHR	Includes all surfaces, rubbing until hands are dry.
HH pre-resident contact	
HH post-resident contact	
HH after contact with body fluids	Soap and water must be used when hands/gloves are visibly soiled and when CDI is present.
HH after touching objects/surfaces	
HH after PPE removal	
Gloves worn	
Gloves appropriate	Appropriate with potential contact with blood, body fluids, mucous membranes or non-intact skin.
Gown worn	
Gown appropriate	Contact precautions or direct resident care if uncontrolled secretions or excretions.
Mask worn	
Mask appropriate	Droplet precautions.

WOUND CARE	
Clean surface	Work surface cleaned and draped/covered.
All supplies assembled	Multi-dose wound medications should be dedicated to resident or placed in container and not enter room.
HH performed	
Clean gloves donned	
Prevented cross contamination	Soiled dressing discarded immediately. Avoid aerosolized irrigation solutions. Avoid touching clean supplies.
Contaminated glove changed	
HH performed	
Clean gloves donned	
Clean dressing applied	
Unused supplies discarded/dedicated	Supplies should not be used for another resident.
Soiled surfaces disinfected	Use appropriate environmental disinfectant.
Gloves removed	
HH performed	
POC GLUCOSE TESTING	
HH performed	
Clean gloves donned	
Single use lancet used	
Equipment cleaned per policy	Use disinfectant specific for brand of glucometer.
Gloves removed	
HH performed	
ADMINISTERING MEDICATIONS	
Cross contamination avoided	Maintain clean work surface. Oral medications not touched with bare hands.
HH performed on entering room	
Objects not contaminated	Objects such as med keys should not touch surfaces in room and then transferred to med cart.
HH performed on leaving room	

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization for Pennsylvania and West Virginia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 12SOW-QI-QII-051320

Facemask Do's and Don'ts

For Healthcare Personnel

When putting on a facemask

Clean your hands and put on your facemask so it fully covers your mouth and nose.



DO secure the elastic bands around your ears.



DO secure the ties at the middle of your head and the base of your head.

When wearing a facemask, don't do the following:



DON'T wear your facemask under your nose or mouth.



DON'T allow a strap to hang down. DON'T cross the straps.



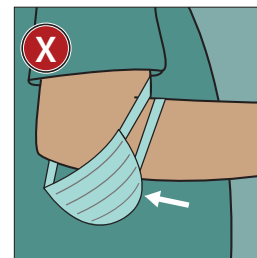
DON'T touch or adjust your facemask without cleaning your hands before and after.



DON'T wear your facemask on your head.



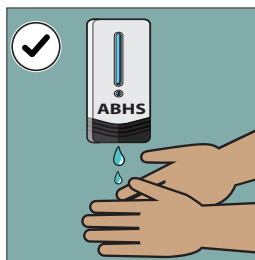
DON'T wear your facemask around your neck.



DON'T wear your facemask around your arm.

When removing a facemask

Clean your hands and remove your facemask touching only the straps or ties.



DO leave the patient care area, then clean your hands with alcohol-based hand sanitizer or soap and water.



DO remove your facemask touching ONLY the straps or ties, throw it away*, and clean your hands again.

*If implementing limited-reuse: Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. Folded facemasks can be stored between uses in a clean, sealable paper bag or breathable container.

Additional information is available about how to safely put on and remove personal protective equipment, including facemasks:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>.

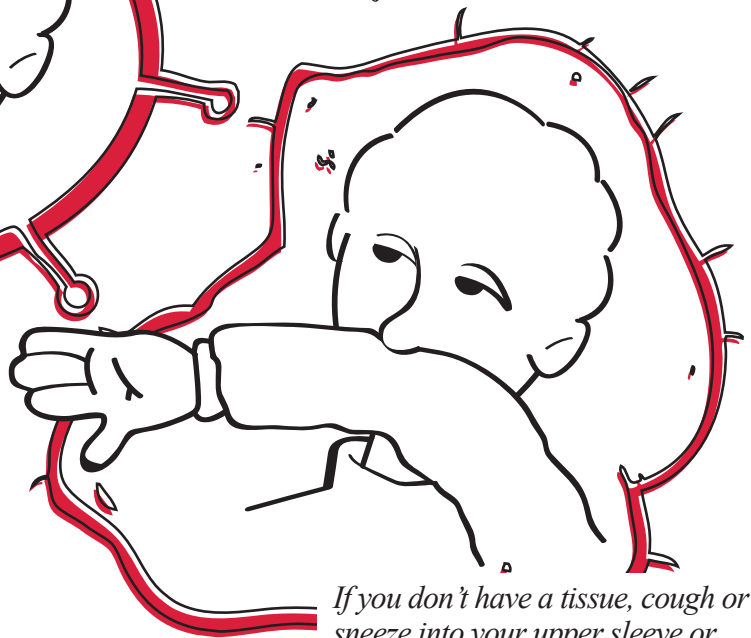
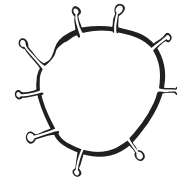
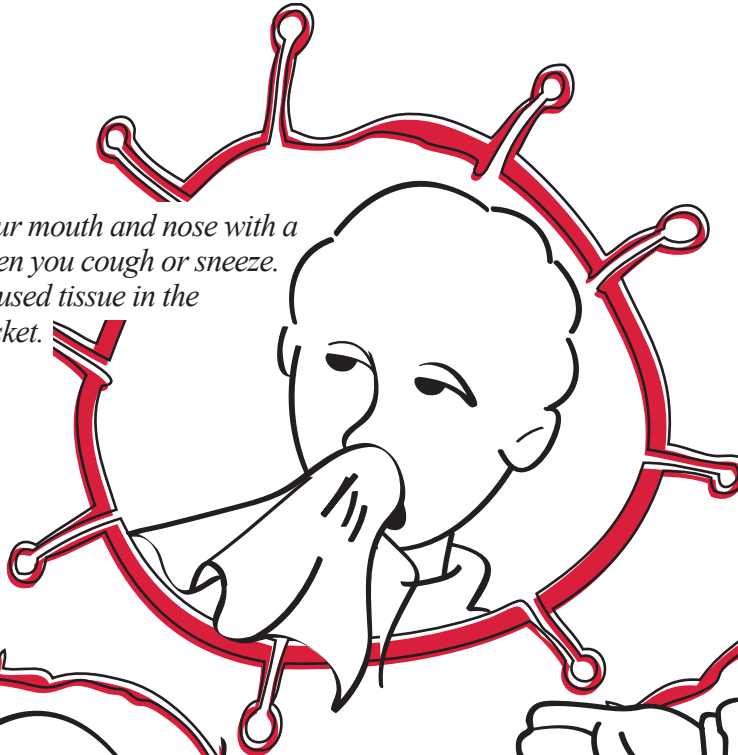


[cdc.gov/coronavirus](https://www.cdc.gov/coronavirus)

Cover Cough

— *Stop the spread of germs that can make you and others sick!* —

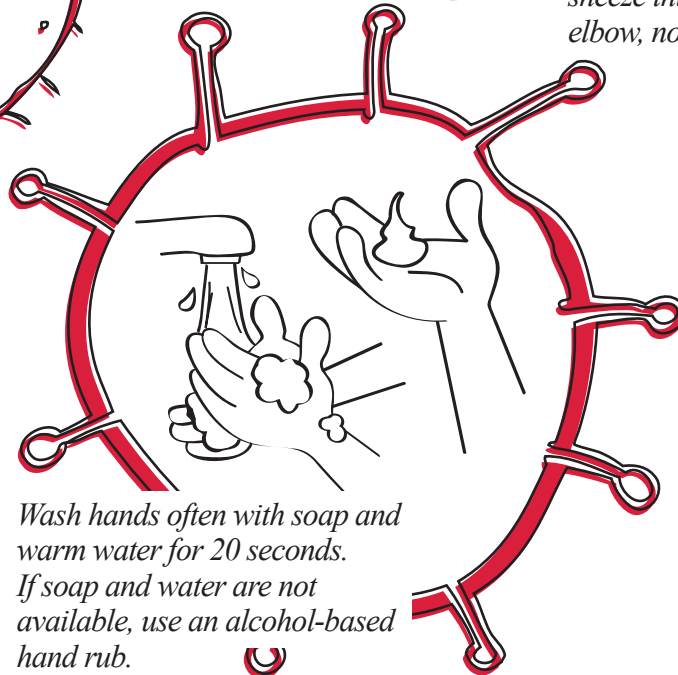
Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.



If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.



You may be asked to put on a facemask to protect others.



Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.



Symptoms of Coronavirus (COVID-19)

Know the symptoms of COVID-19, which can include the following:



Symptoms can range from mild to severe illness, and appear 2–14 days after you are exposed to the virus that causes COVID-19.

Seek medical care immediately if someone has Emergency Warning Signs of COVID-19

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone

This list is not all possible symptoms. Please call your healthcare provider for any other symptoms that are severe or concerning to you.



**Centers for Disease
Control and Prevention**
National Center for Emerging and
Zoonotic Infectious Diseases

[cdc.gov/coronavirus](https://www.cdc.gov/coronavirus)

Síntomas del coronavirus (COVID-19)

Conozca los síntomas del COVID-19, que pueden incluir:



Los síntomas pueden ser de leves a graves, y aparecer de 2 a 14 días después de la exposición al virus que causa el COVID-19.

Busque atención médica de inmediato si alguien tiene signos de advertencia de una emergencia del COVID-19

- Dificultad para respirar
- Dolor o presión persistentes en el pecho
- Estado de confusión de aparición reciente
- No puede despertarse o permanecer despierta
- Color pálido, gris o azulado de la piel, los labios, o el lecho de las uñas, dependiendo del tono de piel

Esta lista no incluye todos los síntomas posibles. Llame a su proveedor de atención médica si tiene cualquier otro síntoma que sea grave o que le preocupe.



Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases

cdc.gov/coronavirus-es

How to Read a Disinfectant Label

Read the entire label.

The label is the law!

Note: Below is an **example** of information that can be found on a disinfectant label

Active Ingredients:

What are the main disinfecting chemicals?

EPA Registration Number:

U.S. laws require that all disinfectants be registered with EPA.

Directions for Use (Instructions for Use):

Where should the disinfectant be used?

What germs does the disinfectant kill?

What types of surfaces can the disinfectant be used on?

How do I properly use the disinfectant?

Contact Time:

How long does the surface have to stay wet with the disinfectant to kill germs?



ACTIVE INGREDIENTS:

Alkyl (60% C14, 30% C16, 5% C12, 5% C18)
Dimethyl Benzyl Ammonium Chloride10.0%
OTHER INGREDIENTS:90.0%
TOTAL:100.0%

EPA REG NO. 55555-55-55555

CAUTION

Directions for Use

INSTRUCTIONS FOR USE:

It is a violation of Federal law to use this product in a manner inconsistent with its labeling.

For Disinfection of Healthcare Organisms:

Staphylococcus aureus,
Pseudomonas aeruginosa.

To Disinfect Hard, Nonporous Surfaces:

Pre-wash surface.
Mop or wipe with disinfectant solution.
Allow solution to stay wet on surface for at least 10 minutes.
Rinse well and air dry.



EXP MM-DD-YYYY



PRECAUTIONARY STATEMENTS:

Hazardous to humans and domestic animals. Wear gloves and eye protection.

CAUSES MODERATE EYE IRRITATION. Avoid contact with eyes, skin or clothing. Wash thoroughly with soap and water after handling. Avoid contact with foods.

FIRST AID: IF IN EYES: Hold eye open and rinse slowly and gently with water for 15-20 minutes. Remove contact lenses, if present, after the first 5 minutes, then continue rinsing eye. **IF ON SKIN OR CLOTHING:** Take off contaminated clothing. Rinse skin immediately with plenty of water for 15-20 minutes.

POISON CONTROL: Call a Poison Control Center (1-866-366-5048) or doctor for treatment advice.

STORAGE AND DISPOSAL: Store this product in a cool, dry area away from direct sunlight and heat. When not in use keep center cap of lid closed to prevent moisture loss. Nonrefillable container. Do not reuse or refill this container.

Signal Words (Caution, Warning, Danger):

How risky is this disinfectant if it is swallowed, inhaled, or absorbed through the skin?

Precautionary Statements:

How do I use this disinfectant safely? Do I need PPE?

First Aid:

What should I do if I get the disinfectant in my eyes or mouth, on my skin, or if I breathe it in?

Storage & Disposal:

How should the disinfectant be stored? How should I dispose of expired disinfectant? What should I do with the container?



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



WWW.CDC.GOV/PROJECTFIRSTLINE

CDC Environmental Checklist for Monitoring Terminal Cleaning¹

Date:	
Unit:	
Room Number:	
Initials of ES staff (optional):²	

Evaluate the following priority sites for each patient room:

High-touch Room Surfaces ³	Cleaned	Not Cleaned	Not Present in Room
Bed rails / controls			
Tray table			
IV pole (grab area)			
Call box / button			
Telephone			
Bedside table handle			
Chair			
Room sink			
Room light switch			
Room inner door knob			
Bathroom inner door knob / plate			
Bathroom light switch			
Bathroom handrails by toilet			
Bathroom sink			
Toilet seat			
Toilet flush handle			
Toilet bedpan cleaner			

Evaluate the following additional sites if these equipment are present in the room:

High-touch Room Surfaces ³	Cleaned	Not Cleaned	Not Present in Room
IV pump control			
Multi-module monitor controls			
Multi-module monitor touch screen			
Multi-module monitor cables			
Ventilator control panel			

Mark the monitoring method used:

- Direct observation Fluorescent gel
 Swab cultures ATP system Agar slide cultures

¹Selection of detergents and disinfectants should be according to institutional policies and procedures

²Hospitals may choose to include identifiers of individual environmental services staff for feedback purposes.

³Sites most frequently contaminated and touched by patients and/or healthcare workers





STOP

1



Clean hands, including before entering and when leaving the room.

2



Put on gown before room entry. Discard gown before room exit.

3



Put on a N95 respirator or higher before room entry. Discard respirator after exiting room.

4



Ensure eyes are covered with goggles or face shield before entering room. Remove eye protection before leaving the room.

5



Put on gloves before room entry. Discard gloves before room exit.

6



Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person.



Aerosol-Generating Procedure in Progress

PPE REQUIRED TO ENTER!

- **HAND HYGIENE**
- **N95**
- **EYE WEAR**
- **GOWN**
- **GLOVES**

**KEEP DOOR CLOSED DURING USE
AND 1 HOUR POST TREATMENT**

(See nurse for time frames)



**Indiana
Department
of
Health**



CONTACT PRECAUTIONS



EVERYONE MUST:



Clean their hands, including before entering and when leaving the room.

PROVIDERS AND STAFF MUST ALSO:



**Put on gloves before room entry.
Discard gloves before room exit.**



**Put on gown before room entry.
Discard gown before room exit.**

**Do not wear the same gown and gloves
for the care of more than one person.**



**Use dedicated or disposable equipment.
Clean and disinfect reusable equipment
before use on another person.**





DROPLET PRECAUTIONS



EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.



Make sure their eyes, nose and mouth are fully covered before room entry.



or



Remove face protection before room exit.





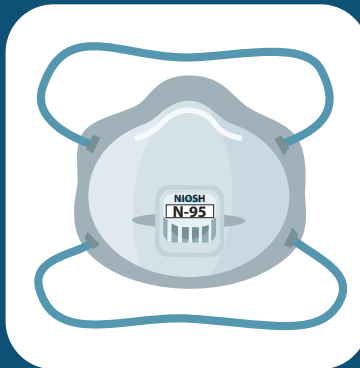
AIRBORNE PRECAUTIONS



EVERYONE MUST:



Clean their hands, including before entering and when leaving the room.



Put on a fit-tested N-95 or higher level respirator before room entry.

Remove respirator after exiting the room and closing the door.



Door to room must remain closed.

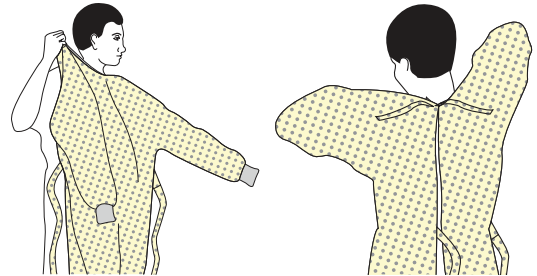


SEQUENCE FOR **PUTTING ON** PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

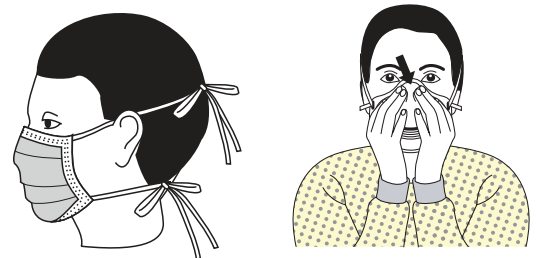
1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



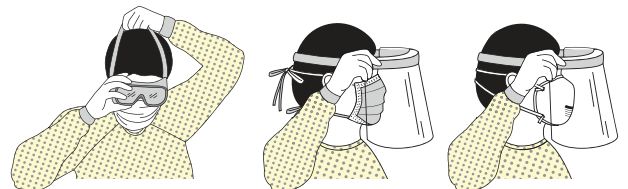
2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator



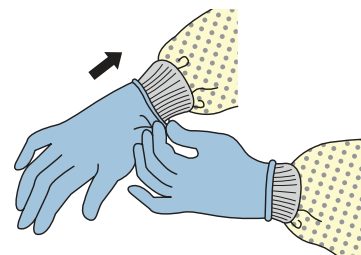
3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene



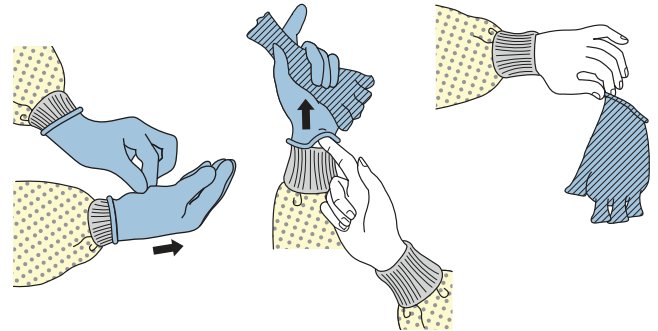
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)

EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



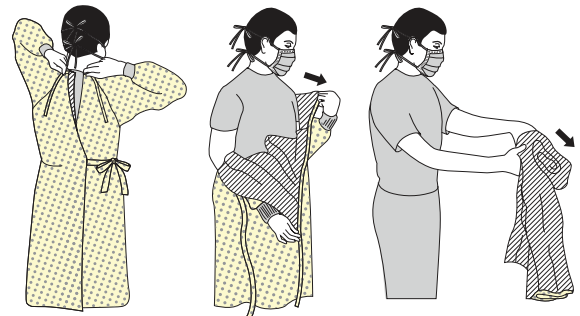
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container



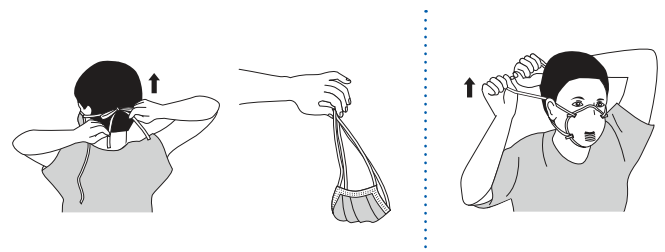
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

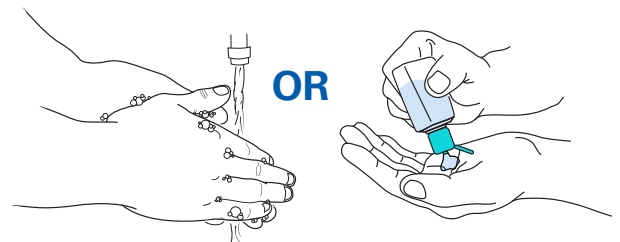


4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — **DO NOT TOUCH!**
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

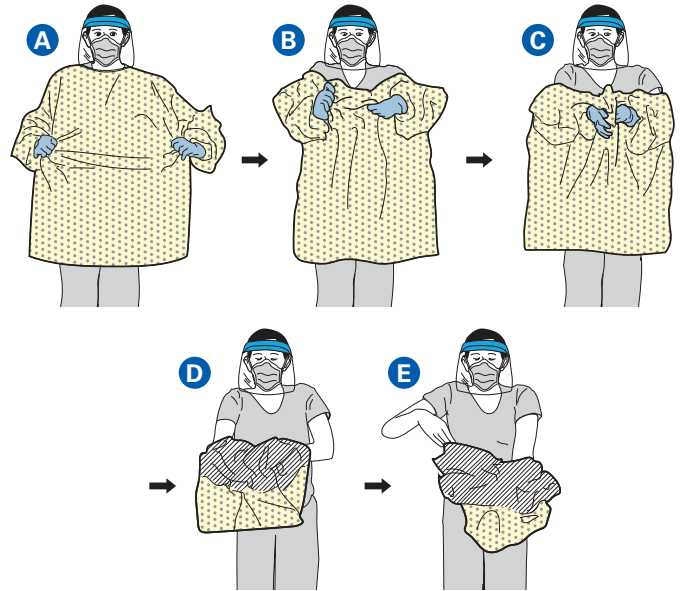


HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



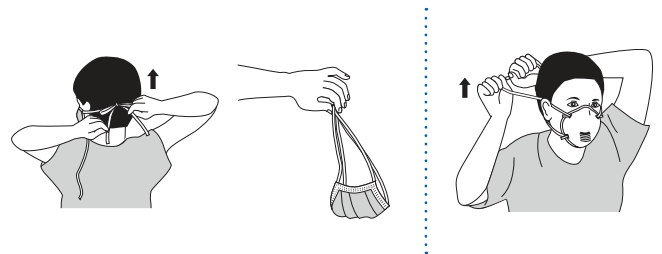
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

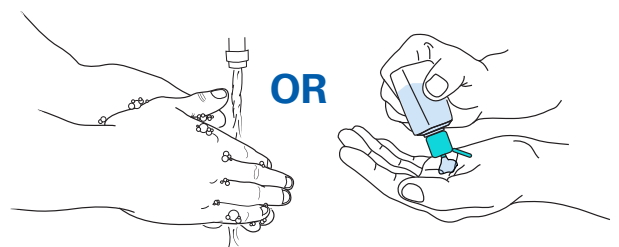


3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE




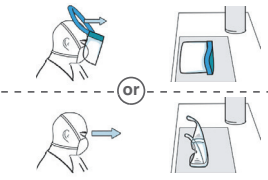






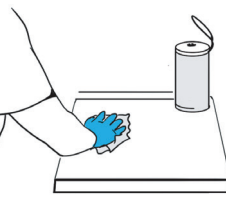
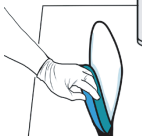
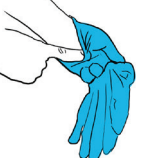



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE



Safe Reuse of Face Shield

After gown and glove removal...

<p>1 Sanitize hands.</p> 	<p>2 Put on fresh gloves.</p> 	<p>3 Place wipe on table.</p> 	<p>4 Remove eyewear and place on wipe.</p> 	<p>5 Remove gloves.</p> 	<p>6 Sanitize hands.</p> 	<p>7 Put on fresh gloves.</p> 
<p>8 Wipe front and back of shield with approved disinfectant.</p> 	<p>9 Wipe elastic band.</p> 	<p>10 Wipe foam band.</p> 	<p>11 Wipe table.</p> 	<p>12 Place shield upside down to dry, per contact time.</p> 	<p>13 Remove gloves.</p> 	<p>14 Sanitize hands.</p> 

Safe Reuse of Goggles/Protective Eyewear

After gown and glove removal...

<p>1 Sanitize hands.</p> 	<p>2 Put on fresh gloves.</p> 	<p>3 Place wipe on table.</p> 	<p>4 Remove eyewear and place on wipe.</p> 	<p>5 Remove gloves.</p> 	<p>6 Sanitize hands.</p> 	<p>7 Put on fresh gloves.</p> 
<p>8 Wipe front and back of lens with approved disinfectant.</p> 	<p>9 Wipe both ear pieces.</p> 	<p>10 Wipe table.</p> 	<p>11 Place goggles on clean table to dry per contact time.</p> 	<p>12 Remove gloves.</p> 	<p>13 Sanitize hands.</p> 	

Filtering out Confusion: Frequently Asked Questions about Respiratory Protection

User Seal Check

Over 3 million United States employees in approximately 1.3 million workplaces are required to wear respiratory protection. The Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134) requires an annual fit test to confirm the fit of any respirator that forms a tight seal on the wearer's face before it is used in the workplace.¹ Once a fit test has been done to determine the best respirator model and size for a particular user, a **user seal check** should be done every time the respirator is to be worn to ensure an adequate seal is achieved.



What is a User Seal Check?

A user seal check is a procedure conducted by the respirator wearer to determine if the respirator is being properly worn. The user seal check can either be a positive pressure or negative pressure check.

During a **positive pressure user seal check**, the respirator user **exhales** gently while blocking the paths for air to exit the facepiece. A successful check is when the facepiece is slightly pressurized before increased pressure causes outward leakage.

During a **negative pressure user seal check**, the respirator user **inhales** sharply while blocking the paths for air to enter the facepiece. A successful check is when the facepiece collapses slightly under the negative pressure that is created with this procedure.

A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on). It is only applicable when a respirator has already been successfully fit tested on the individual.

How do I do a User Seal Check while Wearing a Filtering Facepiece Respirator?

Not every respirator can be checked using both positive and negative pressure. Refer to the manufacturer's instructions for conducting user seal checks on any specific respirator. This information can be found on the box or individual respirator packaging.

The following positive and negative user seal check procedures for filtering facepiece respirators are provided as examples of how to perform these procedures.



How to do a positive pressure user seal check

Once the particulate respirator is properly donned, place your hands over the facepiece, covering as much surface area as possible. Exhale gently into the facepiece. The face fit is considered satisfactory if a slight positive pressure is being built up inside the facepiece without any evidence of outward leakage of air at the seal. Examples of such evidence would be the feeling of air movement on your face along the seal of the facepiece, fogging of your glasses, or a lack of pressure being built up inside the facepiece.

If the particulate respirator has an exhalation valve, then performing a positive pressure check may be impossible. In such cases, a negative pressure check should be performed.

How to do a negative pressure user seal check



Negative pressure seal checks are typically conducted on particulate respirators that have exhalation valves. To conduct a negative pressure user seal check, cover the filter surface with your hands as much as possible and then inhale. The facepiece should collapse on your face and you should not feel air passing between your face and the facepiece.

In the case of either type of seal check, if air leaks around the nose, use both hands to readjust the nosepiece by placing your fingertips at the top of the metal nose clip. Slide your fingertips down both sides of the metal strip to more efficiently mold the nose area to the shape of your nose. Readjust the straps along the sides of your head until a proper seal is achieved.²

If you cannot achieve a proper seal due to air leakage, you may need to be fit tested for a different respirator model or size.

Can a user seal check be considered a substitute for a fit testing?

No. The user seal check does not have the sensitivity and specificity to replace either fit test methods, qualitative or quantitative, that are accepted by OSHA (29 CFR 1910.134). A user should only wear respirator models with which they have achieved a successful fit test within the last year. NIOSH data suggests that the added care from performing a user seal check leads to higher quality donnings (e.g., reduces the chances of a donning with a poor fit).³

Where can I Find More Information?

This information and more is available on the [NIOSH Respirator Trusted-Source webpage](#).

References

1. OSHA [1998]. Respiratory Protection. 29 CFR 1910.134. Final rule. Fed Regist 63:1152-1300.
2. NIOSH [2010]. How to properly put on and take off a disposable respirator. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication No. 2010-133 <https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf>
3. Viscusi DJ, Bergman MS, Zhuang Z, and Shaffer RE [2012]. Evaluation of the benefits of the user seal check on N95 filtering facepiece respirator fit. J Occup and Environ Hyg. 9(6):408-416.

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Long-Term Care (LTC) Respiratory Surveillance Line List

Instructions for the Long-Term Care (LTC) Respiratory Surveillance Line List

The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home or other LTC facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness.

Each row represents an individual resident or staff member who may have been affected by the outbreak illness (i.e., case). The information in the columns of the worksheet capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes. While this template was developed to help with data collection for common respiratory illness outbreaks the data fields can be modified to reflect the needs of the individual facility during other outbreaks.

Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

LTC Respiratory Surveillance Line List

Instruction Sheet for Completion of the Long-Term Care (LTC) Respiratory Surveillance Line List

Section A: Case Demographics

In the space provided per column, fill in each line with name, age and gender of each person affected by the current outbreak at your facility. Please differentiate residents (R) from staff (S).

*Staff includes all healthcare personnel (e.g., nurses, physicians and other providers, therapists, food services, environmental services) whether employed, contracted, consulting or volunteer.

For residents only: Short stay (S) residents are often admitted directly from hospitals, require skilled nursing or rehabilitation care, and are expected to have a length of stay less than 100 days. Long stay (L) residents are admitted to receive residential care or nursing support and are expected to have a length of stay that is 100 days or more. Indicate the stay type for each resident in this column.

Section B: Case Location

For resident only: Indicate the building (Bldg), unit or floor where the resident is located and the room and bed number for each resident being monitored for outbreak illness. *Answers may vary by facility due to differences in the names of resident care locations.

For staff only: For each staff member listed, indicate the floor, unit or location where that staff member had been primarily working at the time of illness onset.

Section C: Signs and Symptoms (s/s)

Symptom onset date: Record the date (month/day) each person developed or reported signs/symptoms (e.g., fever, cough, shortness of breath) consistent with the outbreak illness.

Symptoms: Fill in the box (Y or N) indicating whether or not a resident or staff member experienced each of the signs/symptoms listed within this section.

Additional documented s/s (select all codes that apply): In the space provided, record the code that corresponds to any additional s/s the resident or staff member experienced. If a resident or staff member experienced a s/s that is not listed, please use the space provided by "Other" to specify the s/s.

H – headache, SB – shortness of breath, LA – loss of appetite, C – chills, ST – sore throat, O – other: Specify _____

Section D: Diagnostics

Chest x-ray: Fill in the box (Y or N) indicating whether or not a chest x-ray was performed.

Type of specimen collected: (Select all codes that apply): In the space provided, record the type of specimen collected for laboratory testing. If the type of specimen collected is not listed, please use the space provided by "Other" to specify the specimen type.

NP – nasopharyngeal swab, OP – oropharyngeal swab, S – sputum, U – urine, O – Other: Specify _____

Date of collection: Record the date (month/day) of specimen collection.

Type of test ordered (select all codes that apply): In the space provided, record the code that corresponds to whether a diagnostic laboratory test was performed for each individual. If no test was performed, indicate "zero". If the laboratory test used to identify the pathogen is not listed, please use the space provided by "Other" to specify the type of test ordered.

0 – No test performed, 1 – Culture, 2 – Polymerase Chain Reaction (PCR), also called nucleic acid amplification testing includes multiplex PCR tests for several organisms using a single specimen, 3 – Urine Antigen, 4 – Other: Specify

Pathogen detected (select all codes that apply): In the space provided, record the code that corresponds to the bacterial and/or viral organisms that were identified through laboratory testing. If the test performed was negative, indicate "zero". If a pathogen not listed was identified through laboratory testing, please use the space provided by "Other" to specify the organism.

0 – Negative results; Bacterial: 1 – *Streptococcus pneumoniae*, 2 – *Legionella*, 3 – *Mycoplasma*

Viral: 4 – Influenza, 5 – Respiratory syncytial virus (RSV), 6 – Human metapneumovirus (HMPV), 7 – Other: Specify _____

Section E: Outcome During Outbreak

Symptom Resolution Date: Record the date that each person recovered from the outbreak illness and was symptom free for 24 hours.

Hospitalized: Fill in the box (Y or N) indicating whether or not hospitalization was required for a resident or staff member during the outbreak period. **Note: The outbreak period is the time from the date of symptom onset for the first case to date of symptom resolution for the last case.**

Died: Fill in the box (Y or N) indicating whether or not a resident or staff member expired during the outbreak period.

Case (C) or Not a case (leave blank): Based on the clinical criteria and laboratory findings collected during the outbreak investigation, record whether or not each resident or staff member meets the case definition (C) or is not a case (leave space blank).

LTC Respiratory Surveillance Line List

Date: ____/____/____

This worksheet was created to help nursing homes and other LTC facilities detect, characterize and investigate a possible outbreak of respiratory illness.

A. Case Demographics				B. Case Location			C. Signs and Symptoms (s/s)				D. Diagnostics				E. Outcome During Outbreak ^A			
Name				Residents Only: Bldg/Floor			Symptom onset date: (mm/dd)				Date of collection: (mm/dd)				Symptom resolution date: (mm/dd)			
Age				Residents Only: Room/Bed			Fever ^B (Y/N)				Type of specimen collected (select all codes that apply)				Hospitalized (Y/N)			
Gender (M/F)				Staff Only: Primary floor assignment			Cough (Y/N)				NP – nasopharyngeal swab, OP – oropharyngeal swab, U – urine, S – sputum, Other: Specify _____				Died (Y/N)			
Resident (R) or Staff (S)							Myalgia (body ache) (Y/N)				Pathogen Detected (Select all codes that apply)				Case (C) or Not a case (leave blank)			
Residents Only: Short stay (S) or Long stay (L)							Additional documented s/s (select all codes that apply) H – headache, SB – shortness of breath, LA – loss of appetite, C – chills, ST – sore throat, O – other: Specify _____				0 – No test performed, 1 – Culture, 2 – PCR, 3 – Urine Antigen, 4 – Other: Specify _____				Bacterial: 1 – <i>S. pneumoniae</i> , 2 – <i>Legionella</i> , 3 – <i>Mycoplasma</i>			
Residents Only: Bldg/Floor											7 – Other: Specify _____				Viral: 4 – Influenza, 5 – RSV, 6 – HMPV			
Residents Only: Room/Bed																		
Staff Only: Primary floor assignment																		
1.																		
2.																		
3.																		
4.																		
5.																		
6.																		
7.																		
8.																		
9.																		
10.																		

If faxing to your local Public Health Department, please complete the following information:

Facility Name: _____ City, State: _____ County: _____

Contact Person: _____ Phone: _____ Email: _____

^A **Note:** Outbreak defined as date of first case to resolution of last case.

^B **Definition of Fever** (Stone N, Ashraf MS, Calder, J, et al. Surveillance Definitions in Long-Term Care Facilities: Revisiting the McGeer Criteria. Infect Control Hosp Epidemiol 2012; 33:965-977):
(1) a single oral temp > 37.8°C (100°F) or (2) repeated oral temps > 37.2°C (99°F) or rectal temps > 37.5°C (99.5°F) or (3) a single temp > 1.1°C (2°F) over baseline from any site (oral, tympanic, axillary).

Long-Term Care (LTC) Respiratory Surveillance Outbreak Summary

Instructions for the Long-Term Care (LTC) Respiratory Surveillance Outbreak Summary

The Respiratory Outbreak Summary Form was created to help nursing homes and other LTC providers summarize the findings, actions and outcomes of an outbreak investigation and response. Completing this outbreak form will provide LTC facilities and other public health partners with a record of a facility’s outbreak experience and highlight areas for outbreak prevention and response.

Instructions for each section of the form are described below. This form should be filled out by the designated infection preventionist with support from other clinicians in your facility (e.g., front-line nursing staff, physicians or other practitioners, consultant pharmacist, laboratory).

A LTC facility can use this form for internal documentation and dissemination of outbreak response activities. Facilities are encouraged to share this information with the appropriate public health authority by contacting the local health department. Should a facility decide to share this form with the local/state public health officials, please include facility contact information at the bottom of the form.

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LTC Respiratory Surveillance Outbreak Summary

Section 1: Facility Information

Health Dept. Contact Name and Phone Number: A LTC facility should have contact information (name or division, phone number) for the local and/or state health department for outbreak guidance and reporting purposes. Enter the health dept. contact information your facility used to request support during an outbreak.

Date First Notified Local Health Dept: Record the date you first contacted local or state public health during this outbreak at your facility.

Total # of residents at facility: Document the total number of residents in the facility at the time of the outbreak.

Total # of employees: Document the total number of staff working in the facility at the time of the outbreak. Staff includes all healthcare personnel (e.g., nurses, providers, consultants, therapists, food services, environmental services) whether employed, contracted or volunteer.

Summary Form Status: Information in the summary form may be completed over the course of the outbreak. Record the dates your facility started collecting information on the form and completed the outbreak summary report.

Section 2: Influenza Vaccination Status

Total # of residents vaccinated: Record the total number of residents that received the Flu Vaccine within the past year.

Total # of staff vaccinated: Record the total number of staff that received the Flu Vaccine within the past year.

Section 3: Pneumococcal Vaccination Status

Total # of residents vaccinated: Record the total number of residents that received at least one dose of the Pneumococcal Vaccine (either polysaccharide or conjugate).

Section 4: Case Definition

Provide a description of the criteria used to determine whether a resident should be considered a case in this outbreak. The description can include: signs/symptoms, presence of positive diagnostic tests, location within facility, and the timeframe during which individuals may have been involved in the outbreak (e.g., within the past 4 weeks).

Example: A Respiratory illness case includes any resident with the following symptoms: cough, shortness of breath, sputum production and fever residing on Units 2E or 2W, with onset of symptoms between Jan 15th and Feb 1st with or without a sputum specimen positive for Streptococcus pneumoniae.

Section 5: Outbreak Period Information

Outbreak start: (Date of symptom onset of first case): Record the date the first person developed signs/symptoms (e.g., fever, cough, shortness of breath) consistent with the outbreak illness.

Average length of illness: Estimate the average number of days it takes for signs/symptoms to resolve, based on clinical course among residents/staff affected by the outbreak illness.

Outbreak end: (Symptom resolution date of last case): Record the date the last person recovered from the outbreak illness and became symptom free for 24 hours.

Total # of Cases: Document the number of residents and staff (if applicable) who were identified as having the outbreak illness.

LTC Respiratory Surveillance Outbreak Summary

Section 6: Staff Information

Were any ill staff delivering resident care? Check yes or no.

- If yes, try to estimate the number of ill staff involved in resident care based on date when a staff member reported symptoms compared with the date when/if staff member was excused from work.

Did any staff seek medical attention for an acute respiratory infection at any time during the outbreak? Check yes or no.

- If yes, try to estimate the number of staff that sought medical attention based on self-report.

If available, indicate if ill staff received care at an emergency department (ED). Check yes or no and estimate number of staff.

If available, indicate if ill staff was hospitalized as a result of the outbreak illness. Check yes or no and estimate number of staff.

Section 7: Diagnostic and Laboratory Tests

Chest x-ray: Fill in the box (yes or no) indicating whether or not residents and staff had an x-ray done as a part of the diagnosis of the outbreak illness. If yes, please record the # of individuals who received chest x-ray and the # of x-rays that had abnormal findings consistent with the outbreak illness.

List all bacterial (e.g., *S. pneumoniae*, *Mycoplasma*); viral (e.g., Influenza, RSV) organisms that were identified through laboratory testing; Use the space provided by "Other" to specify if a parasite or non-infectious cause of respiratory illness was identified.

Diagnostic testing results: In the table, each row corresponds to an organism identified during the outbreak. Use the column to specify the type of testing used to identify each organism (either microbiologic culture, PCR (also known as nucleic acid amplification) or specify if a different diagnostic test was used (e.g., Legionella urinary antigen). For each test type, document the total number of residents and staff that received laboratory confirmation by that test.

Section 8: If Influenza Identified During Outbreak:

Antiviral Treatment: Fill in the box (yes or no) indicating whether or not antiviral treatment was offered. If antiviral treatment was offered, please record the total number of residents and staff that received treatment.

Antiviral Prophylaxis Offered: Fill in the box (yes or no) indicating whether or not antiviral prophylaxis was offered to any additional residents, staff or family members at risk for infection due to the outbreak. If antiviral prophylaxis was offered, please record the total number of residents and staff that received prophylaxis.

Section 9: Resident Outcome

Hospitalizations: During the outbreak, fill in the box (yes or no) indicating whether or not hospitalization was required for any residents. If yes, please record how many residents were hospitalized.

Deaths: During the outbreak, fill in the box (yes or no) indicating whether or not any residents died. If yes, please record how many residents died during the outbreak period (deaths should be recorded even if unable to determine if outbreak illness was the cause).

Section 10: Facility Outbreak Control Interventions

In this section, check if any of the infection control strategies listed were implemented at your facility in response to the outbreak. If a practice or policy change was implemented during the outbreak that is not listed (e.g., new cleaning/disinfecting products used, change to employee sick leave policy), specify in the space provided by "Other". For each strategy, record the date the change was implemented (if available).

Section 11: # of New Cases Per Day

Please fill in the chart with the number of new cases that are residents and staff per day. Once each day is complete, add the number of new cases of residents and staff and place the sum in total column for that corresponding day.

In the space provided under the chart, record the date which corresponds to Day 1 on the outbreak period (i.e., date of outbreak start).

For HD Use Only

Facility Licensed by State: Fill in the box (yes or no) indicating whether or not the facility is licensed by the state.

Facility Certified by CMS: Fill in the box (yes or no) indicating whether or not the facility is certified by the Center for Medicare and Medicaid Services (CMS).

Facility Type: Check that box that best describes the type of care the facility provides: Nursing home, Intermediate Care Facility, Assisted living Facility or Other (specify).

of Licensed Beds: Document the total number of licensed beds at the facility.

of staff employees: Document the total number of facility employed staff working in the facility at the time of the outbreak.

of contract employees: Document the total number of contract/consulting providers working in the facility at the time of the outbreak.

LTC Respiratory Surveillance Outbreak Summary

1. Facility Information

Health Dept. Contact Name: _____ Health Dept. Contact Phone Number: _____
 Health Dept. Fax Number: _____ Date First Notified Local Health Dept.: ___/___/___
 Total # of residents at facility: _____ Total # of employees (staff and contract personnel): _____
 Summary Form Status: Date initiated: ___/___/___ Date completed: ___/___/___

2. Influenza Vaccination Status

Total # of residents vaccinated: _____ Total # of staff vaccinated: _____

3. Pneumococcal Vaccination Status

Total # of residents vaccinated: _____

4. Symptomatic Case Definition

Summarize the definition of a symptomatic case during the outbreak, including symptoms, time range and location (if appropriate) within facility:

5. Outbreak Period Information

Outbreak start: (Date of symptom onset of first case): ___/___/___ Average length of illness: _____ days Outbreak end: (Symptom resolution date of last case): ___/___/___	Total # of Cases Residents: _____ Staff: _____
--	--

6. Staff Information

Were any ill staff delivering resident care at the beginning of the outbreak? Yes No If yes, how many: _____
 Did any ill staff seek outside medical care at the beginning or during the outbreak? Yes No If yes, how many: _____
 ED Visit: Yes No If yes, how many: _____ Hospitalization: Yes No If yes, how many: _____

7. Diagnostic and Laboratory Tests

Chest x-ray: Yes No # performed: _____ # abnormal: _____
 Which organisms were identified through laboratory testing:
Bacterial: Specify _____ **Viral:** Specify _____ **Other:** Specify _____

Total # of Laboratory Confirmed Cases	Culture	PCR	Other Diagnostic Tests: Specify _____
Organism 1 _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____
Organism 2 _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____
Organism 3 _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____	Residents: _____ Staff: _____

8. If Influenza Identified During Outbreak:

Antiviral **treatment** offered: Yes No Antiviral **prophylaxis** offered: Yes No
 If yes, indicate total # : Residents _____ Staff _____ If yes, indicate total # : Residents _____ Staff _____

9. Resident Outcome

Hospitalizations: Yes No If yes, how many: _____ Deaths: Yes No If yes, how many: _____

10. Facility Outbreak Control Measures

- | | |
|---|--|
| <input type="checkbox"/> Educated on hand hygiene practices: Date: _____
<input type="checkbox"/> Implemented transmission-based precautions: Date: _____
<input type="checkbox"/> Dedicate staff to care for only affected residents: Date: _____
<input type="checkbox"/> Suspend activities on affected unit: Date: _____
<input type="checkbox"/> Notified family/visitors about outbreak: If yes, Date: _____
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Monitored appropriate HH and PPE use by staff: Date: _____
<input type="checkbox"/> Cohorted ill residents within unit/building: Date: _____
<input type="checkbox"/> Placed ill staff on furlough: Date: _____
<input type="checkbox"/> Restricted new admissions to affected unit: Date: _____
<input type="checkbox"/> Educated family/visitors about outbreak: If yes, Date: _____
<input type="checkbox"/> Other: _____ |
|---|--|

11. # of New Cases Per Day

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Residents														
Staff														
Total														

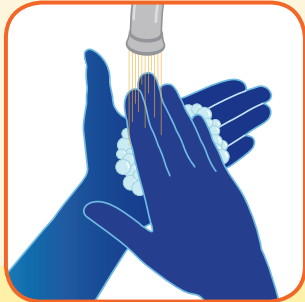
Indicate Date of Day 1: ___/___/___ List units/floors involved in the outbreak: _____

For HD Use Only

Facility Licensed by State: Yes No Facility ID: _____
 Facility Certified by CMS: Yes No Facility Type: Nursing home Assisted living Other (specify): _____
 # of Licensed Beds: _____ # of staff employees: _____ # of contract employees: _____

10 Ways to Protect Your Residents

Keeping residents safe from infection is everyone's responsibility.



Clean Your Hands Before and After Providing Care



Stay Home if You're Sick



Know If Antibiotics are Appropriate



Follow all Posted Precaution Signs



Use Personal Protective Equipment



Get Vaccinated



Use Safe Injection Practices



Keep Resident's Environment and Equipment Clean



Educate Residents on Infection Prevention

Know Your Facility's Infection Preventionist:

Name _____

Number _____

Inter-Facility Infection Control Transfer Form



This inter-facility infection control patient transfer form can assist in fostering communication during transitions of care for patients infected with MDROs, COVID-19, etc. The discharging facility should complete this transfer form and sign at the bottom after all fields are completed. Attach copies of pertinent records and latest laboratory reports to send with the patient to the receiving facility. This form has been adapted from the Centers for Disease Control and Prevention (CDC).

Inter-Facility Infection Control Transfer Form

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer. Please attach copies of latest culture reports.

Sending Healthcare Facility:

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number

Name/Address of Sending Facility	Sending Unit	Sending Facility Phone

Sending Facility Contacts	Contact Name	Phone	E-mail
Transferring RN/Unit			
Transferring physician			
Case Manager/Admin/SW			
Infection Preventionist			

Does the person* currently have an infection, colonization OR a history colonization active infection of positive culture of a multidrug-resistant organism (MDRO) or other or history potentially transmissible infectious organism?	Colonization or History (Check if Yes)	Active Infection on Treatment (Check if Yes)	Pending Labs (Check if Yes)
Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Vancomycin-resistant <i>Enterococcus</i> (VRE)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<i>Clostridioides difficile</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<i>Acinetobacter</i> , multidrug-resistant	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Enterobacteriaceae (e.g., <i>f. coli</i> , <i>Klebsiella</i> , <i>Proteus</i>) producing- Yes Extended Spectrum Beta-Lactamase (ESBL)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Carbapenem-resistant Enterobacteriaceae (CRE)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<i>Pseudomonas aeruginosa</i> , multidrug-resistant	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Carbapenemase-producing Organism (CPO)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<i>Candida auris</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
COVID-19 Choose a Test Type: <input type="checkbox"/> PCR <input type="checkbox"/> POC Antigen	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other, specify (e.g., scabies, norovirus, influenza):	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

Does the person* currently have any of the following? (Check here if none apply)

<input type="checkbox"/> Cough or requires suctioning <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Incontinent of urine or stool <input type="checkbox"/> Open wounds or wounds requiring dressing change <input type="checkbox"/> Central line/PICC Approx. date inserted: <input type="text"/> <input type="checkbox"/> Drainage (source): <input type="text"/>	<input type="checkbox"/> Hemodialysis catheter <input type="checkbox"/> Urinary catheter (Approx. date inserted) <input type="checkbox"/> Suprapubic catheter <input type="checkbox"/> Percutaneous gastrostomy tube <input type="checkbox"/> Tracheostomy
---	--

Is the person* currently in Transmission-Based Precautions? NO YES

Type of Precautions (check all that apply): Contact Droplet Airborne

Other: _____

Reason for Precautions: _____

Vaccine	Date administered (If known)	Lot and Brand (If known)	Year administered (If exact date not known)	Does the person* self-report receiving vaccine?
Influenza (seasonal)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumococcal (PPSV23)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumococcal (PCV13)				<input type="checkbox"/> Yes <input type="checkbox"/> No
COVID-19				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: <input type="text"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No

*Refers to patient or resident depending on transferring facility

Required PPE



Name of staff completing form (print): _____

Signature: _____

If information communicated prior to transfer:

Name of individual at receiving facility: _____

Phone of individual at receiving facility: _____

