1. "One of my doctors wants me to produce proof of the recommendation for shutting down a room for 14 minutes". The recommendation has been in resources from 2003, and life safety OSHA do we Have to or can we make our own policy?" **Follow CDC guidelines for aerosol generating procedures including administrative and engineering controls, and use of appropriate PPE.**

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html#surgical

The time to enter the room depends on the procedure that was performed, the type of PPE the staff entering the room is wearing, and the exchange rate of the room. For aerosol generating procedures, follow CDC guidelines for aerosol generating procedures including administrative and engineering controls, and use of appropriate PPE. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html#surgical

All persons 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 at https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1).

2. "We don't have a current air balance report, and can't get anyone to come out so we don't know our pressure- what do we have to do when the patient is out of the room"?

Once the patient has been discharged or transferred, HCP, including environmental services 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 at https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use. If this information is not currently available, the ASC should refer to policies and procedures established for care of an active Tuberculosis or TB patient.

3. I have a Nurse that says she has elder family staying with her and she cannot come back safely, what can I do? (this was an overall question about staff NOT wanting to return to their position.

Review OSHA COVID-19 information at https://www.osha.gov/SLTC/covid-19/. Refer to the NJ Department of Labor Worker Benefits, Protections and the Coronavirus (COVID-19): What NJ Workers Should Know at https://www.nj.gov/labor/worker-protections/earnedsick/covid.shtml to review Employee scenarios for state and federal benefits and protections.

4. When the surveyors come out what are they expecting in the way of Covid management?
Facilities must be in compliance with State/Federal regulations at all times. In addition, the facilities are also expected to follow any additional guidance related to COVID, i.e. Executive Directives or EOs.

5. Does the DOH support the CDC recommendation to block the OR post extubation or AGP to allow enough time based on the OR's Air Exchange Rate (21 minutes for 20 air exchanges/hr) to permit the reduction of aerosolized particles to 99.9% in order to protect the next patient entering the OR. Our ICC

felt that we cannot be 100% certain that our patients are not infectious, even with a negative COVID 19 test within 96 hours. Our ICC feels that due to of the nature of AGP/ENT procedures, even an asymptomatic infected patient can transmit to others. My ICC's rationale is that the PPE protects the staff, the additional time protects the next patient, who does not have the benefit of PPE. Is this CDC recommendation only for COVID positive patients?

Follow CDC guidelines for aerosol generating procedures including administrative and engineering controls, and use of appropriate PPE.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html#surgical

6. Is a covid-19 test required before emergency? Example a retinal detachment that needs to be done same day or next day. **Yes, it is.**

7. I was wondering about further clarification on PPE

The published requirements from NJDOH state

Page 4 D1(iv) 2. Discusses development of policies for staff training and optimized use of PPE according to non-crisis standards of care

According to CDC, conventional measures consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings. Contingency capacity measures may be used temporarily during periods of expected PPE shortages. Contingency capacity measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel. These practices may be used temporarily during periods of expected PPE shortages. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices. Refer to CDC's Strategies to Optimize the Supply of PPE and Equipment at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.

3. Talks about conservation of PPE and development of policies regarding extended use and reuse of PPE. **Crisis standards for PPE use is not appropriate. Follow CDC guidelines for aerosol generating procedures including administrative and engineering controls, and use of appropriate PPE.**

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html#surgical