COVID-19: Updates and Recommendations

The National Infusion Center Association is closely following the developing situation regarding the global pandemic associated with the viral respiratory illness Coronavirus Disease 2019 (COVID-19), caused by the SARS-CoV-2 virus. As this is a rapidly evolving situation, information and guidance will be updated as needed to reflect the most recent recommendations from the CDC, OSHA and other agencies.

Risk Mitigation Strategies

Every jurisdiction in the United States has reported COVID-19 cases, and nearly all are experiencing some degree of community transmission. Healthcare facilities, including infusion centers, should review their internal emergency response protocols and implement appropriate strategies to mitigate risk of exposure, and transmission among, staff and patients. For general guidance, NICA recommends infusion facilities refer to the following preparedness resources:


**PARTICULAR ATTENTION SHOULD BE PAID TO THE FOLLOWING CONSIDERATIONS AND RECOMMENDATIONS:**

Decontamination

- Increase frequency of cleaning and disinfection procedures using a product known to be effective against SARS-CoV-2. It is very important to follow the manufacturer's instructions on the product label; allow the product to stay on surfaces for the full recommended contact time (the amount of time the disinfectant is in direct contact with the surface/item to be disinfected). If the disinfectant air dries or is wiped dry before the contact time is reached, it may not provide the required level of disinfection.
- Equipment and high-touch surfaces in the patient treatment area should be thoroughly disinfected between patient use (e.g. infusion chairs, chair-side tables, remote controls, infusion pumps/poles, blood pressure cuffs, etc.).
- Additional high-touch environmental surfaces including doorknobs, light switches, faucets, keyboards, and items in the check-in area such as countertops, touchscreens, pens and clipboards should also be frequently and thoroughly disinfected.

**Facility Considerations**

- Utilize private rooms when possible. If private infusion suites are unavailable, reduce seating and/or move infusion chairs to allow placement at least 6 feet apart.
- Consider having patients wait for their appointment in their vehicle, using their mobile phone to communicate with staff. As some patients may use public transportation or are otherwise unable to wait in a vehicle, modify waiting room to allow for social distancing (e.g., reduce seating capacity, place chairs 6 feet apart).
- Post signage at entrances instructing patients to maintain a distance of 6 feet from others, hand and respiratory hygiene and cough etiquette.
- Ensure hand sanitizer, tissues and no-touch receptacles for tissue disposal are readily available in patient treatment areas;
- Consider positioning staff at the door to conduct risk assessments before patients enter the facility/treatment area.

**Operational Considerations**

- Stay informed on the COVID-19 situation in your area and know how to contact your local and state health departments;
- Provide staff with refresher training on proper donning/doffing of PPE;
- Provide education on hand hygiene and respiratory etiquette in communications with patients. The CDC has free print resources available at: [https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html](https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html)
- Consider staggering scheduled appointments and/or extending clinic hours to limit the number of patients in the treatment area at any given time;
- Consider having patients wait for their appointment in their vehicle, using their mobile phone to communicate with staff.
- Restricting non-essential visitors and implementing visitor screening to assess their risk of COVID-19 infection in an effort to reduce the risk of exposure and facility-associated spread.
Risk Assessment Screening

Screen patients, visitors and staff to assess their risk of exposure to SARS-CoV-2 and/or COVID-19 infection. Ideally this should be done by phone prior to their scheduled appointments. If this is infeasible, perform patient screenings immediately upon patient arrival in an area separate from the treatment area and waiting area if possible.

### Ask the Following Questions:

#### Exposure Risk Screening

In the past 14 days, have you had close contact\(^1\) with:

- A person with a known or suspected case of COVID-19;
- A person experiencing COVID-19 symptoms (e.g. fever, cough, shortness of breath); or
- A person who has been instructed to self-monitor/isolate/quarantine at home due to potential exposure?

#### Symptom Screening

- Have you experienced a fever of 100.4 F or greater in the last 14 days?
- Have you experienced respiratory symptoms, such as cough or shortness of breath in the last 14 days?

If symptom screen is positive:

- If patient is experiencing any warning signs (such as shortness of breath, difficulty breathing, persistent chest pain or pressure, confusion or lethargy, or bluish lips or face) they should be advised to seek emergency medical services immediately and notify the emergency care facility ahead of time for guidance on how to enter the facility and check-in.

- Hold scheduled treatment and contact patient’s primary care provider for guidance related to supportive care at home and/or testing according to current local/state public health department guidance. Remind patients not to present to their providers office or the emergency department to request testing-- they should call ahead.

If symptom screen is negative\(^1\) but exposure screen is positive:

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\(^1\) It should be noted that per CDC: “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
Consult with healthcare team (primary care provider, specialist, infusion prescriber) to evaluate risks vs. benefits of proceeding with infusion as scheduled. If appropriate and reasonable, consider postponing scheduled treatment until patient is outside of 14-day exposure window. Considerations for this decision should take into account the potential risk of administering an immunomodulating agent to a patient who may be infected but still in the incubation period, as well as potential exposure of other immunocompromised patients and staff in the infusion center to the SARS-CoV-2 virus. The decision to treat or postpone is ultimately up to the patient and their provider.

Patients who have had close contact with an individual with known or suspected COVID-19 disease within the last 14 days should not be treated in infusion centers under normal circumstances.

- We recognize, however, that as this public health emergency evolves, extenuating circumstances may leave no viable alternative. If the decision is made that an asymptomatic patient reporting potential exposure to COVID-19 must be treated in the infusion center, current CDC guidance indicates that Standard Precautions should be followed, and precautions related to COVID-19 are not required for staff. However, great care must be taken to protect other patients and staff from potential exposure to the SARS-CoV-2 virus. With that in mind, the National Infusion Center Association believes the following considerations would be prudent:

- Nurses providing direct patient care should wear PPE as available based on supply, in conjunction with CDC recommendations. At a minimum, NICA recommends nurses caring for these patients wear a mask, eye protection and gloves. Gowns may be considered (if available) when extensive, close patient contact is anticipated.

- Consider scheduling patients with no known exposure in the first half of the day, and potentially exposed patients in second half of the day so their appointments do not overlap; and,

- Perform thorough decontamination of patient care area, including all surfaces that came in contact with the patient as well as those within 6 feet of the patient during their treatment.

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.*
MASKING

In light of new data and CDC recommendations regarding asymptomatic and pre-symptomatic transmission, it is recommended that source control (cloth face covering or facemask) be implemented for everyone entering the infusion center regardless of exposure/symptoms. Masking is intended to keep potentially infectious droplets/microdroplets from being released into the air by the mask wearer. A surgical mask or cloth face covering will provide source control while optimizing available N95 respirators for those caring for healthcare workers and first responders caring for patients with known or suspected COVID-19 infections.

- Staff should wear a facemask when within 6 feet of other individuals. A facemask is recommended over a cloth face covering, as it provides additional protection against splashes/sprays of potentially infectious material.
- If there is a physical barrier between staff and patients (such as a glass or plexiglass window or partition in a check-in area), PPE is not required.
- Patients and visitors should be asked to wear a face covering while in the facility. If patients/visitors did not arrive wearing a face covering, they should be offered a cloth face covering or a facemask (if supplies allow).

WORKFORCE MANAGEMENT

- As always, require staff to practice diligent hand hygiene;
- Reinforce Standard Precautions practices and rationale with staff;
- Ask employees to self-monitor for symptoms and report illness to their employer right away. In areas experiencing community transmission, consider checking staff temperatures at the beginning and end of each shift and/or asking staff to check their temperature prior to leaving for work;
- Insist staff go home and/or stay home if they are sick, and that calling out due to illness will not result in disciplinary actions;
- Waive any requirement for employees to provide a note from a healthcare provider to validate their illness or return to work. This would require employees with mild symptoms who would otherwise not seek medical attention to unnecessarily burden an extremely busy healthcare system (or to continue working while symptomatic);
- Staff members who work in departments/facilities with greater risk of COVID-19 exposure/transmission (e.g., ED, urgent care, inpatient units caring for COVID-19...
patients) should not enter infusion centers at this time due to the risk of asymptomatic transmission to this high-risk patient population.

**EMERGENCY PREPAREDNESS PLANS**

As of March 11th, the World Health Organization has declared COVID-19 is now a pandemic. Healthcare facilities should take a proactive approach to planning and preparing for the “worst case scenario” in order to be well-positioned to take action when needed. Influenza pandemic plans are likely to be beneficial in the event of COVID-19 pandemic. Emergency preparedness plans are unique to each care setting and geographic location.

Infusion centers should ensure their emergency preparedness plans include:

- Plans for medication storage and handling in the event of power disruption (public utilities are not expected to be impacted by COVID-19, however emergency preparedness plans may be implemented in other situations, such as natural disasters).
- Consideration for limiting non-essential treatments (e.g. “wellness treatments”, elective vitamin infusions) to conserve supplies as well as mitigate the risk of facility-associated transmission in areas with sustained community transmission. Plan for the possibility of additional med-supply shortages, such as IV fluids.

Additional topics that may be addressed in emergency preparedness plans include:

- Identification of a response coordinator who will lead preparedness planning and plan implementation for the practice;
- Identification of key public health points of contact;
- Coordination with local/regional pandemic response groups;
- Work with your medical supply distributors to develop a plan to ensure adequate supply of saline and supplies;
- Training plan to ensure staff have an understanding of the pandemic and their role in infection control and emergency management;
- Plan for screening/triaging patients, visitors and staff during communicable disease outbreaks; and,
- Strategies for managing scare resources (conservation, substitution, re-use, reallocation).
Guidance for developing emergency preparedness plans for ambulatory care settings can be found in the following resources:


**Additional Resources:**


