Personal protective equipment (PPE) guidance for long-term care facility staff during COVID-19

	Face mask*	Respirator/N95*	Gloves	Eye protection	Gown
Residents with confirmed/suspected COVID-19 (including any resident with symptoms)					
Direct physical care		✔	✔	✔	✔
Close proximity to resident(s)		✔	✔	✔	✔
Resident room, distanced		✔	✔	✔	✔
Aerosol generating procedures (suctioning, nebulizer, CPAP, etc.)		✔	✔	✔	✔
COVID-19 case or exposure identified within the facility OR increasing community respiratory viral activity**					
Resident rooms	✔			•	
Resident common areas	✔			•	
Employee only areas	✔			•	
Wear for 10 days after close contact with a confirmed COVID-19 case	✔			•	
Recommendations by procedure					
COVID-19 testing		✔	✔	✔	✔
Aerosol generating procedures (suctioning, nebulizer, CPAP, etc.)	•		•	•	

✔ = PPE is recommended

• = PPE should be considered

*A NIOSH approved particulate respirator with N95 filter or higher is considered respirator protection for staff who have been fit-tested and trained on proper use and seal check. The face mask should be a well-fitting surgical mask, KN95, or other medical-grade mask. Cloth masks are generally not recommended for facility staff unless worn over a disposable mask to enhance fit. Individuals should always be allowed to wear a mask based on personal preference, even if not required by the facility.

The CDC's core IPC practices emphasize that source control remains a key mitigation effort during periods of increasing community respiratory viral activity. CDC's infection control recommendations for COVID-19 gives facilities latitude to determine for themselves which metrics they will use and how to interpret them. See the appendix, specifically under the section titled **"Metrics for community respiratory virus transmission" for more information.

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Utah Department of Health & Human Services

Additional notes

The CDC no longer publishes the community transmission metric. The end of the federal COVID-19 Public Health Emergency means the CDC doesn't receive the necessary data. Healthcare facilities should identify local metrics that could reflect increasing community respiratory viral activity to determine when broader use of source control in the facility might be warranted. Some facilities might consider masking during the typical respiratory virus season (approximately October–April). Facilities could follow data trends on respiratory viruses to learn when respiratory virus season begins or ends:

- RESP-NET—CDC dashboard with data for COVID-19, influenza, and RSV. There are some limitations to this as the data is only collected from select counties which is then applied to the whole state.
- FluView—CDC dashboard that includes influenza-like-illness (ILI) surveillance
- National emergency department visits for COVID-19, influenza, and respiratory syncytial virus
- Other data sources could also include county-level COVID-19 hospital admission data on the CDC COVID data tracker or the state's COVID dashboard.

Close contact: A cumulative time period of 15 minutes or more in a 24-hour period within 6 feet of a person who has confirmed COVID-19 infection or any unprotected direct contact with infectious secretions or excretions. Any duration should be considered prolonged if exposure occurs during an aerosol-generating procedure.

PPE recommendations: The PPE recommendations outlined in this document should be implemented in addition to standard precautions and transmission-based precautions used for other communicable diseases.

Additional PPE requirements: Facilities should ensure familiarity with and compliance with the Occupational Safety and Health Administration (OSHA) and Utah Occupational Safety and Health (UOSH) mandatory standards and guidance for protecting workers.

Please contact hai@utah.gov with questions.