Introduction

The Rhode Island Department of Health (RIDOH) offers this guidance to licensed nursing facilities and assisted living residences.¹

This guidance was developed based on what is currently known about the transmission and severity of COVID-19 and in accordance with the Centers for Disease Control and Prevention (CDC).

This document provides new guidance and expectations relative to visitation. RIDOH recognizes that visitor restrictions are difficult for both residents and families. Therefore, the goal is to identify how visitation will be achieved. Facilities must prepare a Visitation Plan for resuming visitation in accordance with guidelines established below.

Facilities should make every reasonable effort to ensure that residents and their families have access to in-person visitation. It is no longer acceptable for a facility to offer no in-person visitation at all. It is RIDOH’s expectation that every facility has a plan that permits in-person visitation that protects resident health and safety to the maximum extent possible, unless directed by RIDOH to cease in-person visitation due to a cluster or outbreak.

Facility plans must include processes and protocols as further detailed below, and the plans must be submitted via email to ofr.doh@health.ri.gov.

Visitation Plans must address the following elements:

I. Screening procedures
II. Physical space, distancing, and occupancy limits
III. Scheduling and duration of visits
IV. Cleaning and disinfecting procedures
V. Personal Protective Equipment (PPE) and face coverings
VI. Hand hygiene
VII. Communications/Education
VIII. Other considerations

¹ BHDDH group homes, DCYF group homes, detention centers (e.g. Rhode Island Training School), and prisons are out of scope for this guidance.
Additional Considerations

On May 18, 2020, the Centers for Medicare and Medicaid Services (CMS) released Nursing home reopening recommendations for State and Local Officials which includes visitation and service considerations.

All facilities must have established cleaning, health screening, physical distancing, and face covering procedures in line with RIDOH regulations.

Preparation for Visitation

All facilities must have a plan and process in place to allow for indoor and outdoor, in-person visitation between a resident and a visitor. If the facility has any positive cases, indoor visits are not recommended.

In addition to permitting in-person visitations, all facilities must have a process in place, at all times, to allow for remote communications between a resident and a virtual visitor (e.g. video call applications on cell phones or tablets).

The facility must engage in a continuous, ongoing process to implement and monitor recommended long-term COVID-19 infection control processes. Having an established visitation plan and communicating these established criteria and protocols to families and residents will offer everyone support and comfort during the COVID-19 pandemic. Implementing initial criteria and protocols for visitation should assist facilities, residents, and families in preparing for visitation relaxations in the future.

Facilities may want to consider allowing only adults or children of a certain age to visit. A visitor’s ability to wear a cloth face mask should be a factor for consideration.

I. Screening Procedures

• Everyone, including visitors, must be screened at the entrance to the facility for symptoms or risk-factors of COVID-19.
• Visitors and visitor screenings must be done at one entrance. Visitors must be notified of which entrance to use before they visit.
• Signs must be posted to clearly identify the entrance point and the screening process for visitors.

The facility must actively screen everyone for fever and symptoms of COVID-19 before they enter the facility. If fever or COVID-19 symptoms are present, the visitor shall not be allowed to enter the facility. Facilities must evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions. The facility should limit the number of entrances and the hours of visitation to allow screening of all potential visitors. These actions are recommended to help prevent transmission from infected individuals who may or may not have symptoms of COVID-19. Facilities shall keep a daily log that contains the names and contact information of all visitors.

For the most current list of COVID-19 symptoms, visit RIDOH’s website.
II. Physical Space, Distancing, and Occupancy Limits

- Plans must address the location of visits, physical distancing (at least six feet), and number of visitors allowed.
- Facilities should prioritize outside locations and (if indoor visitation is allowed) locations that limit visitors traveling through the facility.

Visits that occur outside are preferred. If a visit must occur inside the facility, the visit shall be restricted to the resident’s room or other area specifically designated for visits. If a resident’s room is used for visitation, only one visitor per resident at a time is allowed in the resident’s room during the visit.

During visitation, each resident should have a maximum of two visitors at a time. (If a visit occurs inside a resident’s room, the resident is limited to one visitor.) Steps should be taken to limit the interaction between those who are entering and exiting the visitation area.

Regardless of the location of the visit, visitors must maintain a six-foot distance from staff and residents. Facilities should implement steps to support physical distancing, such as repositioning furniture, mapping space on the floor with tape or other marking products, and/or providing other visual signals. For instance, if an outside bench normally accommodates three people, provide visual cues to indicate that only one person should sit on the bench at a time.

It is recommended that individuals be escorted to the visitation area to prevent visitors from wandering through the facility. Residents and visitors should not travel through any space designated as COVID-19 care space or space where there are residents who are suspected or confirmed to be infected with COVID-19.

Common rooms used for visitation should not be simultaneously used for other purposes. For example, once communal dining has resumed, visits should not be held in the dining rooms. Ideally, common rooms used for visitation should be located as close to the entrance of the building as possible. Use of these rooms should be scheduled in advance and, as needed, arrangements should be made to assist the resident to get to the room.

In addition to maintaining physical distancing, if a large common room or outside area is used for visitation, the total number of individuals in that area should be limited. If a large common room or outside area is used simultaneously by more than one resident for visitation, there should be approximately 150 square feet per person to support physical distancing and decrease the interactions between those who are present. The spacing should be clearly marked so visitors and residents are clear where they should sit.

If a tent is utilized, the facility must ensure that it is flame retardant and there is no smoking or flames allowed in or near the tent. The tent should not be attached to the building and it should be a minimum of 10 feet from the building. Facilities need to maintain documentation that the tent meets NFPA 701 flame retardant standards. (This should be marked on the tent.) There need to be signs showing the exits from the tent and stating that smoking is not allowed in or near the tent.

Plans shall include how common surfaces and high-touch objects should be cleaned and disinfected after each visitation.

Where not specified above, all organizations shall follow the general guidance from RIDOH and CDC regarding gathering sizes and physical distancing.
III. Scheduling and Duration of Visit

Facility visitation plans should define duration and frequency of visitation. Visits must be scheduled in advance. Unannounced visits are unacceptable and the facility plan should address how they will address unannounced visits.

The facility should have a plan for the duration of the visit that aligns with the facility’s ability to support the visit and the visitor/residents need for a positive visit.

The facility should limit visitors to the facility to only those essential for the resident’s physical and/or emotional well-being and care (e.g., family, care partners, etc.).

IV. Cleaning and Disinfecting Procedures

All covered entities shall ensure the performance of environmental cleaning of their establishments at least once per day.

In general, high-touch surfaces should be cleaned and disinfected at least once every four hours. Examples include, but are not limited to, doorknobs, light switches, handrails, faucet and toilet handles, drinking fountains, elevator buttons, push plates, phones, keys, and remote controls. Dining tables should be cleaned and disinfected after each meal. In addition, commonly touched surfaces, such as shared workstations, elevator buttons, door handles, and railings should be cleaned in accordance with CDC guidance for specific industries.

High-touch surfaces in visitation areas (e.g. tables) shall be cleaned after each visit.

Facilities should have cleaning/disinfecting products readily available to staff, and staff shall use the products in the manner intended. All facilities shall maintain records documenting the date, time, location, and procedures for the cleaning activities.

V. Face Masks and Other Personal Protective Equipment

Plans from each facility shall include how they will implement face covering procedures that comply with RIDOH regulations. For visitors and patients, a cloth face covering is required. Surgical face masks are preferred. Respirators, like N-95s, should be reserved for healthcare workers.

Facilities shall include in their plan a policy about how to handle a visitor who arrives without a cloth face covering. The facility may choose to provide the visitor with a non-returnable face mask, if supplies are available, or may decline the visit until the visitor has an appropriate face covering.

VI. Hand hygiene

It is expected that all visitors shall perform hand hygiene upon entry to the facility or to the outside visitation area or before entering the resident’s room. Either soap and water or hand gel containing at least 60%
alcohol shall be available and used. Visitors will perform hand hygiene again before leaving the patient room’s and before leaving the facility. All hand hygiene should be witnessed and documented by facility staff.

VII. Clear Communications Plan

The facility must establish procedures for informing and training all visitors, which shall include:

- The facility shall have signs posted at the entrance to the facility, instructing visitors that visit must be scheduled, and if the visit has not been previously coordinated with the facility, the visit cannot take place.
- If the visitor has symptoms of COVID-19, the visit cannot take place even if it was previously coordinated with the facility.
- The facility shall provide instruction, before visitors visit patients, on hand hygiene, limiting surfaces touched, and proper use of PPE according to current facility policy.
- All visitors shall be instructed to always wear a face mask or cloth face covering while in the facility.
- All visitors shall be required to perform frequent hand hygiene, including when entering and exiting the facility.
- Each facility shall have an easily viewed, publicly posted visitation policy informing families, visitors, and residents of their policy, including when visitation will be limited or restricted.
- Visitors shall be notified that visitation presents a risk of transmitting a communicable disease to a resident and that COVID-19 can be transmitted by asymptomatic individuals.
- All visitors must be advised to monitor themselves for symptoms of COVID-19 for 14 days after exiting the facility. If symptoms occur, the facility must advise them to isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations in the facility they visited. Facilities should immediately screen individuals of reported contact, and take all necessary actions based on findings.
- The facility should also encourage the use of alternate mechanisms for patient and visitor interactions, such as video-call applications on cell phones or tablets.

VIII. Other Considerations

- Plans must ensure enough staffing to meet resident care needs and facilitate and monitor the visitation process. A staff member trained in resident safety and infection control measures must monitor the visit during the entire duration of the visit.
- If a facility identifies a new onset case in the same facility, the facility should ensure that the case is isolated and the case contacts are quarantined in accordance with existing guidance and protocols.
- Visitation may continue to occur for non-infected, asymptomatic residents and those not required to quarantine if it can occur completely outside the facility, in a well ventilated outdoor area. During the outside visit the visitor, resident, and staff must all wear a mask and remain six feet apart.
- If there is a new onset cluster of cases in the same facility, the facility should contact RIDOH as soon as possible. RIDOH will work with the facility to develop a visitation plan to be implemented during the cluster.
  - A cluster is defined as two new onset cases in the facility.
- If there is a new onset outbreak of cases in the same facility, the facility should contact RIDOH as soon as possible. RIDOH will work with the facility to develop a visitation plan to be implemented during the outbreak.
  - An outbreak is defined as three new onset cases in the same facility.