DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

Health and Safety Guidance for Child Care Providers: Coronavirus (COVID-19) Recovery Period

(Updated June 25, 2021)

The Office of the State Superintendent of Education (OSSE) issues this guidance for child care providers currently operating. This document is based on guidance from the Centers for Disease Control and Prevention (CDC) and the District of Columbia Department of Health (DC Health).

This guidance is effective as of June 25, 2021 and supersedes any previously released guidance by OSSE on the topic. This document includes reopening guidance for child care providers issued by DC Health on May 25, 2021 and provides additional guidance on select topics. Required activities for child care providers are mandatory in accordance with applicable Mayor's Orders.[1] Where activities for child care providers are noted with "must," the activities are mandatory. Provisions noted with "should" or "as feasible" are not required but are recommended to reduce the risk of COVID-19, as appropriate within a given child care setting. OSSE's Child Development Facility Licensing Regulations at Title 5A DCMR Chapter 1, and any subsequent Mayor's Orders or other legal authority related to child care health and safety or reopening. This guidance may be superseded by any applicable Mayor's order, regulation, or health mandates from DC Health.

As articulated in Mayor's Order 2021-069, child care providers should operationalize education guidance as it relates to COVID-19 to the extent feasible to ensure full access to in-person learning and care.

Per DC Health guidance and unless otherwise stated in this guidance, individuals who have been vaccinated against COVID-19 must continue following all precautions in child care facilities until DC Health instructs otherwise, including wearing face masks, physical (social) distancing, washing hands, and frequently cleaning commonly touched surfaces and items.

The information in this guidance is divided into three sections. The first section on prevention addresses the actions that child care providers either must or should take to protect children and staff and slow the spread of COVID-19. The second section on response addresses the actions that child care providers either must or should take when an individual becomes sick with or exposed to COVID-19. Finally, the

[1] Including Mayor's Order 2020-075, *Phase Two of Washington, DC Reopening*, Section II.3 (June 19, 2020), Mayor's Order 2020-079, *Extensions of Public Health Emergency and Delegations of Authority During COVID-19, Section V.3* (July 22, 2020), Mayor's Order 2021-038, *Extension of the Public Emergency and Public Health Emergency and Modified Measures in Phase Two of Washington, DC Reopening* Section IX.1 (March 17, 2021), Mayor's Order 2021-060, *Modified Measures in Phase Two of Washington, DC Reopening* Section VII.1 (April 26, 2021), Mayor's Order 2021-066, *Wearing of Masks and Other Activities in the District of Columbia to Prevent the Spread of COVID-19 Including Modification for Fully Vaccinated Persons* Section IX.1 and IX.2(May 1, 2021), Mayor's Order 2021-069: *Modified Measures for Spring/Summer 2021 of Washington, DC Reopening and Extension of Public and Public Health Emergencies* Section XI (May 17, 2021).

appendices (third section) provide additional information on physical temperature checks, personal protective equipment (PPE), and COVID-19 testing.

A layered mitigation strategy is the most effective approach to preventing the spread of COVID-19 in child care facilities.

For more information on the District of Columbia Government's response to coronavirus (COVID-19), please visit coronavirus.dc.gov. The CDC's most recent, supplemental guidance for child care providers can be accessed here. OSSE's Health and Safety guidance will be updated as additional recommendations from the CDC or DC Health become available.

Child care providers should institute an auditing program at least every two weeks to monitor the implementation of practices described in this guidance document.

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PREVENTION

A. COMMUNICATION WITH STAFF AND FAMILIES

To support clear communication with children, staff, and families, child care facilities should post signs in highly visible locations (e.g., facility entrances, restrooms) that promote everyday protective measures and describe how to stop the spread of germs (such as by properly washing hands and properly wearing a face mask). At a minimum, child care providers should place signage in every classroom and near every sink reminding staff of handwashing protocols and in every classroom reminding staff of cleaning protocols.

To support clear communications with children, staff, and families, facilities should:

- Include messages about behaviors that prevent the spread of COVID-19 when communicating with staff and families (such as on child care provider websites, in emails, and on social media accounts).
- Educate staff, children, and families about COVID-19, physical (social) distancing, when they must stay home, and when they can return to child care.
- Educate staff on COVID-19 prevention and response protocols.

To ensure a clear and efficient process for communication each child care provider must identify a staff member as the COVID-19 point of contact (POC). This person is responsible for ensuring the appropriate steps are followed in the event of a confirmed case of COVID-19 (See Section L: Exposure Reporting, Notifications, and Disinfection).

B. VACCINES AND HEALTH FORMS

Routine Pediatric Vaccinations

According to the Centers for Disease Control and Prevention (CDC) and DC Health data, the COVID-19 pandemic has resulted in a significant reduction in childhood vaccine administrations across the country including in the District of Columbia and Maryland.

To prevent a vaccine-preventable disease outbreak in a child care setting, it is imperative for all children who attend child care to be **fully vaccinated** according to CDC and DC Health standards.

- Ensure a policy is in place to adhere to all OSSE licensing standards regarding immunizations.
- A review of immunization requirements can be found here, and health forms can be found here.
- A list of pediatric immunization locations can be found here. A search tool to find a primary care center in DC can be found here.

COVID-19 Vaccination

- Child care staff are strongly recommended to get the COVID-19 vaccine.
- Access to COVID-19 vaccination should not be considered a prerequisite to reopening child care facilities.
- For more information about getting the COVID-19 vaccine, visit coronavirus.dc.gov/vaccine

Health Forms

Child development facility licensing regulations require a licensee to ensure that each child attending a facility shall, prior to the child's first day of services and at least annually thereafter, submit to the facility appropriate, complete documentation of a comprehensive physical health examination, and, for

each child 3 years of age or older, evidence of an oral health examination (5A DCMR § 152.1). For children age 3 and older, OSSE previously authorized, pursuant to its enforcement authority, a 90-day extension to submit Universal Health Certificates (UHCs), Oral Health Assessments (OHAs), and Medication and Treatment Authorization Forms. **This extension has now expired.** Children must now be caught up on necessary health forms and immunizations as required by District law.

Both old and new versions of the health forms shall be accepted. Partial UHCs completed via telehealth visits shall be accepted.

C. REOPENING AND MAINTAINING BUILDINGS

Child care facilities that remained close due to the public health emergency must submit an Unusual Incident Report (UIR) to notify OSSE of the program's planned reopening date. The reopening UIR must be sent to OSSE.childcarecomplaints@dc.gov and is to be sent as soon as the reopening date is set. When sending the UIR, indicate the planned date for reopening in the description and details section of the UIR.

Child care providers who are reopening after a prolonged facility shutdown should verify necessary maintenance is completed to all ventilation and water systems and features (e.g., sink faucets, drinking fountains) so that they are ready for use and occupancy and are adequately maintained throughout the operating period.

Child care providers should verify ventilation systems operate properly, including inspecting and routinely replacing HVAC filters and checking that all HVAC system components and exhaust fans, if applicable, are operable to design.

Child care providers should increase circulation of outdoor air as much as possible, for example by opening windows and doors. Increase in air circulation should be continued after reopening where safe and possible. Fans may be used to increase the effectiveness of open windows. Do not open windows and doors if doing so poses a safety or health risk (e.g., risk of falling, triggering asthma symptoms) to children and staff using the facility. Under **no circumstances** may fire-rated doors be propped or otherwise left open.

Child care providers should consider ventilation system upgrades or improvements and other steps to increase the delivery of outside filtered air to aid in the dilution of potential contaminants in the facility. In consultation with an experienced HVAC professional, child care providers should review and implement as appropriate additional recommendations from the CDC, the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Guidance for Building Operations During the COVID-19 Pandemic, and ASHRAE guidelines for schools and universities, which includes further information on ventilation recommendations for different types of buildings.

Child care providers should flush water systems to clear out stagnant water and replace it with fresh water. This will remove any metals (e.g., lead and copper) that may have leached into the water and minimize the risk of Legionnaires' disease and other diseases associated with water. Steps for this process can be found on the CDC website.

It may be necessary to conduct ongoing regular flushing after reopening. For additional resources, refer to EPA's Information on Maintaining or Restoring Water Quality in Buildings with Low or No Use.

D. PHYSICAL (SOCIAL) DISTANCING

Maintaining Cohorts

Cohorting consists of separating children and staff into distinct groups that stay together throughout the day. This is an important part of maintaining child care operations if a case of COVID-19 occurs in a facility. Limiting mixing between cohorts will decrease the number of children and staff that are potentially exposed if a case occurs in a child care facility.

- Child care facilities may resume following group sizes and adult-to-child ratios set in child care licensing regulations, provided they are able to do so while preserving appropriate physical distancing to the extent feasible. Keep the same groups of children and staff together each day as much as possible (as opposed to rotating teachers or children).
- Child care providers should stagger arrival/drop-off times by cohort and minimize staff contact with parents/caregivers at drop off.
- Cohorts should be maintained for all activities including meals with minimal mixing between cohorts. The safest arrangement is for each cohort to have their own classroom. Each cohort should maintain 6 feet distance from other cohorts, indoors and outdoors, as much as is possible.
- The use of floating staff poses an avoidable increased risk of exposure if staff test positive for COVID-19. Limiting the use of floating staff will reduce this risk.
- Substitutes are allowable, if necessary, and they should follow the provisions above for floating staff members.
- If specialized staff (for example, early intervention specialists) are providing services to children within multiple cohorts or multiple childcare facilities, they should take prevention measures to limit the potential transmission of COVID-19, including getting vaccinated, and wearing masks or other recommended personal protective equipment. They should limit interactions with children to only the children they are there to see. Specialized staff should keep detailed logs of interactions in the facility to support contact tracing if needed.

Physical Distancing

- Staff should remain 6 feet of distance from other staff at all times. This is a critical mitigation measure to prevent spread between classrooms.
- Child care providers should maximize spacing between children, and between children and staff, with a goal of 6 feet of distance when feasible.
    - Children or staff who are members of the same household do not have to physical distance from each other.
- *[UPDATED]* Child care providers should implement distancing so that children's naptime mats, cots, or beds are spaced out as much as possible with a goal of 6 feet of distance, but there must be no fewer than 2 feet of distance between them. Children should be placed head-to-toe to maximize distance between their faces. Masks must not be worn when sleeping.

To the greatest extent feasible, child care providers should:

- Pay special attention to physical distancing during the following time: entry and exit of the building, at meal times, in the restroom, on playgrounds, in hallways, and in other shared spaces.
- Avoid large group activities and activities requiring children to sit or stand in close proximity, e.g., circle time.
- Consider implementing curb- or door-side drop-off and pick-up of children.

- If transport vehicles (e.g., vans or buses) are used by the child care facility, drivers must wear face masks and should practice all other safety actions and protocols as indicated for other staff (e.g., hand hygiene, physical distancing).
- To the extent feasible, child care providers should promote physical distancing and improved ventilation on school buses and shared transport (e.g., leaving empty rows of seats, opening windows).
- Setup indoor and outdoor settings to maximize spacing between individuals, including while at tables and in group and individual activities. For example, space out seating areas, turn tables to face the same direction, or seat children only on one side of tables, physically distanced.
- Use visual cues to promote physical distancing, such as tape or decals on the floor, or signs on walls
- Stagger staff shifts, start times, and break times as much as possible.
- Limit the number of employees in a breakroom at any given time to ensure physical distancing.
- Implement a lane system in hallways, stairwells, and other common areas.

E. DAILY HEALTH SCREENING

Child care providers should have a procedure to conduct a daily health screening for all persons entering the child care facility, including children, staff and essential visitors**.** The screening can be performed before (via phone or app) or upon arrival and can be based on self-report or report from caregivers. For a sample screening tool, see Screening Tool Guidance at coronavirus.dc.gov/healthguidance. The screening procedure should:

- Be conducted using appropriate physical distancing measures and should adhere to procedures and PPE best practices as articulated in Appendices A and B;
- **ASK**: Parents/guardians, staff, and essential visitors should be asked about whether the child, staff member or essential visitor has experienced one or more of the following symptoms in the last 24 hours:
    - Fever (subjective or 100.4 degrees Fahrenheit) or chills
    - Cough
    - Congestion or runny nose[2]
    - Sore throat
    - Shortness of breath or difficulty breathing
    - Diarrhea
    - Nausea or vomiting
    - Fatigue
    - Headache
    - Muscle or body aches
    - Poor feeding or poor appetite
    - New loss of taste or smell

[2] If the runny nose is circumstantial (e.g., after playing outdoors in cold weather) and temporary (subsides within 30 minutes), and the individual is not experiencing other COVID-19 symptoms nor other criteria for exclusion, the individual does not need to be excluded.

- **ASK**: Parents/guardians, staff, and essential visitors should be asked if the child, staff member, or essential visitor has been in close contact within the past 10 days with a person confirmed to have COVID-19.[3,4]
- **LOOK**: Child care staff should visually inspect each child, staff member, and essential visitor for signs of illness, which could include flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness.

Children with COVID-19 infection often present with non-specific symptoms, such as only breathing or stomach symptoms, with the most common being cough and/or fever.

Any child, staff member, or essential visitor meeting "Yes" for any of the above "ASK, ASK, LOOK" criteria in the program's daily health screening must not be admitted. If the child, staff member, or essential visitor is not able to immediately leave the premises, they must be isolated from other individuals and, if developmentally appropriate, wear a face mask; any accompanying staff member(s) should follow PPE best practices per the "suspected or confirmed COVID-19" section of Appendix B. Such families, staff, or essential visitors should be instructed to call their healthcare provider to determine next steps.

Note: Children or staff with pre-existing health conditions that present with specific COVID-19-like symptoms must not be excluded from entering the building on the basis of those specific symptoms if a healthcare provider has provided written or verbal documentation that those specific symptoms are not due to COVID-19.

Per DC Health's Guidance for Travel, unvaccinated or partially vaccinated individuals who have traveled domestically to any place other than Maryland or Virginia must either (1) not attend child care for 10 days after returning, or (2) not attend child care until tested for COVID-19 three to five days after returning AND receive a negative COVID-19 viral test.

Per DC Health's Guidance for Travel, unvaccinated or partially vaccinated individuals who have traveled internationally must either (1) not attend child care for 10 days after returning, or (2) not attend child care for seven days after returning, get tested for COVID-19 three to five days after returning, AND receive a negative COVID-19 viral test. Even if the test is negative, the individual must still not attend child care for seven days.

Provided that they do not currently have any symptoms consistent with COVID-19, an individual who has **tested positive for COVID-19 within the last 90 days or is fully vaccinated** may be admitted

[3] Returning to child care after 10 days is intended to minimize the risk of transmission of the virus while also minimizing the burden. Recent DC Health guidance allows for child care providers to continue to implement the more stringent 14-day return to care recommendation if they choose to. Waiting 14 days before returning to child care remains the most effective strategy for decreasing the transmission of COVID-19. DC Health strongly recommends that individuals who live or work with someone at higher-risk for COVID-19 (see Section I) wait 14 days before returning to child care.

[4] Individuals may return immediately after close contact with an individual with confirmed COVID-19 if they do not have any symptoms consistent with COVID-19 and either they have tested positive for COVID-19 within the last 90 days or they are fully vaccinated against COVID-19. A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

immediately after domestic or international travel.[5] They should get a COVID-19 test three to five days after international travel.[6] Any individual with symptoms consistent with COVID-19 must follow the existing exclusion criteria.

For more detailed guidance related to returning from domestic and international travel, see DC Health's Guidance for Travel. Private institutions, including child care providers, may implement more stringent restrictions after travel. Child care providers may choose to incorporate questions about recent travel into their daily health screenings.

If screening is performed, screening tools must be reviewed routinely after submission in order to be effective. Records of screening are strongly recommended to be stored for 30 days.

Temperature checks at the facility as a screening tool are not recommended by DC Health. Child care providers that choose to implement a physical temperature check should adhere to the following guidance:

- Confirm that the child, staff member, or essential visitor had their temperature checked at home two hours or less before their arrival, and the temperature was less than 100.4 degrees Fahrenheit.
    - Upon arrival, the parent/guardian, staff member, or essential visitor should show a photograph of the thermometer or verbally confirm that the temperature was less than 100.4 degrees Fahrenheit.
    - This option eliminates the use of supplies, risk to screeners, and congregation of individuals while waiting to complete the temperature check upon arrival.

OR

- Physically check the child, staff member, or essential visitor's temperature upon their arrival.
    - For this option, the parent/guardian, staff member, or essential visitor should use a thermometer provided by the child care provider and must follow the below protocol:
        - Maintain a distance of 6 feet from the staff conducting the health screening.
        - Parents/guardians should take their child's temperature, and staff or essential visitors should take their own temperature.
        - A non-contact thermometer is strongly recommended. Forehead, tympanic (ear), or axillary (armpit) thermometers are also acceptable. Oral and rectal temperature checks should be avoided.
        - Thermometers should be cleaned per manufacturer instructions, including between uses.
        - *Family:* The parent/guardian should then check the child's temperature, after washing hands and wearing disposable gloves.
        - *Staff member or essential visitor*: The staff member or essential visitor should check their own temperature, after washing hands and wearing disposable gloves.
        - Any child, staff member, or essential visitor with a temperature of 100.4 degrees Fahrenheit or higher must not be admitted and should be instructed to call their healthcare provider to determine next steps. If the child, staff

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member, or essential visitor is not immediately able to leave the premises, they must be isolated from other individuals and, if developmentally appropriate, wear a face mask; any accompanying staff member(s) should follow PPE best practices per the "suspected or confirmed COVID-19" section of Appendix B.

- *If a Staff Member Takes Another Individual's Temperature:*
    - In the event a child care staff member takes another individual's temperature at any point, they should follow CDC guidelines to do so safely, including with use of a barrier protection *or* Personal Protective Equipment (PPE), as articulated in Appendix A.

Symptoms While at Child Care:
If a child, staff member, or essential visitor develops any of the symptoms above during the course of the day, the child care provider must have a process in place that allows them to isolate until it is safe to go home, and they should seek healthcare guidance. For more information, please see Section K. Exclusion, Dismissal, and Return to Child Care Criteria.

Return to Child Care:
To determine when a child or staff member may return to care, please see Section K. Exclusion, Dismissal, and Return to Care Criteria.

F. FACE MASKS

All staff and essential visitors, including those who are fully vaccinated, must wear a face mask at all times while participating in child care activities. A face mask may be a non-medical (cloth) face covering. If an adult has a contraindication to wearing a face mask, either medical or otherwise, then it is recommended that the individual should not participate in child care activities. Staff may wear face masks with clear plastic windows, or briefly remove their face masks, when interacting with children with disabilities identified as having hearing or vision impairments, who require clear speech or lip-reading to access instruction.

All parents/guardians, including those who are fully vaccinated, must wear face masks any time they interact with child care staff, including for drop-off and pick-up.

Children age 2 and older, including those who are fully vaccinated, must wear a face mask. Parents and child care staff should discuss individual considerations for children of any age, including medical or developmental conditions that may prevent them from wearing a mask, and consult with the child's healthcare provider if necessary (e.g., for children with certain health conditions), to determine if an individual child is able to wear a mask and attend child care safely. Any discontinuation of wearing a face mask for any child age 2 and older should be rare due to the risk it poses to the child in potentially catching or transmitting COVID-19 within the facility. If a child is unable to wear a face mask throughout the day, mask breaks are acceptable at times in which physical (social) distance can be maintained (e.g., when outside) or during snacks or meals. **Masks must not be worn when sleeping.**

Children should be able to safely use, avoid touching and remove the face mask without assistance. Staff may assist a child with putting on their face masks as long as proper hand hygiene is followed and staff are careful not to touch the child's eyes, nose, or mouth.

Children may be afraid or uncomfortable with the face mask at first, or they may want to remove and play with it. If a child does not keep their face mask on or constantly touches it, child care staff should provide demonstration, reminders, repetition and practice in properly wearing the face mask, similar to how children are taught to properly wash their hands. The American Academy of Pediatrics offers guidance on face masks for children during COVID-19, including age-specific tips for supporting children to feel more comfortable. This guidance can be found here. Families are also encouraged to demonstrate and practice proper face mask use at home. For children that have difficulty keeping a face mask on, it is recommended to also ask a parent or caregiver at home for support in practicing wearing face masks as much as possible. A flyer to use with parents and caregivers during COVID-19 is available here.

Essential visitors to child care should be limited. Any essential visitor must wear a face mask at all times on the facility grounds and inside the facility buildings.

Instances when face masks should not be worn:

- By children younger than age 2; and
- By anyone who has trouble breathing, or anyone who is unconscious or unable to remove the mask without assistance.

Instances when face masks do not need to be worn:

- When actively drinking or eating a meal;
- When in the water in a swimming pool;
- When in an enclosed office that no one else is permitted to enter;
- When giving a speech for broadcast or an audience, provided no one is within six feet of the speaker;
- When speaking to or translating for a deaf or hard of hearing person; and
- When required to use equipment for a job that precludes the wearing of a mask and the person is wearing or using that equipment.

Child care providers should implement additional protocols to support the safe use of clean face masks.

- Staff and children wearing face masks should bring multiple clean coverings each day, as feasible.
- Child care facilities are encouraged to have face masks available to staff, children, and essential visitors in the event they forget or soil their face masks.
- Staff and children should exercise caution when removing the face mask, always store it out of reach of other children, and wash hands immediately after removing. Individuals should be careful not to touch eyes, nose, or mouth while removing the mask.
- Face masks that are taken off temporarily to engage in any of the aforementioned activities should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded face mask can be stored in a plastic bag if it is wet or dirty or in a paper bag if it is not wet or dirty. Face masks can also be placed next to the child on a napkin or directly on the table, if the surface is cleaned afterward.
- When not being worn, face masks should be stored in a space designated for each child that is separate from others. Children's face masks should also be clearly identified with their names or initials to avoid confusion or swapping. Children's face masks may also be labeled to indicate top/bottom and front/back.
- As much as possible, staff should prevent children from playing with their or others' face masks and should implement procedures to support their safe removal and storage.

- Children and staff should be taught to speak more loudly, rather than remove their face mask, if speaking in a noisy environment.

Please refer to DC Health's Guidance About Cloth Face Coverings and Masks for the General Public for more details on face masks requirements for all District residents and visitors.

Face masks are recommended as a simple barrier to help prevent respiratory droplets from traveling into the air and onto other people when the person wearing the mask coughs, sneezes, talks, or raises their voice. This is called source control.

- Face masks protect the wearer and other people.
- To be effective, face masks must be worn correctly. Masks should be two to three layers of tightly woven fabric, cover the nose and mouth, and fit snugly against the sides of the face.
- A face mask is not a substitute for physical (social) distancing.
- Face masks with exhalation valves or vents should NOT be worn in child care facilities. This type of mask does not prevent the person wearing the mask from transmitting COVID-19 to others (source control).
- Consider clear masks (not face shields) for children or staff who are deaf or hard of hearing.

Further guidance from CDC on the use of face masks, including information on types of masks, mask adaptations and alternatives, and instructions on how to store and wash masks, is available here and here.

G. HYGIENE

Hand Hygiene and Respiratory Etiquette

- Child care providers should teach and model good hand hygiene and respiratory etiquette practices, including covering coughs and sneezes with an elbow or tissue. Used tissues should be thrown in the trash and hands washed immediately with soap and water for at least 20 seconds, or if soap and water is unavailable, cleaned with hand sanitizer.
- Handwashing must take place frequently throughout the day in accordance with all OSSE licensing standards regarding health, safety, and welfare and the following:
    - Upon arriving for the day, after breaks, or when moving from one group to another;
    - At the entrance to the facility;
    - Next to parent sign-in sheets, including sanitary wipes to clean pens between uses;
    - Before and after putting on, touching, or removing face masks or touching your face;
    - Before and after preparing food or beverages;
    - Before and after eating, drinking, handling food, or feeding a child;
    - Before and after handling clean utensils or equipment;
    - Before and after diapering;
    - Before and after assisting or training a child in feeding or toileting;
    - Before and after providing any medication or applying any medical ointment or cream;
    - After going to the bathroom;
    - After blowing or supporting a child with blowing their nose, coughing, or sneezing;
    - After handling or contact with any bodily secretions, such as blood, urine, stool, mucus, saliva, or drainage from wounds;
    - After handling wastebaskets or garbage;
    - After playing on outdoor or shared equipment;

    - After removing gloves; and
    - After handling a pet or other animal.
- If soap and water are not available, and the hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60 percent alcohol should be used. This should only be used by a child under very close observation from a staff person or parent/guardian to prevent ingestion and following the manufacturer's instructions.
- Child care staff who work with very young children should take additional steps. While washing, feeding, or holding infants or very young children, staff should:
    - Wear a face mask;
    - Pull long hair off of neck, as in a ponytail;
    - Wear a gown/coverall;[7]
    - Remove and wash their clothing and/or the child's clothing if touched by any secretions; and
    - Wash their hands, arms, or body if touched by secretions or after handling soiled clothes.
- Additional PPE best practices for educators and staff in close contact with children and/or working with any individual with suspected or confirmed COVID-19, are articulated in Appendix B.

Facility-wide Hygiene

- Child care providers should place signage in every classroom and near every sink reminding staff of hand-washing protocols. CDC has signs on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face mask.
- Child care providers must make available adequate supplies (e.g., soap, paper towels, hand sanitizer, tissues) to support healthy hygiene practices.

To the extent feasible, child care facilities should:

- Make available adequate supplies to minimize sharing of high touch materials (e.g., avoid sharing electronic devices, toys, books, learning aids; assign each child their own art supplies or equipment). When shared supplies must be used, limit use of supplies and equipment to one group of children at a time and clean between use.
- Keep each child's belongings separated from others' and in individually labeled containers, cubbies, or areas.
- Encourage staff and children (as appropriate) to bring their own water bottles and to avoid touching or utilizing water fountains. If water fountains are used, they should be cleaned and sanitized frequently.
- Install no-touch fixtures: automatic faucets and toilets; touchless foot door openers, touchless trashcans; sensor water bottle fillers.

H. CLEANING, DISINFECTION, AND SANITIZATION *[UPDATED]*

Routine Cleaning, Disinfection, and Sanitization

Child care facilities must follow all OSSE licensing standards regarding cleaning, disinfection and sanitization. Additionally, facilities should follow DC Health's COVID-19 Guidance on Cleaning and

[7] The coverall may be a large, button-down, long-sleeved shirt.

Disinfection for Community Facilities. In most situations, routine cleaning of surfaces once a day is adequate to prevent the spread of COVID-19 from surfaces. At a minimum, child care providers should:

- Prioritize cleaning high touch surfaces; at a minimum, high-touch surfaces should be cleaned at least once a day. This may include cleaning objects/surfaces not ordinarily cleaned daily (e.g., chairs, tables, countertops, sink handles, faucets, computers, handrails, door handles, light switches).
    - If child care providers adopt a rotating in-person schedule, enhanced cleaning should occur between cohorts.
    - Child care providers should properly train staff on cleaning procedures and monitor cleaning schedules to ensure compliance.
    - Child care providers should place signage in every classroom reminding staff of cleaning procedures.
- If a child care provider determines that disinfection is needed, implement the DC Health Guidance on Cleaning and Disinfection for Community Facilities.
- For additional information, please refer to Caring for Our Children Appendix J: Selecting an Appropriate Sanitizer or Disinfectant.
- Practice safe storage of all cleaning products, including storing and using chemicals out of the reach of children. See CDC's guidance for safe and correct application of disinfectants.
    - Avoid using cleaning products near children.
    - Children should not participate in disinfection.
    - *[UPDATED]* Custodial staff, as well as classroom educators and other staff who may be cleaning and disinfecting spaces throughout the building, should wear gloves and should adhere to other PPE best practices as articulated in Appendix B.
- Consider cleaning more frequently or routinely disinfecting (in addition to cleaning) items in shared spaces where there is high traffic, in spaces that are occupied by individuals at increased risk for severe illness from COVID-19, and in spaces occupied by young children or others who may not be diligent about wearing face masks and practicing good hand hygiene and respiratory etiquette.
- Limit the use of shared objects and equipment (e.g., gym or physical education equipment, art supplies, toys, games). If shared objects or equipment are used, to the extent feasible, clean between uses.
    - **Shared toys**, including those used indoors and outdoors, must be frequently cleaned and sanitized throughout the day.
        - Toys that have been in children's mouths or soiled by bodily secretions must be immediately set aside. These toys must be cleaned and sanitized by a staff member wearing gloves before being used by another child.
        - Machine washable toys should be used by only one child and laundered between uses.
        - To the extent possible, toys should be assigned to individual groups to avoid mixing of toys between groups. Toys shared between groups should be cleaned prior to use by another group.
    - **Mats/cots/cribs/beds and bedding** are to be individually labeled with the name of the child to whom it is assigned and sufficiently separate from play space to prevent access to sleeping areas by children at play.

        - *[UPDATED]* Implement distancing so that children's naptime mats/cots/beds are spaced out as much as possible with a goal of 6 feet of distance, but there must be no fewer than 2 feet of distance between them.
        - Mats/cots/cribs/beds should be arranged head to toe and to allow greater physical distance, head to head, between children when in use.
        - Mats/cots/cribs/beds must be kept clean and sanitary and should be cleaned and sanitized between uses.
        - Bedding such as sheets and blankets cannot be shared, must be washable, and must be kept clean and sanitary at all times.
        - Mats/cots may be stacked between uses if they are cleaned and sanitized appropriately before stacking.
- **Playground structures** should be included as part of routine cleaning.
    - High-touch surfaces made of plastic or metal, such as grab bars, play structures and railings, should be cleaned regularly.
    - Cleaning and disinfection of wooden surfaces (such as wood play structures, benches, tables) or groundcovers (such as mulch and sand) is not recommended.
    - Spraying cleaning products or disinfectants in outdoor areas – such as on sidewalks, roads, or groundcover – is not necessary, effective, or recommended.
    - The CDC has guidance for cleaning various surfaces in playgrounds, available here.
- **For shared bathrooms**, assign a bathroom to each group of children and staff. If there are fewer bathrooms than the number of groups, assign each group to a particular bathroom and, where feasible, clean and disinfect bathrooms after each group has finished.

Aerosol-Generating Procedures

- In the event a space in the child development facility is used for an aerosol-generating procedure (e.g., tracheostomy suctioning or nebulized medication administration), that room should be only occupied by the child and staff member engaged in the treatment.
    - Children who receive nebulized treatments should be ***strongly encouraged*** to replace the nebulizer with oral inhalers whenever possible.
    - Child care facilities are encouraged to work with families and healthcare providers to identify opportunities to transition the schedule for tracheostomy suctioning and the administration of nebulized medication to before or after care, if medically appropriate.
    - If tracheostomy suctioning or nebulized medication is needed during care, providers should have well ventilated rooms dedicated for this purpose, ideally each assigned for exclusive use by a given child, and if possible, with windows open.
    - If assignment of a particular room to a particular child is not feasible, the room should be closed for 24 hours after the treatment to allow respiratory droplets to settle, then cleaned and disinfected prior to use by another individual.
    - Child care facilities are strongly encouraged to provide nebulized treatments outside, if feasible and weather permitting.
    - Nurses and staff performing tracheostomy suctioning or administering nebulized medication should adhere to PPE best practices articulated in Appendix B.

***[UPDATED]* Procedures after Suspected or Confirmed Cases of COVID-19**

In accordance with DC Health's Guidance on Cleaning and Disinfection for Community Facilities, the following protocols including disinfection apply in in circumstances in which a child, staff member, or essential visitor becomes ill with symptoms of COVID-19 or tests positive for COVID-19.

- *[UPDATED]* If a child, staff member, or essential visitor develops symptoms of or tests positive for COVID-19 **during the day or within 24 hours of being in the facility**, the child care facility should clean and disinfect the area(s) where they have been.
    - *[UPDATED]* Facilities should close areas where the sick individual has been.
        - If a COVID-19 case is confirmed during the day AND the COVID-19 positive individual is in the facility, then the cohort should be dismissed and the room vacated as soon as possible.
        - It is acceptable for the cohort to remain in the room until the end of the day in the following circumstances:
            - If an individual has symptoms but is not confirmed to have COVID-19; or
            - If a COVID-19 case is confirmed and the COVID-19 positive individual has not been in the facility that day.
    - Staff supporting, accompanying, or cleaning up after a sick child should adhere to PPE best practices as articulated in Appendix B.
    - Once the room is vacated, facilities should wait as long as possible before entering the room to clean and disinfect (at least several hours). Facilities should perform cleaning and disinfection of the full classroom and any other spaces or equipment in which the ill individual was in contact. *This includes the isolation room after use by an ill child or staff member.*
        - During cleaning and disinfection, facilities should increase air circulation to the area (e.g., open doors, open windows, use fans, or adjust HVAC settings).
        - *[UPDATED]* Staff must wear a face mask for all steps of the cleaning and disinfection process. Staff should also wear gloves and follow additional PPE best practices as articulated in Appendix B.
        - For additional material-specific considerations, including for soft surfaces, laundry, electronics and outdoor areas, see DC Health's Guidance on Cleaning and Disinfection for Community Facilities with Suspected or Confirmed COVID-19.
- *[UPDATED]* If a child, staff member, or essential visitor develops symptoms of or tests positive for COVID-19 and it has been **more than 24 hours, but fewer than three days**, since the individual was in the child care facility, the facility should clean any areas where the individual has been. Disinfection is not necessary.
- If a child, staff member, or essential visitor develops symptoms of or tests positive for COVID-19 and it has been **more than three days** since the individual was in the facility, no special cleaning and disinfection procedures are necessary, and the child care facility should follow routine cleaning and disinfection procedures.

I. HIGH-RISK INDIVIDUALS

Child care providers should notify all families and staff that DC Health recommends that any individual at high-risk for experiencing severe illness due to COVID-19 consult with their medical provider ***before*** participating in child care activities. This includes, but is not limited to, older adults and people with the following conditions:

- Cancer
- Chronic kidney disease
- Chronic lung diseases, including COPD (chronic obstructive pulmonary disease), asthma (moderate-to-severe), interstitial lung disease, cystic fibrosis, and pulmonary hypertension
- Dementia or other neurological conditions
- Diabetes (type 1 or type 2)
- Down syndrome
- Heart conditions (such as heart failure, coronary artery disease, cardiomyopathies, or hypertension)
- HIV infection
- Immunocompromised state (weakened immune system)
- Liver disease
- Overweight and obesity
- Pregnancy
- Sickle cell disease or thalassemia
- Smoking, current or former
- History of solid organ or blood stem cell transplant
- History of stroke or cerebrovascular disease
- Substance use disorders

Information from the CDC for older adults is available here. A complete list of conditions that might place an individual at increased risk for severe illness from COVID-19 is available here.

There is less evidence to date about conditions which put children at increased risk of severe illness from COVID-19. Current information suggests that children with medical complexity (like genetic, neurologic, or metabolic conditions, and congenital heart disease) are generally at increased risk compared to their healthier peers. Like adults, conditions such as obesity, diabetes, asthma or chronic lung disease, sickle cell disease, or immunosuppression also appear to put children at increased risk for severe COVID-19.

Any staff member or parent/guardian of a child who has a medical condition not listed, but who is concerned about their safety, should also consult with their healthcare provider before participating in child care activities.

Child care providers are not required to secure written clearance from high-risk individuals prior to participating in congregate child care.

J. MEALS

Child care facilities must follow all applicable federal and local food safety requirements. Additionally, child care providers should follow the below recommendations.

All child care providers should serve meals following the physical (social) distancing and hygiene guidance.

- Meals should be eaten outdoors as much as possible. Indoor meals should take place in well-ventilated spaces.

- Meals should be served individually. If meals are typically served family style or via self-service stations (such as hot bars and salad bars), child care facilities should discontinue this practice and, instead, individually plate each child's meal so that utensils are not shared.
- Children must wash hands before and after eating, drinking, or handling food.
- Child care facilities should use disposable foodservice items (e.g., utensils, dishes). If disposable items are not feasible or desirable, child care facilities must implement procedures for all non-disposable foodservice items to be either manually washed, rinsed, and sanitized in a three compartment sink or in a dishwasher.
- If disposable foodservice items are not used, children must be provided with individual clean and sanitary eating and drinking utensils that must be washed and sanitized after each use. Children should not share utensils, cups, or plates during meals.
- Staff must wash hands before and after handling food or helping children to eat.
- Staff should follow all PPE best practices in Appendix B;
- Tables and chairs should be cleaned and sanitized before and after the meal.
- If handling individual lunch boxes, staff should wash their hands between the handling of each lunch box. Food items should be removed from the lunch box and placed with the child, or plated separately, and then the lunch box should be returned to the child's cubby.
- Staff should routinely clean, disinfect, and sanitize surfaces and objects that are frequently touched such as kitchen countertops, cafeteria and service tables, door handles, carts, and trays (if applicable).
- Child care facilities should avoid sharing of utensils and other personal items.

Note: Children may open and handle their own lunch boxes if developmentally appropriate.

RESPONSE

K. EXCLUSION, DISMISSAL, AND RETURN TO CARE CRITERIA AND PROTOCOLS

Child care programs should adhere to the below exclusion, dismissal, and return to care criteria and protocols.

Exclusion Criteria

A child, staff member, or essential visitor **must stay home, or not be admitted,** and must follow applicable DC Health guidance for isolation or quarantine, if they:

- Have had a temperature of 100.4 degrees Fahrenheit or higher or any of the symptoms listed above in the "Daily Health Screening" section of this guidance in the last 24 hours.
- Are confirmed to have COVID-19.
- Have been in close contact in the last 10 days with an individual confirmed to have COVID-19.[8]

[8] Returning to child care after 10 days is intended to minimize the risk of transmission of the virus while also minimizing the burden. Recent DC Health guidance allows for child care providers to continue to implement the more stringent 14-day return to care recommendation if they choose to. Waiting 14 days before returning to child care remains the most effective strategy for decreasing the transmission of COVID-19. DC Health strongly recommends that individuals who live or work with someone at higher-risk for COVID-19 (see Section I) wait 14 days before returning to child care.

- Are awaiting COVID-19 test results or have a household member who is awaiting COVID-19 test results.[9]
- Have traveled domestically in the last 10 days to any place other than Maryland or Virginia, unless they did not attend child care until tested for COVID-19 three to five days after returning to DC AND received a negative COVID-19 viral test.
- Have traveled internationally in the last 10 days, unless they did not attend child care for 7 days, got tested for COVID-19 three to five days after returning to DC, AND received a negative COVID-19 viral test.

Children or staff with pre-existing health conditions that present with specific COVID-19-like symptoms must not be excluded from entering the building on the basis of those specific symptoms, if a healthcare provider has provided written or verbal documentation that those specific symptoms are not due to COVID-19. This documentation can be provided to the facility in the form of a phone call, fax, email or written note from the healthcare provider.

Provided that they do not currently have any symptoms consistent with COVID-19, an individual who has **tested positive for COVID-19 within the last 90 days or is fully vaccinated** may be admitted after close contact with someone with confirmed COVID-19, close contact with an individual awaiting COVID-19 test results, or after travel. A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine). Any individual with symptoms consistent with COVID-19 must follow the exclusion criteria outlined above.

Provided that they do not currently have any symptoms consistent with COVID-19, an individual who is **has tested positive for COVID-19 in the last 90 days or is fully vaccinated** against COVID-19 may be admitted immediately after international travel. They should get a COVID-19 test three to five days after international travel. A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine). Any individual with symptoms consistent with COVID-19 must follow the exclusion criteria outlined above.

If excluded, parents/guardians, staff, and essential visitors should call their healthcare provider for further directions.

DC Health recommends that children and staff should get tested for COVID-19 if anyone in their household has symptoms of COVID-19, even if the child or staff member themself does not have symptoms. All members of the household should be tested at the same time. Individuals who are fully vaccinated against COVID-19 should only get tested in this instance if they develop symptoms.[10]

[9] This exclusion criterion applies in all cases except in the circumstance of awaiting the result of a test administered through a formal screening or surveillance testing program. Per DC Health, child care facilities that are participating in a formal screening or surveillance testing program as part of the broader policy of an umbrella organization should defer to the testing policy of their umbrella organization. Child care providers wishing to implement a screening or surveillance program in consultation with their health services provider should develop a testing plan and share that plan with the Deputy Mayor for Education and OSSE teams at EdSupport@dc.gov.
[10] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

Dismissal Criteria and Protocols

If a child, staff member, or essential visitor develops a fever or other signs of illness, the program director must follow the above exclusion criteria and must follow OSSE Licensing Guidelines regarding the exclusion and dismissal of children, staff members, and essential visitors.

- For children, the program director must immediately isolate the child from other children. If developmentally appropriate, the child should put on a face mask or surgical mask, if not wearing already.
    - Notify the child's parent/guardian of the symptoms and that the child should be picked up *as soon as possible* and instruct them to seek healthcare provider guidance.
    - Identify a staff member to accompany the isolated child to the isolation area and supervise the isolated child while awaiting pickup from the parent/guardian.
        - The staff member(s) briefly responding to the sick child in the classroom, accompanying the child to the isolation area, and supervising the child in the isolation area should comply with PPE best practices per Appendix B.
    - Follow guidance for use of the isolation room below.
    - Immediately follow all cleaning and disinfection protocols for any area and materials with which the child was in contact, per Section H: Cleaning, Disinfection, and Sanitization.
- For staff and essential visitors, the program director must send the staff member or essential visitor home immediately or isolate until it is safe to go home, instruct the staff member or essential visitor to seek healthcare provider guidance, and follow cleaning and disinfecting procedures for any area, toys, and equipment with which the staff member or essential visitor was in contact.

Isolation Room: Providers must isolate a child who exhibits symptoms of COVID-19. Providers should identify more than one well-ventilated space to isolate sick individuals until they are able to leave the facility. The space should be in an area that is not frequently passed or used by other children or staff and not simply behind a barrier in a room being utilized by other individuals. If safe and weather permitting, providers are encouraged to isolate sick individuals outdoors under appropriate supervision. When in the isolation area, the sick individual must wear a face mask or surgical mask (if developmentally feasible), be within sight of the supervising staff member, and be physically separated from other individuals by at least 6 feet. Providers should isolate only one sick individual in the isolation area at a time. The isolation area should be immediately cleaned and disinfected after the sick individual departs. Supervising staff should comply with the PPE best practices in Appendix B.

Return Criteria

Table 1 below identifies the criteria that child care providers should use to allow the return of a child or staff member with: (1) COVID-19 symptoms; (2) positive COVID-19 test results; (3) negative COVID-19 test results; (4) documentation from a healthcare provider of alternate diagnosis; (5) close contact with an individual with confirmed COVID-19; (6) a household member awaiting COVID-19 test results; or (7) travel to any place other than Maryland or Virginia.

For all scenarios, individuals must follow applicable DC Health guidance for isolation and quarantine.

Table 1. Return to Care Criteria for Children and Staff

Child or Staff Member With:	Criteria to Return *Note: Criteria below represent standard criteria to return to care. In all cases, individual guidance from DC Health or a healthcare provider would supersede these criteria.*
1. COVID-19 symptoms (e.g., fever, cough, difficulty breathing, loss of taste or smell)	Recommend the individual seek healthcare guidance to determine if COVID-19 testing is indicated. If the individual is tested: • If positive, see #2. • If negative, see #3. • Individuals must not attend child care while awaiting test results. If the individual does not complete test, they should: • Submit documentation from a healthcare provider of an alternate diagnosis, and meet standard criteria to return after illness; OR • Meet symptom-based criteria to return: o At least 24 hours **after** the fever has resolved without the use of fever-reducing medication (e.g., Motrin, Tylenol) and symptoms have improved; AND o At least 10 days from when symptoms first appeared, whichever is later. Note: Children or staff with pre-existing health conditions that present with specific COVID-19-like symptoms must not be excluded from entering the facility on the basis of those specific symptoms if a healthcare provider has provided written or verbal documentation that those specific symptoms are not due to COVID-19. Note: Standard criteria to return after illness refers to the individual facility's existing policies and protocols for a child or employee to return to care after illness. DC Health recommends that children should get tested for COVID-19 if anyone in their household has symptoms of COVID-19, even if the child or staff member themself does not have symptoms. All members of the household should be tested at the same time. Individuals who are fully vaccinated against COVID-19 should only get tested in this instance if they develop symptoms.[11]
2. Positive COVID-19 Test Result (Antigen or PCR Test)	If symptomatic, may return after: • At least 24 hours **after** the fever has resolved without the use of fever-reducing medication (e.g., Motrin, Tylenol) and symptoms have improved; AND

[11] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

See DC Health's Guidance for Persons Who Tested Positive for COVID-19 for more information	• At least 10 days after symptoms first appeared, whichever is later. If asymptomatic, may return after: • 10 days from positive test. Regardless of whether symptomatic or asymptomatic, close contacts (including all members of the household) who are not fully vaccinated against COVID-19 must not attend child care for at least 10 days from the last date of close contact with the positive individual.
3. Negative COVID-19 Test Result After Symptoms of COVID-19	May return when: • Meet standard criteria to return after illness. • If the individual received a negative antigen test, that result should be confirmed with a negative PCR test. The individual must not attend child care until the PCR test result returns. Note: Standard criteria to return after illness refers to the individual facility's existing policies and protocols for a child or employee to return to care after illness. *Per Scenario #5, a negative test result after close contact with an individual with confirmed COVID-19 does *not* shorten the time period of at least 10 days before returning to child care.
4. Documentation from Healthcare Provider of Alternate Diagnosis After Symptoms of COVID-19 (e.g., chronic health condition, or alternate acute diagnosis such as strep throat)	May return when: • Meet standard criteria to return after illness. Note: Standard criteria to return after illness refers to the individual child care facility's existing policies and protocols for a child or employee to return to care after illness.
5. Close Contact of an Individual with Confirmed COVID-19 *See DC Health's Guidance for Contacts of a Person Confirmed to have COVID-19 for more information*	May return after: • A minimum of 10 days from last exposure to COVID-19 positive individual, provided that no symptoms develop, or as instructed by DC Health. Note: Returning to child care after 10 days (on day 11) is only acceptable if: • The close contact did not develop symptoms of COVID-19 at any point during the 10 days. AND • The close contact continues to self-monitor for symptoms until 14 days after the last exposure to the COVID-19 positive individual. If the close contact is a household member, may return after at least 10 days from the end of the COVID-19 positive individual's infectious period (see Scenario #2), or as instructed by DC Health.

	Returning to child care after 10 days is intended to minimize the risk of transmission of the virus while also minimizing the burden. Recent DC Health guidance allows for child care providers to continue to implement the more stringent 14-day return to care recommendation if they choose to. Waiting 14 days before returning to child care remains the recommended and most effective strategy for decreasing the transmission of COVID-19. DC Health strongly recommends that individuals who live or work with someone at higher-risk for COVID-19 (see Section I) quarantine for 14 days. DC Health recommends that children should get tested for COVID-19 if anyone in their household has symptoms of COVID-19, even if the child or staff member themself does not have symptoms. All members of the household should be tested at the same time. Individuals who are fully vaccinated against COVID-19 should only get tested in this instance if they develop symptoms.[12] Individuals may return immediately after close contact with an individual with confirmed COVID-19 if the following are true: • They do not have any symptoms consistent with COVID-19. AND • They have tested positive for COVID-19 within the last 90 days; OR • They are fully vaccinated against COVID-19.[13]
6. Household Member Awaiting a COVID-19 Test Result[14]	If the household member tests negative: • May return immediately if the child or staff member has no symptoms of COVID-19 nor other exclusionary criteria met. If the household member tests positive: • See Scenario #5. Individuals may return immediately in the event of a household member awaiting a COVID-19 test result if the following are true: • They do not have any symptoms consistent with COVID-19. AND

[12] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).
[13] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of two-dose series, or after one dose of a single-dose vaccine).
[14] These return criteria do not apply in the circumstance of awaiting the result of a test administered through a formal screening or surveillance testing program. Per DC Health, child care facilities that are participating in a formal screening or surveillance testing program as part of the broader policy of an umbrella organization should defer to the testing policy of their umbrella organization. Child care providers wishing to implement a screening or surveillance program in consultation with their health services provider should develop a testing plan and share that plan with the Deputy Mayor for Education and OSSE teams at EdSupport@dc.gov.

	• They have tested positive for COVID-19 within the last 90 days; OR • They are fully vaccinated against COVID-19.[15]
7. Travel to Any Place Other than Maryland or Virginia *See DC Health's Guidance for Travel and the CDC's COVID-19 Travel Recommendations by Destination for more information*	If the individual is unvaccinated or partially vaccinated, may return from domestic travel after: • 10 days from return. OR • Being tested for COVID-19 three to five days after return and receiving a negative result. If the individual is unvaccinated or partially vaccinated, may return from international travel after: • 10 days from return. OR • Seven days, if tested for COVID-19 three to five days after return, and received a negative result. o Even if the test is negative, the individual must not attend child care for seven days. If the individual has tested positive for COVID-19 in the last 90 days or is fully vaccinated,[16] may return immediately after domestic or international travel, provided that they do not currently have any symptoms consistent with COVID-19. • If the individual is returning from international travel, they should get a COVID-19 test three to five days after traveling. For more detailed guidance related to returning from domestic and international travel, see DC Health's Guidance for Travel.

Implement Leave Policies for Staff

Child care facilities should implement leave policies that are flexible and non-punitive and that allow sick employees to stay home. Leave policies are recommended to account for the following:

- Employees who report COVID-19 symptoms,
- Employees who were tested for COVID-19 due to symptoms, travel, or exposure and have test results pending,
- Employees who tested positive for COVID-19,
- Employees who are a close contact of someone who tested positive for COVID-19, and
- Employees who need to stay home with their children if there are school or child care closures, or to care for a sick family member.

[15] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

[16] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

Keep abreast of current law, which has amended both the DC Family and Medical Leave Act and the DC Sick and Safe Leave Law and created whole new categories of leave, like Declared Emergency Leave.

Learn about and inform your employees about COVID-19-related leave provided through new federal law, the Families First Coronavirus Response Act (FFCRA), and all applicable District law relating to sick leave.

L. EXPOSURE REPORTING, NOTIFICATIONS, & DISINFECTION *[UPDATED]*

To ensure a clear and efficient process for communication each child care provider must identify a staff member as the COVID-19 point of contact (POC). This person is responsible for:

- Ensuring the below steps are followed in the event of a confirmed case of COVID-19.
- Ensuring that the child care facility has contact information for all contract staff. It is critical that DC Health have reliable contact information in the event of a positive case or close contact among contract staff.
- Acting as the POC for families and staff to notify if a child or staff member test positive for COVID-19.

Step 1: Reporting to OSSE and DC Health
Refer to DC Health's First Steps for Non-Healthcare Employers when Employees Test Positive for COVID-19.

Facilities must notify DC Health when:

- A staff member or essential visitor notifies the facility they tested positive for COVID-19 (not before results come back)

OR

- A parent/guardian notifies the facility that a child tested positive for COVID-19 (not before results come back).

AND

- The person was on the grounds of the facility or participated in facility activities **during their infectious period.**
    - The infectious period starts two days before symptom onset date (or positive test date for people who do not have symptoms) and typically ends 10 days after symptom onset date (or positive test date for people who do not have symptoms).

In the event of a confirmed case of COVID-19 in a child, staff member, or essential visitor, child care providers must complete the following steps as soon as possible on the same day the case was reported to the facility:

- File an Unusual Incident Report (UIR) with OSSE at OSSE.ChildCareComplaints@dc.gov *and*
- Notify DC Health by submitting an online form on the DC Health COVID-19 Reporting Requirements website: dchealth.dc.gov/page/covid-19-reporting-requirements.
    - Submit a **Non-Healthcare Facility COVID-19 Consult Form.**

An investigator from DC Health will follow-up within 24 hours to all appropriately submitted notifications. Please note this time may increase if cases of COVID-19 increase in the District.

In the event of a confirmed COVID-19 case, child care providers do not need to automatically close the entire facility. DC Health will instruct child care providers within 24 hours on dismissals and other safety precautions in the event a known COVID-19 individual came in close contact with others at the facility.

If a child care provider identifies a child or staff member with COVID-19 who is currently in the facility, they should be prepared to dismiss that child or staff member, and the potentially exposed cohort(s) until DC Health is able to complete the case investigation.

- The exposed cohort should remain in their designated area and follow routine procedures while they are waiting for their parents/caregivers to pick them up.
- If the facility is notified of a case who is not currently in the building, the affected cohort may remain until the end of the school day.

Note: While child care providers await a response from DC Health, plans should be made as soon as practical to close, clean, and disinfect, as necessary, any areas or equipment that the COVID-19 positive individual may have used (see Step 3).

Step 2: Communication to Families and Staff

Child care providers should have communication protocols in place that protect the privacy of individuals and alert their families and staff to a COVID-19 case. DC Health will identify close contacts based on its case investigation. Child care providers do not need to wait for a response from DC Health before informing families that an incident with a COVID-19 case has occurred. Communication is to be completed, per DC Health directive and will include:

- Notification to the entire program or the affected classroom(s) that there was a COVID-19 positive case, those impacted will be notified and told they must not attend child care, steps that will be taken (e.g., cleaning and disinfection), and the facility's operating status;
- Education about COVID-19, including the signs and symptoms of COVID-19, available at coronavirus.dc.gov;
- Referral to the Guidance for Contacts of a Person Confirmed to have COVID-19, available at coronavirus.dc.gov/healthguidance; and
- Information on options for COVID-19 testing in the District of Columbia, available at coronavirus.dc.gov/testing.

***[UPDATED]* Step 3: Cleaning and Disinfection of Affected Spaces**

In the event of a confirmed COVID-19 case in a child, staff member, or essential visitor, the provider should immediately follow DC Health's Guidance on Cleaning and Disinfection for Community Facilities as well as cleaning and disinfection guidance from the CDC, linked here:

- *[UPDATED]* If the COVID-19 positive individual has been in the facility **within the past 24 hours**, the child care facility should clean and disinfect the area(s) where they have been.
    - *[UPDATED]* Facilities should close areas where the sick individual has been.
        - If a COVID-19 case is confirmed during the day AND the COVID-19 positive individual is in the facility, then the cohort should be dismissed and the room vacated as soon as possible.
        - If the COVID-19 positive individual has not been in the facility that day, then it is acceptable to remain in the room until the end of the day.
    - Staff supporting, accompanying, or cleaning up after a sick child should adhere to PPE best practices as articulated in Appendix B.
    - Once the room is vacated, facilities should wait as long as possible before entering the room to clean and disinfect (at least several hours). Facilities should perform deep

cleaning and disinfection of the full classroom and any other spaces or equipment in which the ill individual was in contact. *This includes the isolation room after use by an ill child or staff member.*
    - During cleaning and disinfection, facilities should increase air circulation to the area (e.g., open doors, open windows, use fans, or adjust HVAC settings).
    - *[UPDATED]* Staff must wear a face mask for all steps of the cleaning and disinfection process. Staff should also wear gloves and follow additional PPE best practices as articulated in Appendix B.
    - For additional material-specific considerations, including for soft surfaces, laundry, electronics, and outdoor areas, see DC Health's Guidance on Cleaning and Disinfection for Community Facilities with Suspected or Confirmed COVID-19.
- *[UPDATED]* If it has been **more than 24 hours, but fewer than three days**, since the COVID-19 positive individual was in the school building, the facility should clean any areas where the individual has been. Disinfection is not necessary.
- If it has been **more than three days** since the COVID-19 positive individual was in the facility, no special cleaning and disinfection procedures are necessary, and the child care facility should follow routine cleaning and disinfection procedures.

M. QUESTIONS?

If you have questions relating to this guidance, please contact Eva Laguerre, director of Licensing and Compliance, Division of Early Learning, at (202) 741-5942 or Eva.Laguerre@dc.gov.

For resources and information about the District of Columbia Government's coronavirus (COVID-19) response and recovery efforts, please visit coronavirus.dc.gov.

APPENDIX A: PROCEDURE FOR STAFF CONDUCTING PHYSICAL TEMPERATURE CHECKS

Temperature checks as a screening tool at the facility are not recommended by DC Health. Child care providers that choose to implement a physical temperature check should adhere to the following guidance:

In the event a staff member must take another individual's temperature, they should follow one of two options articulated below, per guidance from the Centers for Disease Control and Prevention (CDC), to do so safely. During temperature checks, use of barriers or personal protective equipment (PPE) helps to eliminate or minimize exposures due to close contact with a person who has symptoms. Use of non-contact thermometers is strongly encouraged.

- OPTION 1: Barrier/partition controls
  - **Wash hands** with soap and water for 20 seconds. If soap and water are not available, use a hand sanitizer with at least 60 percent alcohol.
  - **Put on** disposable gloves.
  - **Stand behind a physical barrier**, such as a glass or plastic window, or partition that can serve to protect the staff member's eyes, nose, and mouth from respiratory droplets if the person being screened sneezes, coughs, or talks.
  - **Make a visual inspection** of the individual for signs of illness, which include flushed cheeks, rapid breathing (without recent physical activity), fatigue, or extreme fussiness.
  - **Check the temperature, reaching around the partition or through the window.**
    - Make sure your face stays behind the barrier at all times during the temperature check.
  - If performing a **temperature check on multiple individuals:**
    - Use a **clean pair of gloves for each individual** and that the **thermometer has been thoroughly cleaned** in between each check.
    - If you use disposable or non-contact thermometers and you did not have physical contact with the individual, you do not need to change gloves before the next check.
  - **Remove your gloves** following proper procedures.
  - **Wash hands** with soap and water for 20 seconds. If soap and water are not available, use a hand sanitizer with at least 60 percent alcohol.
  - **Clean the thermometer** following the directions below.

- OPTION 2: Personal Protective Equipment (PPE)
  - PPE can be used if a temperature check cannot be performed by parent/guardian (for a child) or a staff member or essential visitor (for him/herself) *or* barrier/partition controls cannot be implemented.
  - CDC states that reliance on PPE is less effective and more difficult to implement because of PPE shortages and training protocols.
  - If staff do not have experience in using PPE, the CDC has recommended sequences for donning and doffing PPE.
  - To follow this option, staff should:
    - **Wash hands** with soap and water for 20 seconds. If soap and water are not available, use a hand sanitizer with at least 60 percent alcohol.

- **Put on PPE.** This includes a surgical face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), and a single pair of disposable gloves. A gown/coverall should be considered if extensive contact with the individual being screened is anticipated.[17]
- **Take** the individual's **temperature**.
- If performing a **temperature check on multiple individuals:**
    - Use a **clean pair of gloves for each individual** and that the **thermometer has been thoroughly cleaned** in between each check.
    - If you use disposable or non-contact thermometers and you did not have physical contact with the individual, you do not need to change gloves before the next check.
- **Remove and discard PPE**.
- **Wash hands** with soap and water for 20 seconds. If soap and water are not available, use a hand sanitizer with at least 60 percent alcohol.
- **Clean the thermometer** following the directions below.

- APPROPRIATE USE OF THERMOMETERS, INCLUDING HYGIENE AND CLEANING PRACTICES:
    - Use of non-contact thermometers is highly encouraged. Forehead, tympanic (ear), or axillary (armpit) thermometers are also acceptable. Oral and rectal temperature checks should not be performed.
    - Thoroughly clean the thermometer before and after each use per manufacturer instructions.
    - If you use non-contact thermometers, clean them with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual screened. You can reuse the same wipe as long as it remains wet.

[17] The coverall may be a large, button-down, long-sleeved shirt.

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APPENDIX B: PPE BEST PRACTICES FOR CHILD CARE STAFF *[UPDATED]*

Child care facility staff should adhere to the guidance below at a minimum. These guidelines do not replace professional judgment, which should always be used to support the safest environment for children and staff.

Note: Staff and children should practice good hand hygiene throughout all of the scenarios and maintain physical distance to the maximum extent feasible.

[UPDATED] **Wearing gloves is not a substitute for good hand hygiene.** Gloves should be changed between children and care activities, and hand hygiene must be performed between glove changes. If skin comes into contact with any secretions or bodily fluids, it must be immediately washed. Contaminated clothing should be immediately removed and changed.

WORKING WITH CHILDREN WHO ARE <u>NOT KNOWN OR NOT SUSPECTED</u> TO HAVE COVID-19

Lower Risk:[18] *Six feet of physical distance cannot always be maintained. Close contact with secretions or bodily fluids is not anticipated.*

- Face mask (A face mask may be a non-medical [cloth] face covering)

Medium Risk:[19] *Staff are in close/direct contact with less than 6 feet of physical distance from the child. Close contact with secretions or bodily fluids is possible or anticipated.*

- Face mask
    - If there is the potential for bodily fluids to be splashed or sprayed (e.g., child who is spitting or coughing), use surgical mask and eye protection (face shield or goggles) instead of non-medical (cloth) face covering
- Gown/coverall (e.g., large, button-down, long-sleeved shirt)
- Gloves must be used per existing procedures and licensing requirements (e.g., when diapering)

[18] Scenarios that would be classified as "lower risk" include situations where staff may be within 6 feet of children who are not known or suspected to have COVID-19 *and* in which the children are not consistently wearing their face masks. This includes services by related service providers in which close contact with secretions is not anticipated. This also includes scenarios in which staff administering the Daily Health Screening are wearing a face mask, maintain 6 feet of physical distance *and* are <u>not</u> performing a physical temperature check.

[19] Scenarios that would be classified as "medium risk" include close contact between a child and an educator, classroom aide, or related service provider in which close contact with secretions or bodily fluids is possible or anticipated. When washing, feeding, or holding infants or very young children, staff must wear face mask, pull long hair off of neck, and wear a coverall.

Higher Risk: *Staff who are in close/direct contact with less than 6 feet of physical distance from the student and performing a higher-risk or aerosol-generating procedure, including administration of nebulized medication.*[20]

- N95 mask (with access to Respirator Fit Testing Program)[21]
- Eye protection (face shield or goggles)
- Gown/coverall
- Gloves

WORKING WITH CHILDREN WHO ARE KNOWN OR SUSPECTED TO HAVE COVID-19

Staff working with any child who is known to have COVID-19 or who is exhibiting symptoms of COVID-19 should take additional steps.

While responding briefly to a sick child, or while escorting a sick child to the isolation area:

- If the sick child is wearing a face mask and is able to maintain 6 feet of distance, the accompanying staff should wear:
    - Face mask

- If the sick child is not wearing a face mask or is not able to maintain 6 feet of distance, accompanying staff should wear:
    - Surgical mask
    - Eye protection (face shield or goggles)
    - Gown/Coverall
    - Gloves

While supervising a sick child in the isolation area, staff should always wear:

- Surgical mask
- Eye protection (face shield or goggles)
- Gown/Coverall
- Gloves
- *Note:* The child in the isolation room should also wear a face mask or surgical mask, as feasible and developmentally appropriate.

The sick child and any staff accompanying or supervising them to/in the isolation area should safely remove and store their face mask, or dispose of their surgical mask, after use.

[20] Per the Centers for Disease Control and Prevention, aerosol-generating procedures include administering nebulized medication, open suctioning of airways, sputum induction, cardiopulmonary resuscitation, endotracheal intubation and extubation, non-invasive ventilation (e.g., BiPAP, CPAP), bronchoscopy, and manual ventilation. More information can be found here.

[21] Any individual using an N95 mask must have access to a comprehensive Respirator Fit Testing program. An individual who has not completed a Respirator Fit Testing program should NOT wear an N95 and must NOT participate in higher-risk scenarios. For additional information, see the Occupational Safety and Health Administration's Occupation Safety and Health Standards for respiratory protection.

PPE FOR STAFF WITH SPECIFIC ROLES

Staff Administering a COVID-19 Test

- N95 mask (with access to Respirator Fit Testing program)[22]
- Eye protection (face shield or goggles)
- Gown/coverall
- Gloves

[UPDATED] **Custodial Staff**

- Face mask
    - If there is an increased risk of exposure to COVID-19 (e.g., cleaning an area occupied by an individual with symptoms of COVID-19), wear surgical mask instead of non-medical (cloth) face covering.
- Gown/coverall
- Gloves
- Other PPE, including eye protection and respiratory protection, may be recommended based on cleaning/disinfectant products being used and whether there is a risk of splash. Follow all product instructions on the product's safety data sheets (SDS). For more information, visit the CDC's website here.

Classroom educators and staff who are cleaning and disinfecting areas or equipment utilized by a sick individual must follow Custodial Staff guidelines above. Classroom educators and staff doing routine cleaning (e.g., of high-touch surfaces) must wear a face mask. Other PPE may be recommended based on cleaning/disinfectant products being used and whether there is a risk of splash. For more information, visit the CDC's website here.

Foodservice Staff

- Face mask
- Gloves (when handling food products)
- Additional PPE may be required per food preparation regulation and requirements

Performing Physical Temperature Check: per Appendix A

[22] Any individual using an N95 mask must have access to a comprehensive Respirator Fit Testing program. An individual who has not completed a Respirator Fit Testing program must NOT wear an N95 nor administer a COVID-19 test. For additional information, see the Occupational Safety and Health Administration's Occupation Safety and Health Standards for respiratory protection.

APPENDIX C: COVID-19 TESTING

DEFINITIONS

For information about each type of testing, see DC Health's resource Coronavirus 2019 (COVID-19): PCR, Antigen, and Antibody Tests.

Diagnostic testing for SARS-CoV-2 is intended to identify occurrence at the individual level and is performed when there is a reason to suspect that an individual may be infected, such as having symptoms or suspected recent exposure, or to determine resolution of infection. Examples of diagnostic testing include testing symptomatic individuals who present to their healthcare provider, testing individuals through contact tracing efforts, testing individuals who indicate that they were exposed to someone with a confirmed or suspected case of coronavirus disease 2019 (COVID-19), and testing individuals present at an event where an attendee was later confirmed to have COVID-19.[23]

Screening tests for SARS-CoV-2 are intended to identify occurrence at the individual level even if there is no reason to suspect infection—e.g., there is no known exposure. This includes, but is not limited to, screening of non-symptomatic individuals without known exposure with the intent of making decisions based on the test results. Screening tests are intended to identify infected individuals without, or prior to development of, symptoms who may be contagious so that measures can be taken to prevent further transmission. Examples of screening include testing plans developed by a workplace to test its employees, and testing plans developed by a school to test its students, faculty, and staff. In both examples, the intent is to use the screening testing results to determine who may return and the protective measures that will be taken.[24]

Surveillance for SARS-CoV-2 includes ongoing systematic activities, including collection, analysis, and interpretation of health-related data that are essential to planning, implementing, and evaluating public health practice. Surveillance testing is generally used to monitor for a community- or population-level occurrence, such as an infectious disease outbreak, or to characterize the occurrence once detected, such as looking at the incidence and prevalence of the occurrence. Surveillance testing is used to gain information at a population level, rather than an individual level, and results of surveillance testing can be returned in aggregate to the requesting institution. Surveillance testing may sample a certain percentage of a specific population to monitor for increasing or decreasing prevalence and to determine the population effect from community interventions, such as social distancing. An example of surveillance testing is a plan developed by a state public health department to randomly select and sample a percentage of all individuals in a city on a rolling basis to assess local infection rates and trends.[25]

TESTING RECOMMENDATION

The CDC and DC Health recommend prioritizing testing for individuals with symptoms of COVID-19.

DC Health does not recommend universal testing of all children and staff as a prerequisite to participating in child care. Per DC Health, child care facilities that are participating in a formal screening or surveillance testing program as part of the broader policy of an umbrella organization should defer to

[23] Centers for Disease Control and Prevention (CDC) (Oct. 23, 2020). *Interim guidance for use of pooling procedures in SARS-CoV-2 diagnostic, screening, and surveillance testing*. Centers for Disease Control and Prevention. cdc.gov/coronavirus/2019-ncov/lab/pooling-procedures.html.
[24] Ibid.
[25] Ibid.

the testing policy of their umbrella organization. Child care providers wishing to implement a screening or surveillance program in consultation with their health services provider should develop a testing plan and share that plan with the Deputy Mayor for Education and OSSE teams at EdSupport@dc.gov.

TESTING AVAILABILITY

Testing is available through one's healthcare provider, home test kits available from DC Health, and the city's public testing sites. At present, anyone who is a District of Columbia resident, age 3 or older, or who works at a child care facility in the District of Columbia who presents for a test, symptomatic or not, can get a free test at one of the city's testing sites.

- You do not need a doctor's note for any of the walk-in sites.
- Testing sites and additional information can be found at coronavirus.dc.gov/testing.