



DISTRICT OF COLUMBIA

OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

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

(Updated Dec. 21, 2020)

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 Dec. 21, 2020 and supersedes any previously released guidance by OSSE on the topic. This document includes reopening guidance for child care providers issued by the DC Health on [Dec. 10, 2020](#) and provides additional guidance on select topics. **All provisions as stated throughout are *required* except those provisions described as items that facilities “should” do or classified as “where feasible” or “developmentally appropriate.”** Required activities for child care providers are mandatory in accordance with [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 2020-110, Modified Requirements Regarding Self-Quarantines, Testing, and Travel During the COVID-19 Public Health Emergency](#) (Nov. 6, 2020), [Mayor's Order 2020-119, Modified Requirements to Combat Escalation of COVID-19 Pandemic During Phase Two](#) (Nov. 23, 2020), OSSE's Child Development Facility Licensing Regulations at Title 5-A 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 This guidance may be superseded by any applicable Mayor's order, regulation, or health mandates from DC Health.

The information in this guidance is divided into two categories: prevention and response. The prevention information addresses the actions that child care providers must take or should consider taking to protect children and staff and slow the spread of COVID-19. The response information addresses the actions that child care providers must take when a child or staff member becomes sick with COVID-19.

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](#). This 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 ensure practices, as described in this guidance document, are being followed.

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PREVENTION

A. COMMUNICATION WITH STAFF AND FAMILIES

To support clear communication with children, staff, and families, child care facilities must 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 cloth face covering](#)). At a minimum, child care providers must place signage in every classroom and near every sink reminding staff of hand-washing 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 should 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

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. An influenza outbreak in the child care setting will compound the current COVID-19 pandemic, resulting in significant harm for children and the child care community.

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](#).

Currently, 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 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 was effective through Nov. 2, 2020 for UHCs and Medication and Treatment Authorization Forms and is effective through Jan. 31, 2021 for OHAs.** As stated above, this 90-day extension for children age 3 and older does not affect the

requirement for all children to continue to timely receive all necessary immunizations as required by District law. Child care providers must continue to collect timely, unexpired UHCs from all infants and toddlers age 2 and younger.

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 *[UPDATED]*

Child care facilities 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 must ensure all ventilation and water systems and features (e.g., sink faucets, drinking fountains) are safe to use and are adequately maintained throughout the operating period.

Child care providers must ensure ventilation systems operate properly, including inspecting and routinely replacing HVAC filters and ensuring 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 must: flush water systems to clear out stagnant water and replace it with fresh water. This will remove any metals (e.g., lead) 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 and are articulated below:

- Flush hot and cold water through all points of use (e.g., showers, sink faucets).
 - Flushing may need to occur in segments (e.g., floors, individual rooms) due to facility size and water pressure. The purpose of building flushing is to replace all water inside building piping with fresh water.
 - Make sure that your water heater is set to at least 140 degrees Fahrenheit.
- Flush until the hot water reaches its maximum temperature.
- Care should be taken to minimize splashing during flushing.

- Other water-using devices, such as ice machines, may require additional cleaning steps in addition to flushing, such as discarding old ice. Follow water-using device manufacturers' instructions.

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 *[UPDATED]*

Child care facilities must ensure appropriate physical distancing by:

- ***[UPDATED]* For infants, toddlers, preschoolers, and school-aged children:** No more than 12 individuals (staff and children) clustered in one group. One additional adult (13 total individuals) can briefly be added to the group if necessary.
 - For indoor activities, this means no more than 12 (or, briefly, 13) individuals in one group.
 - For outdoor activities, each group of 12 (or, briefly, 13) individuals must interact only with their own group and not mix between other groups. Each group must have extra social distance (more than 6 feet) between them and the next group.
- ***[NEW]*** Child care providers must continue to adhere to maximum group sizes and staff-to-child ratios per OSSE licensing guidelines Section 121.
- Grouping the same children and staff together each day and throughout the entire day (as opposed to rotating teachers or rotating or combining groups of children).
- No mixing between groups to include entry and exit of the building, at meal time, in the restroom, on the playground, in the hallway, and other shared spaces.
- ***[UPDATED]* To the maximum extent feasible, floating staff should be strictly limited and used only when necessary.**
 - Floating staff members may be used to provide breaks or serve as runners.
 - Floating staff members should **not attend to more than two classrooms or cohorts per day.**
 - Floating staff members may be used **only when they:**
 - Meet the non-medical (cloth) face covering criteria as listed in Section F;
 - Wash their hands prior to entry and exit of the room and prior to touching a child;
 - Social distancing implemented;
 - Wear a clean smock (e.g., gown/coverall) over their clothes;¹ and
 - Wear booties over their shoes as used for infant classrooms (note: smocks [e.g., gown/coverall] and booties worn by runners do not need to be changed between entering each classroom unless they come into contact with secretions).²
 - If DC Health identifies concerns with floating staff members through a contact tracing investigation, a complaint may be filed to OSSE to investigate, and if inappropriate floating staff use was identified, OSSE may close the facility until the facility remediates.
- Substitutes are allowable, if necessary, and must follow provisions above for floating staff members.

¹ The coverall may be a large, button-down, long-sleeved shirt.

² The coverall may be a large, button-down, long-sleeved shirt.

- No large group activities and activities requiring children to sit or stand in close proximity, e.g., circle time.
- Nap mats, cots, and cribs must be placed head to toe, where head to head distance is at least 6 feet apart.
- Stagger drop-off and pick-up times or implement other protocols that avoid large groups congregating and limit direct contact with parents.
- Curb- or door-side drop-off and pick-up of children.
- No field trips.
 - Note: Regularly scheduled outings, such as neighborhood walks, are allowed as long as proper social distancing and mask-wearing is maintained. If the regularly scheduled outing is to a nearby park or field, it is essential that the group maintain at least 6 feet of distance from any other group. Children should not utilize public playground structures or toys that are not regularly cleaned.

Where feasible, child care providers should:

- Setup indoor and outdoor settings to maximize spacing (6 feet at minimum) between individuals, including while at tables and in group and individual activities.
- Install physical barriers, such as sneeze guards and partitions, particularly in areas in which it is difficult for individuals to remain 6 feet apart (e.g., reception areas, between bathroom sinks).
- Create individually labeled bins and sets of supplies to reduce the sharing of materials between children. For those materials that are shared, child care providers must ensure they are cleaned between each use per Section H: Cleaning, Disinfection, and Sanitization.
- Restrict all outside volunteers or visitors, except adults approved to pick up or drop off enrolled children or those providing therapeutic services to a child as stated in an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).
- Convert in-person adult gatherings (e.g., staff meetings) to virtual.
- Close communal-use space such as breakrooms and lounges. If it is not feasible to close the space, stagger use, ensure strict physical distance between individuals, ensure face coverings are worn at all times except while eating or napping, and clean and disinfect the space between uses.
- Encourage administrative staff to telework.
- Implement a lane system in hallways, stairwells, and other common areas.
- Eliminate non-essential travel for staff and teachers (e.g., conferences). If staff must travel, they must abide by [Mayor's Order 2020-110, Modified Requirements Regarding Self-Quarantines, Testing, and Travel During the COVID-19 Public Health Emergency](#).

More than one group may occupy a room ***if the below provisions and additional required physical distancing measures as stated above are followed:***

- Child care providers may use partitions to separate groups;
- Partitions must be at least 6 feet tall and of solid material with no holes or gaps (e.g., solid barrier or fire-resistant vinyl blankets);
- Individuals must be at least 6 feet away from the partition on each side;
- To effectively create a barrier, the 6-foot-tall partition must extend the length of the area which children and staff are using for activities. No classroom activities should occur outside the barrier of the partition. The open space at each end of the partition *may not* be used to congregate *but* may function as a hallway to be used with appropriate social distancing measures.

- Partitions must align with regulatory safety protocols to ensure they are not fall hazards, allow for proper ventilation, meet fire safety regulations, and meet any other safety regulations. For more information please refer to the District of Columbia Department of Consumer and Regulatory Affairs (DCRA) website [here](#).

E. DAILY HEALTH SCREENING *[UPDATED]*

Child care providers must have a procedure to conduct a daily health screening upon arrival for children, staff, and essential visitors. The screening procedure must:

- Be conducted using appropriate physical distancing measures of 6 feet and must adhere to procedures and PPE requirements as articulated in Appendices A and B;
- **[UPDATED] 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 nose³
 - 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
 - Or any other symptom of not feeling well.
- **[UPDATED] 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-19.⁴
- **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.

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 shall 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 covering; any accompanying staff member(s) must follow PPE guidance per the “suspected or confirmed COVID-19” section of Appendix B.

³ 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.

⁴ The 10-day quarantine recommendation is intended to minimize the risk of transmission of the virus while also minimizing the burden of quarantine. Recent DC Health guidance allows for child care providers to continue to implement the more stringent 14-day quarantine requirement if they choose to. Fourteen days of quarantine 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) quarantine for 14 days.

Such families, staff, or essential visitors shall 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 should 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.

[UPDATED] Individuals who have traveled to any place other than Maryland, Virginia or a low-risk state, country or territory must either (1) self-monitor and limit daily activities—including not attending child care—for 14 days, or (2) self-monitor and limit daily activities—including not attending child care—for at least three to five days and then receive a negative COVID-19 PCR test before returning to child care, per [Mayor’s Order 2020-110, Modified Requirements Regarding Self-Quarantines, Testing, and Travel During the COVID-19 Public Health Emergency](#)). The low-risk states will be posted by DC Health on [coronavirus.dc.gov/phasetwo](#). The CDC website contains a [list of countries and territories by risk-level](#). Individuals who have traveled to countries or territories with Level 3 risk are subject to the Mayor’s Order travel restrictions after return to the District, as above. 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.

[NEW] Results of the daily screening must be reviewed routinely. Records of screening are strongly recommended to be stored for 30 days.

[UPDATED] 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 need for 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 must 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 shall not be admitted and shall be instructed to call their healthcare provider to determine next steps. If the child, staff 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 covering; any accompanying staff member(s) must follow PPE guidance 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 must take another individual’s temperature at any point, they must 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. NON-MEDICAL (CLOTH) FACE COVERINGS [UPDATED]

All staff and essential visitors must wear a non-medical (cloth) face covering or a face mask at all times while in the facility. If a staff member is unable to wear a face covering for a medical reason, they may be able to get a waiver from OSSE to participate in congregate child care by receiving a written note from their healthcare provider. Staff without a medical clearance from a healthcare provider *and* a waiver from OSSE must wear a face covering or may not participate in congregate child care.

Parents/guardians must wear non-medical face coverings any time they interact with child care staff, including for drop-off and pick-up.

[UPDATED] Children age 2 and older must wear a face covering. 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 conditions such as asthma), to determine if an individual child is able to wear a mask and attend child care safely.

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

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

Instances when face coverings do not need to be worn:

- Non-medical face coverings **should not** be placed on children younger than age 2, anyone who has trouble breathing, or anyone who is unconscious or unable to remove the mask without assistance.
- Face coverings **should not** be worn by children during naptime.
- When participating in vigorous physical activity outdoors, face coverings do not need to be worn if social distancing of at least 6 feet is feasible. When outdoors but *not* participating in physical activity, face coverings must continue to be worn.
- Face coverings do not need to be worn by anyone who is actively drinking or eating a meal.
- Face coverings do not need to be worn when in an enclosed office that no one else is permitted to enter.
- Staff may wear face coverings with clear plastic windows, or briefly remove their face coverings, when interacting with children with disabilities identified as having hearing or vision impairments, who require clear speech or lip-reading to access instruction.

Ensure additional protocols are in place to support the safe use of clean face coverings.

- Staff and children wearing face coverings should bring multiple clean coverings each day, as feasible.
- Child care facilities are encouraged to have face coverings available to staff, children, and essential visitors in the event they forget or soil their face coverings.
- Staff and children must exercise caution when removing the face covering, always store it out of reach of other children, and wash hands immediately after removing. Be careful not to touch eyes, nose, or mouth while removing the covering.
- Face coverings 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 covering can be stored between uses in a clean sealable paper bag or breathable container. They 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 coverings should be stored in a space designated for each child that is separate from others. Children's face coverings should also be clearly identified with their names or initials to avoid confusion or swapping. Children's face coverings 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 coverings and should ensure they are removed and stored safely.
- The benefit of a face covering is to limit the spread of secretions by stopping individuals from touching their mouth or nose, to limit spread if an individual has COVID-19, and to limit individuals from contracting COVID-19 if around a COVID-19 positive person. **If children play with their or others' face coverings or if they are not removed and stored safely, their use should be discontinued.**
- Children and staff should be taught to speak more loudly, rather than remove their face covering, if speaking in a noisy environment.

Please refer to DC Health's [Guidance About Masks and Other Face Coverings for the General Public](#) and [Mayor's Order 2020-080: Wearing of Masks in the District of Columbia To Prevent the Spread of COVID-19](#) for more details on face covering requirements for all District residents and visitors.

Note: Face coverings or masks with exhalation valves or vents must 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).

Further guidance from CDC on the use of face coverings, including instructions on how to make and safely remove a cloth covering, is available [here](#) and [here](#).

G. HYGIENE

Child care providers must follow the below hygiene practices to help keep child care facilities clean and safe:

- 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 covering](#).
- Ensure adequate supplies (e.g., soap, paper towels, hand sanitizer, tissues) to support healthy hygiene practices.
- Teach and model good hygiene practices, including covering coughs and sneezes with an elbow or tissue and washing hands with soap and water for at least 20 seconds.
- Handwashing must take place frequently throughout the day, including:
 - 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 cloth face coverings or touching your face;
 - After going to the bathroom or changing a diaper;
 - Before eating, handling food, or feeding a child;
 - After blowing or supporting a child with blowing their nose, coughing, or sneezing;
 - Before and after staff gives medication to a child;
 - After handling wastebaskets or garbage;
 - After playing on outdoor or shared equipment; 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 is to be used. This should only be used by a child under very close observation from a staff person or parent/guardian and following the manufacturer's instructions.
- Child care staff that work with very young children must take additional steps. While washing, feeding, or holding infants or very young children, staff must:
 - Wear a non-medical (cloth) face covering;
 - Pull long hair off of neck, as in a ponytail;
 - Wear a gown/coverall⁵;
 - Remove and wash their clothing and/or the child's clothing if touched by any secretions;and

⁵ The coverall may be a large, button-down, long-sleeved shirt.

- Wash their hands, arms, or body if touched by secretions or after handling soiled clothes.
- Additional PPE requirements 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.

To the extent feasible, child care facilities should:

- Increase air circulation where safe and possible and ensure ventilation systems are operating properly.
- Ensure 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 and disinfect 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 must be used, they must be cleaned and sanitized frequently.
- Encourage staff and children to cover coughs and sneezes with a 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.
- Install no-touch fixtures: automatic faucets and toilets; touchless foot door openers, touchless trashcans; sensor water bottle fillers.

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

Child care providers must:

- *[UPDATED]* Routinely clean and disinfect surfaces and objects that are frequently touched; at a minimum, high-touch surfaces must be cleaned and disinfected daily, and as often as possible. This may include cleaning objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, classroom sink handles, countertops).
 - For an example schedule for routine cleaning, sanitizing, and disinfecting child care facilities and guidance for selecting cleaning products, please refer to [OSSE's Supplementary Guidance for Cleaning, Sanitizing, and Disinfecting Child Care Facilities](#).
 - If child care providers adopt a rotating in-person schedule, enhanced cleaning and disinfection must occur between cohorts.
 - Use [EPA-approved disinfectants effective against SARS-CoV2 \(COVID-19\)](#). When feasible, preference should be given to products with [asthma-safer ingredients](#) (e.g., citric acid or lactic acid), as recommended by the US EPA Design for Environment Program.
 - For detailed descriptions of the terms "cleaning," "sanitizing," and "disinfecting" please refer to [Caring for Our Children Appendix J: Selecting an Appropriate Sanitizer or Disinfectant](#).
 - For all cleaning, disinfecting, and sanitizing products, follow the manufacturer's instructions for concentration, application method, contact time, and drying time before use by a child. Ensure safe storage of all cleaning products. See [OSSE's Supplementary](#)

[Guidance for Cleaning, Sanitizing, and Disinfecting Child Care Facilities](#) and [CDC's guidance for safe and correct application of disinfectants](#). Dirty surfaces must be cleaned with a detergent or soap and water before disinfection.

- Custodial staff, as well as classroom educators and other staff who may be cleaning and disinfecting spaces throughout the building, must adhere to PPE requirements as articulated in Appendix B.
- Limit use of shared objects and equipment (e.g., gym or physical education equipment, art supplies, toys, games). If shared objects or equipment must be used, to the extent feasible, clean, disinfect, and when appropriate sanitize between uses.
- **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 must be cleaned, disinfected, and sanitized prior to use by another group.
- **Mats/cots/cribs and bedding** are to be individually labeled and stored.
 - Mats/cots/cribs must be arranged head to toe and to allow at least 6 feet of distance, head to head, between children. Mats/cots/cribs must be cleaned and sanitized between uses.
 - Bedding must be washable and washed at least weekly or before use by another child.
 - Mats/cots may be stacked between uses if they are cleaned and sanitized appropriately before stacking.
- **Playground structures** must be included as part of routine cleaning. High touch surfaces, e.g., handlebars, should also be disinfected.
- Providers must place signage in every classroom reminding staff of cleaning protocols.
- **[UPDATED]** 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 aftercare, 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 must 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 must adhere to PPE requirements articulated in Appendix B.

In addition to these routine cleaning requirements, the following protocols apply in circumstances where children, staff, or essential visitors become ill:

- **Child, staff member, or essential visitor develops symptoms of COVID-19** throughout the day but **is not** confirmed to have COVID-19:
 - Immediately rope off or close, then clean and disinfect areas and equipment in which the ill individual has been in contact.
 - Once the room is vacated at the end of the day, perform deep cleaning and disinfection of 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.*
 - Staff supporting, accompanying, or cleaning up after a sick child must adhere to PPE requirements as articulated in Appendix B.
- **Child, staff member, or essential visitor is confirmed to have COVID-19:**
 - If seven days or fewer have passed since the individual who is sick used the facility, follow these steps:
 - Close off areas used by the individual who is sick.
 - *[UPDATED]* Note: Such areas must be immediately roped off or closed if it is during the day when the COVID-19 case is confirmed AND the COVID-19 positive individual is in the building. If it is during the day when the COVID-19 case is confirmed AND the COVID-19 positive individual was appropriately excluded from in-person activities while awaiting test results, it is acceptable to close, clean, and disinfect the spaces used by the COVID-19 positive individual after the children and staff in those spaces leave for the day.
 - Open outside doors and windows to increase air circulation in the areas.
 - Wait 24 hours or as long as possible before cleaning or disinfecting to allow respiratory droplets to settle.
 - Clean and disinfect all areas used by the individual who is sick, such as classrooms, bathrooms, and common areas.
 - If more than seven days have passed since the individual who is sick used the facility, additional cleaning and disinfection is not necessary. Continue routine cleaning and disinfection.
 - Staff conducting cleaning must adhere to PPE requirements as articulated in Appendix B.

To the extent feasible, child care providers should:

- Place signage in every room reminding staff of cleaning protocols.
- Avoid using cleaning products near children and ensure adequate ventilation when using these products. Children must not participate in disinfection.
- Increase air circulation only where safe and possible and ensure ventilation systems are operating properly.
- **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.

- If transport vehicles (e.g., vans or buses) are used by the child care facility, drivers must practice all safety actions and protocols as indicated for other staff (e.g., hand hygiene, non-medical (cloth) face coverings).

I. HIGH-RISK INDIVIDUALS [UPDATED]

Child care providers must 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.

- People with the following conditions **are at increased risk** of severe illness from COVID-19:
 - Cancer,
 - Chronic kidney disease,
 - COPD (Chronic obstructive pulmonary disease),
 - Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies,
 - Immunocompromised conditions,
 - Obesity (Body Mass Index (BMI) of 30 kg/m² or higher but less than 40 kg/m²),
 - Severe obesity (BMI greater than or equal to 40 kg/m²),
 - Pregnancy,
 - Sickle cell disease,
 - Smoking, and
 - Type 2 diabetes mellitus.

A complete list of conditions that might place an individual at increased risk for severe illness from COVID-19 is available [here](#).

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

All child care providers must serve meals following the physical (social) distancing and hygiene guidance articulated in the guidance:

- All meals must be served in individual classrooms to avoid large group gatherings, and maximize space between children during meals;
- Meals must be served individually. If meals are typically served family style or via self-service stations (such as hot bars and salad bars), 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 and may not share utensils, cups, or plates;
- Staff must wash hands before and after preparing food and after helping children to eat;
- Staff must follow all PPE requirements in Appendix B and as required per food safety regulation or requirements, including wearing gloves whenever handling food products and changing gloves and washing hands when changing activities;

- Tables and chairs must be cleaned and sanitized before and after the meal;
- If handling individual lunch boxes, staff must 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 must 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);
- Use disposable foodservice items (e.g., utensils, dishes). If disposable items are not feasible or desirable, ensure that all non-disposable foodservice items are handled with gloves and washed with dish soap and hot water or in a dishwasher; and
- Observe all other local and federal food safety guidelines.

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

RESPONSE

K. EXCLUSION, DISMISSAL, AND RETURN TO CARE CRITERIA AND PROTOCOLS [UPDATED]

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

[UPDATED] Exclusion Criteria

A child, staff member, or essential visitor **must stay home, or not be admitted**, 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-19.⁶
- Are awaiting COVID-19 test results, or have a close contact who is awaiting COVID-19 test results.⁷
- Have traveled in the last 14 days to any place other than Maryland, Virginia or a low-risk state, country, or territory, unless they received a negative COVID-19 PCR test after limiting daily activities for at least three to five days after returning from travel.

Children or staff with pre-existing health conditions that present with specific COVID-19-like symptoms should not be excluded from entering the building on the basis of those specific symptoms, if a

⁶ The 10-day quarantine recommendation is intended to minimize the risk of transmission of the virus while also minimizing the burden of quarantine. Recent DC Health guidance allows for child care providers to continue to implement the more stringent 14-day quarantine requirement if they choose to. Fourteen days of quarantine 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) quarantine for 14 days.

⁷ This quarantine guidance applies in all cases except in the circumstance of formal screening or surveillance testing. 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 and quarantine requirements of their umbrella organization. Child care providers wishing to implement a screening or surveillance program in consultation with their health services provider must develop a testing plan and share that plan with the Deputy Mayor for Education and OSSE teams at EdSupport@dc.gov.

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.

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

[NEW] 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 themselves does not have symptoms. All members of the household should be tested at the same time.

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 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 cloth (non-medical) or surgical face covering, if not wearing already.
 - Notify the child's parent/guardian of the symptoms and that the child needs to 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 must comply with PPE requirements 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.

[UPDATED] **Isolation Room:** Providers must identify a 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 non-medical (cloth) face covering 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. Isolate only one sick individual in the isolation area at a time. The isolation area must be immediately cleaned and disinfected after the sick individual departs. Supervising staff must comply with the PPE requirements in Appendix B.

***[UPDATED]* Return Criteria**

Table 1 below identifies the criteria that child care providers must 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) close contact with an individual awaiting COVID-19 test results; or (7) travel to any place other than Maryland, Virginia or a low-risk state, country, or territory.

Table 1. Return to Care Criteria for Children and Staff [UPDATED]

Child or Staff Member With:	Criteria to Return <i>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.</i>
<p>1. COVID-19 symptoms (e.g., fever, cough, difficulty breathing, loss of taste or smell) [UPDATED]</p>	<p>Recommend the individual seek healthcare guidance to determine if COVID-19 testing is indicated.</p> <p>If the individual is tested:</p> <ul style="list-style-type: none"> • If positive, see #2. • If negative, see #3. • Individuals must quarantine while awaiting test results. <p>If the individual does not complete test, they must:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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 ○ At least 10 days from when symptoms first appeared, whichever is later. <p>Note: Children or staff with pre-existing health conditions that present with specific COVID-19-like symptoms may 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.</p> <p>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.</p> <p>[NEW] 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 themselves does not have symptoms. All members of the household should be tested at the same time.</p>
<p>2. Positive COVID-19 Test Result</p> <p>(Antigen or PCR Test) See DC Health’s Guidance for Persons</p>	<p>If symptomatic, may return after:</p> <ul style="list-style-type: none"> • 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 • At least 10 days* after symptoms first appeared, whichever is later.

<p>Who Tested Positive for COVID-19 for more information</p>	<p><i>*Note: Some individuals, including those with severe illness, may have longer quarantine periods per DC Health or their healthcare provider.</i></p> <p>If asymptomatic, may return after:</p> <ul style="list-style-type: none"> • 10 days from positive test. <p>Regardless of whether symptomatic or asymptomatic, close contacts (including all members of the household) must quarantine for at least 10 days from the last date of close contact with the positive individual.</p>
<p>3. Negative COVID-19 Test Result After Symptoms of COVID-19 [UPDATED]</p>	<p>May return when:</p> <ul style="list-style-type: none"> • Meet standard criteria to return after illness. • If the individual received a negative antigen test, that result must be confirmed with a negative PCR test. The individual must quarantine until the PCR test result returns. <p>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.</p> <p><i>*Per Scenario #5, a negative test result after close contact with an individual with confirmed COVID-19 does <i>not</i> shorten the duration of quarantine of at least 10 days.</i></p>
<p>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)</p>	<p>May return when:</p> <ul style="list-style-type: none"> • Meet standard criteria to return after illness. <p>Note: Standard criteria to return after illness refers to the individual school’s existing policies and protocols for a student or employee to return to school after illness.</p>
<p>5. Close Contact of an Individual with Confirmed COVID-19 [UPDATED]</p> <p><i>See DC Health’s Guidance for Contacts of a Person Confirmed to have COVID-19 for more information</i></p>	<p>May return after:</p> <ul style="list-style-type: none"> • A minimum of 10 days from last exposure to COVID-19 positive individual, provided that no symptoms develop, or as instructed by DC Health. <p>Note: Ending quarantine after 10 days (on day 11) is only acceptable if:</p> <ul style="list-style-type: none"> • The close contact did not develop symptoms of COVID-19 at any point during the quarantine. AND • The close contact continues to self-monitor for symptoms until 14 days after the last exposure to the COVID-19 positive individual. <p>If the close contact is a household member:</p>

	<ul style="list-style-type: none"> • Isolate from the COVID-19 positive individual, then may return to care after quarantine of at least 10 days from last exposure to the COVID-19 positive individual, or as instructed by DC Health. • If unable to isolate from the COVID-19 individual, may return to care after quarantine of 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. <p><i>[NEW]</i> The 10-day quarantine recommendation is intended to minimize the risk of transmission of the virus while also minimizing the burden of quarantine. Recent DC Health guidance allows for child care providers to continue to implement the more stringent 14-day quarantine requirement if they choose to. Fourteen days of quarantine remains the most effective strategy for decreasing the transmission of COVID-19.</p> <p>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.</p> <p><i>[NEW]</i> 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 themselves does not have symptoms. All members of the household should be tested at the same time.</p>
<p>6. Close Contact of an Individual Awaiting a COVID-19 Test Result⁸ <i>[NEW]</i></p>	<p>If the close contact tests negative:</p> <ul style="list-style-type: none"> • May return immediately if the child or staff member has no symptoms of COVID-19 nor other exclusionary criteria met. <p>If the close contact tests positive:</p> <ul style="list-style-type: none"> • See Scenario #5.
<p>7. Travel to Any Place Other than Maryland, Virginia or a Low-Risk State, Country or Territory <i>[UPDATED]</i></p> <p><i>See DC Health’s Guidance for Travel and the CDC’s COVID-19 Travel Recommendations by</i></p>	<p>May return after:</p> <ul style="list-style-type: none"> • Self-monitoring and limiting daily activities—including not attending child care – for 14 days. <p>OR</p> <p>Self-monitoring and limiting daily activities – including not attending child care – until tested for COVID-19 (within three to five days after return) and receive a negative result</p>

⁸ This quarantine guidance applies in all cases except in the circumstance of formal screening or surveillance testing. 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 and quarantine requirements of their umbrella organization. Child care providers wishing to implement a screening or surveillance program in consultation with their health services provider must develop a testing plan and share that plan with the Deputy Mayor for Education and OSSE teams at EdSupport@dc.gov.

Destination for more information	
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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 and test results are 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.

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 should 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.

[UPDATED] Step 1: Reporting to OSSE and DC Health

[NEW] Refer to DC Health's [First Steps for Non-Healthcare Employers when Employees Test Positive for COVID-19](#).

The facility must follow existing procedures for reporting communicable disease. 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 or date of test if asymptomatic, and typically ends 10 days after symptom onset/test date.

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**.

[UPDATED] Only notify DC Health for a **confirmed** COVID-19 case, not before results come back. 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. 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.

Note: While child care providers await a response from DC Health, plans should be made as soon as practical to close, clean, and disinfect any areas or equipment that the COVID-19 positive individual may have used in the last seven days (see Step 3). If it is during the day when the COVID-19 case is confirmed AND the COVID-19 positive individual was appropriately excluded from in-person activities while awaiting test results, it is acceptable to close, clean, and disinfect the spaces used by the positive individual after the children and staff in those spaces leave for the day. If it is during the day when the COVID-19 case is confirmed AND the positive individual is in the building, the individual and their cohort must be dismissed as soon as practical. The cohort should remain in their classroom and follow routine procedures while they await pick-up from caregivers.

***[UPDATED]* Step 2: Communication to Families and Staff**

Child care providers must 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. It is not the responsibility of the provider to define those who must quarantine. Communication is to be completed, per DC Health directive and will include:

- Notification to the entire program or the affected classroom that there was a COVID-19 positive case, those impacted will be notified and told to quarantine, 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;
- Information on options for COVID-19 testing in the District of Columbia, available at coronavirus.dc.gov/testing; and
- Information for facility staff on accessing priority testing at the public testing sites, including the location of public testing sites, available at coronavirus.dc.gov/testing. Child care facility staff

may identify to testing site staff that they are educators or child care staff to receive priority. Priority does not affect the turnaround time for receiving test results.

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

In the event of a confirmed COVID-19 case in a child, staff member, or essential visitor, the provider must immediately follow all steps outlined by DC Health as well as cleaning, disinfection, and sanitization guidance from the CDC, linked [here](#):

- If **seven days or fewer** have passed since the individual who is sick used the facility, follow these steps:
 1. Close off areas used by the individual who is sick.
 - Note: Such areas must be immediately roped off or closed if it is during the day when the COVID-19 case is confirmed AND the COVID-19 positive individual is in the building. If it is during the day when the COVID-19 case is confirmed AND the COVID-19 positive individual was appropriately excluded from in-person activities while awaiting test results, it is acceptable to close, clean, and disinfect the spaces used by the positive individual after the children and staff in those spaces leave for the day.
 2. Open outside doors and windows to increase air circulation in the areas.
 3. Wait 24 hours or as long as possible before cleaning or disinfecting to allow respiratory droplets to settle.
 4. Clean and disinfect all areas used by the individual who is sick, such as classrooms, bathrooms, and common areas.
- If **more than seven days** have passed since the individual who is sick used the facility, additional cleaning and disinfection is not necessary. Continue routine cleaning and disinfection.
- Staff conducting cleaning must adhere to PPE requirements as articulated in Appendix B.

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 [UPDATED]

[UPDATED] 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 must adhere to the following guidance:

In the event a staff member must take another individual's temperature, they must 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:**
 - Ensure that you 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 requirements.
 - 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.

- **[UPDATED] 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.⁹
 - **Take the individual's temperature.**
 - If performing a **temperature check on multiple individuals:**
 - Ensure that you 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.

⁹ The coverall may be a large, button-down, long-sleeved shirt.

APPENDIX B: PPE REQUIREMENTS FOR CHILD CARE STAFF [UPDATED]

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

Note: Staff and children must practice good hand hygiene throughout all of the scenarios and maintain physical distance of 6 feet to the maximum extent feasible.

Wearing gloves is not a substitute for good hand hygiene. Gloves must 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 must be immediately removed and changed.

WORKING WITH CHILDREN WHO ARE NOT KNOWN OR NOT SUSPECTED TO HAVE COVID-19

Lower Risk:¹⁰ *Six feet of physical distance cannot always be maintained. Close contact with secretions or bodily fluids is not anticipated.*

- Non-medical (cloth) face covering

Medium Risk:¹¹ *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.*

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

¹⁰ 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 coverings. 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 covering, maintain 6 feet of physical distance *and* are not performing a physical temperature check.

¹¹ 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 non-medical (cloth) face covering, pull long hair off of neck, and wear a large, button-down, long-sleeved shirt or coverall.

[UPDATED] 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.¹²

- N95 mask (with access to Respirator Fit Testing Program)¹³
- 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 must 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 covering (non-medical (cloth) or surgical mask) and is able to maintain 6 feet of distance, the accompanying staff must wear:
 - Non-medical (cloth) face covering
- If the sick child is not wearing a face covering (non-medical (cloth) or surgical mask) or is not able to maintain 6 feet of distance, accompanying staff must wear:
 - Surgical mask
 - Eye protection (face shield or goggles)
 - Gown/Coverall
 - Gloves

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

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

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

¹² 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](#).

¹³ 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](#).

[UPDATED] PPE FOR STAFF WITH SPECIFIC ROLES

[NEW] Staff Administering a COVID-19 Test

- N95 mask (with access to Respirator Fit Testing program)¹⁴
- Eye protection (face shield or goggles)
- Gown/coverall
- Gloves

[UPDATED] Custodial Staff

- Non-medical (cloth) face covering
 - 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 needed 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 non-medical (cloth) face covering and gloves. Other PPE may be needed 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

- Non-medical (cloth) face covering
- Gloves (when handling food products)
- Additional PPE may be required per food preparation regulation and requirements

Performing Physical Temperature Check: per Appendix A

¹⁴ 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 [NEW]

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-19.¹⁵

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.¹⁶

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.¹⁷

TESTING RECOMMENDATION

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

DC Health does not recommend screening or surveillance testing in the child care setting. 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 and quarantine requirements

¹⁵ 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](https://www.cdc.gov/coronavirus/2019-ncov/lab/pooling-procedures.html).

¹⁶ Ibid.

¹⁷ Ibid.

of their umbrella organization. Child care providers wishing to implement a screening or surveillance program in consultation with their health services provider must 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.
- Child care facility staff may access priority testing at the public testing sites by identifying to testing site staff that they are an educator or child care staff.
 - Note: Priority does not affect the turnaround time for receiving test results.