

# COVID 19 Safety Precaution Plan

## WomanCare Acupuncture & Herbs

New York State's rollout of Forward NY [forward.ny.gov](https://forward.ny.gov) (Business Safety Precautions) has outlined specific factors to be included in plans documented for businesses to reopen. A business must create, document and implement a plan that address the following three (3) factors:

1. Protection for employees and customers
2. Changes to physical workspace
3. Implementation of processes to meet changing public health obligations

The following worksheet is intended for Acupuncture practices to develop an appropriate Safety Precaution Plan as required by NYS.

**Name of Business** : Emily Rieffel, L.Ac., DBA WomanCare Acupuncture & Herbs

**Industry Category for Reopen Phase** : Essential services / Healthcare Services

**Business structure** : Sole Proprietor

**Number of Employees** : 1

### Protection for employees and patients

**1. Describe adjustments to hours of operations and shift design to reduce the density of people in the office.**

Hours of operation for seeing patients in the office will be limited, and will include shifts with significant breaks between them. Monday & Thursday 8:30am-1:15am, Wednesday 1-4pm. These shifts will allow for patients to be appropriately staggered across 2 separated treatment rooms in shifts with time between patients in each room and at the end of the shift to thoroughly clean.

**2. Describe additional social distancing protocols implemented for employees (consider office workspace, interaction with patients, schedules,...)**

I am self-employed with no other employees. I share a building with another business owner, who occupies a separate space, separated by a door which will remain closed.

Our entrances and exits are separate. If we happen to need the shared kitchen, we will maintain social distancing and wear masks.

Telephone scheduling, online invoicing and payment options have been instituted to reduce the need for patients to approach the desk for long periods and reduce social interaction between employees and patients.

Practitioners and patients will be required to wear appropriate masks at all times when interacting with each other in both treatment rooms and at the reception desk.

**3. Describe additional social distancing protocols implemented for patients (consider waiting and reception areas, bathrooms, treatment spaces, scheduling, payment methods...)**

Seeing only one patient in the office at a time facilitates maximal social distancing.

The practitioner will meet each patient at the door, where they will immediately sanitize their hands with the provided touch-less, wall-mounted hand sanitizer.

Next the patient will be screened for COVID-19 symptoms as well as with a touch-free forehead thermometer and a pulse oximeter. They will then be escorted immediately into a treatment room.

All unnecessary items have been removed from the waiting room, and upholstered chairs have been covered with washable covers or replaced with hard surfaces that are washable.

Patients will be asked to utilize the bathroom only if needed.

Treatment rooms are single occupancy and not shared with multiple patients. Rooms will be thoroughly cleaned and disinfected between patients.

As indicated above, masks for practitioners and patients are required at all times, check-in/out procedures, scheduling, and invoicing/payments have been switched to online methods to reduce time at the front desk.

**4. Describe methods implemented to reduce, limit, or otherwise restrict non-essential travel for employees (consider work-from-home options, inter-office travel for multiple locations, schedules...)**

This is a single-office practice and there is no travel expected during the work shift. I also have a home-office set up to do much of my administrative work from home, as applicable. Home office hours will include tasks including pre-screening, scheduling, and discussions with patients about their treatment plans and progress to reduce intake time during face-to-face interactions.

**5. Describe changes to service delivery implemented to reduce patient travel and time physically in the office. (Consider tele-health options, online invoicing/payment/scheduling...)**

Telehealth appointments via [doxy.me](https://doxy.me) are available each week and will be used as frequently as possible for patient herbal and acupuncture/moxibustion consults as well as initial intakes prior to physical appointment times, in order to reduce necessary face-to-face time in the treatment rooms.

Herbal formulae will be drop-shipped, or curbside pickup will be arranged on a case-by-case basis.

**Changes to Physical Workspace**

**1. Describe policies for the use of Personal Protection Equipment (PPE) to be used by employees (masks, gloves, office clothing,...) while in the office.**

Masks - practitioners will wear either N95/KN95 masks (as available) or disposable surgical masks at all times when interacting with others in the office. Patients will be required to also wear a mask at all times. They may utilize disposable surgical-style or cloth masks. Disposable surgical masks will be provided to them if they do not have their own upon arrival.

Gloves - Disposable nitrile gloves will be used during the entire patient encounter, including the acupuncture treatment, with the practitioner engaging in proper hand washing hygiene before and after each treatment and utilizing Clean Needle Technique as outlined in the CNT Manual. Gloves will be worn while cleaning/disinfecting the treatment rooms and office area, and while managing laundry.

Office Clothing - Practitioners will wear clean, freshly laundered clothing each day at work. Scrubs will be used as a new uniform. Scrubs/office clothing will be laundered at the end of the day. Lab coats or surgical gowns are not required for the risk level associated with private acupuncture practices.

**2. Describe specific plans for appropriate cleaning and sanitation protocols (references to regulatory authorities related to the Acupuncture Industry and local health department requirements as appropriate are helpful. Consider cleaning of surfaces, treatment spaces, bathrooms, equipment, office spaces, air quality, laundry, etc. Provide attachments for checklists used to document sanitation as appropriate for the office).**

Cleaning and sanitizing protocols are in place in accordance with the recommendations outlined by the [CCAOM Clinic Infection Control Advisory 2020](#) , which references current [CDC guidelines](#) as well.

Between each patient:

- High-touch surfaces in treatment rooms will be cleaned and sanitized between each patient using EPA-approved disinfectants used with proper contact and dwell times.
- Treatment tables are covered with cleanable vinyl that is disinfected between each patient and covered with table linens that are changed between each patient following proper laundry protocol (see below).
- Checklists for treatment room and bathroom cleaning/sanitizing will be utilized and initialed after each cleaning session, and filed in office records for documentation. (See attachment).
- Decorative rugs, drapes, and textile decorations in the treatment rooms have been removed.

Daily:

- Wooden floors in the treatment rooms and tile floor in the bathroom will be mopped daily, as required, with EPA-approved cleaner.

- Bathroom and high-touch surfaces in waiting room will be cleaned and sanitized using EPA-approved disinfectants used with proper contact and dwell times.

### **CDC Laundry Procedures**

- Wear gloves when handling used laundry. These gloves may be reusable rubber gloves. After use, disinfect gloves according to the manufacturer's instructions. Always wash hands before putting on and after removing gloves.
- Clean laundry should be stored outside of treatment rooms, or if inside treatment room, clean laundry should be stored in a closed cabinet or sealed container (not on an open shelf).
- No sheets, pillowcases, drapes, cloth heating pads, mattress pads, cloth pulse pillows, or blankets can be re-used in patient care without laundering between patients.
- Roll used laundry so that areas in direct contact with patients are on the inside. Do not carry used linens against the body.
- All laundry used in patient care should be isolated into a closed, leak-proof hamper after treatment. Use a disposable bag or reusable laundry bag to transport laundry and clean it with the laundry. Hampers should be disinfected daily.
- Commercial processing of clinic laundry is preferred. If you are processing laundry yourself, it must be processed separately from personal items. Do not shake out laundry before washing.
- Follow instructions from the washer/dryer manufacturer.
- Use hot water(70–80°CX10min)[158–176°F]) and an approved laundry detergent. Disinfectant is generally not needed.
- Dry linens completely in a commercial dryer.

### **3. Describe hand-washing policies for employees and patients.**

Patients and Practitioners are required to wash/sanitize hands immediately upon entering the facility, after treatment, after using the bathroom facilities, and before/after doffing/donning their mask. Practitioners additionally must wash hands or use sanitizer upon entering and leaving the treatment room, before and after treatment applications, before and after donning/doffing gloves, and before and after cleaning activities.

Posters/signs are posted at entry and bathroom to educate all on proper hand hygiene. (See handout)

## **Processes to meet changing public health obligations**

### **1. Describe pre-screening and day-of-appointment screening processes for employees and patients implemented to identify potential cases of COVID-19 (include attachments of scripts, checklists or protocols used in the office as appropriate).**

Pre-screening: Patients will be called 24 hours prior to appointments to confirm appointment and engage in pre-screening using attached script and checklist (see attached) as recommended by the CDC. Pre-screening checklists will be signed and stored in a daily pre-screening office file.

Day-of-Appointment Screening: Upon arrival, patients will be immediately screened for symptoms of illness using the attached screening checklist which includes body temperature with a forehead thermometer, oxygen saturation levels with a pulse oximeter, and questions about presenting signs or symptoms (see attached) as recommended by the CDC. Screening documentation will be included in the patient's chart.

### **2. Describe policies in place for employees and patients who do not pass pre-screening or screening protocols upon arrival (include resources given for contacting further medical care as appropriate and consider appropriate time-lines for individuals to be able to return to the office).**

Patients who do not pass one or more items on the pre-screening or screening checklist will be instructed that their appointment must be rescheduled and referred to their

primary care physician (PCP) for evaluation. If the patient does not have a regular primary care provider, they will be referred to their [local county health department](#) and/or the [NY COVID website](#) and hotline (1-888-364-3065). Patients will be followed up with via phone call to confirm contact with medical services has happened within 48 hours.

Patients will be given a report of findings from the screening to bring to their medical evaluation (see attached).

Patients will be given an educational handout about COVID19, and resources for self care (see attached).

Patients will be informed of the earliest date recommended for them to reschedule their appointment, and this date will be documented as a red flag in the patient's chart to prevent premature rescheduling.

### **3. Describe sick-leave policies for employees.**

As a solo practitioner who is self-employed, I do not receive paid "sick-leave". I will self-screen daily using the same screening checklist I use for my patients. If at any time I develop symptoms or have a suspected exposure to COVID 19, I will immediately cancel scheduled patients until I can be appropriately evaluated and/or tested. I will cancel appointments for the duration of time indicated by my PCP and the CDC depending on evaluation results.

### **4. Describe methods and resources used to remain current on local mandates and requirements.**

- Daily checks of the [Saratoga County Health Department webpage](#)
- Frequent checks of resources provided by state and local professional organizations:
  - [Acupuncture Society of New York \(ASNY\)](#)
  - [American Society of Acupuncturists \(ASA\)](#)
  - [National Certification Commission for Acupuncture and Oriental Medicine \(NCCAOM\)](#) - Continuing education classes as available
  - [Council of Colleges of Acupuncture and Oriental Medicine \(CCAOM\)](#) - provides updated documents including the [Clean Needle Technique](#) manual and

the [Clinic Infection Control Advisory](#) as well as other website resources.

**5. Describe resources used to educate employees and patients of the policies, circumstances, risks, and liabilities surrounding COVID19 and other infectious diseases (include documents, website links, postings, and handouts as appropriate).**

All Patients, new and current, will receive and sign the COVID19 Treatment Waiver (see attached).

Patient Handouts are developed and available for distribution as needed including the resource websites and documents developed by the CDC, and NY.gov (see attached)

Educational Signs are posted in waiting room, treatment rooms, bathroom, and at the reception desk as appropriate (see attached).

Copies of this plan are readily accessible upon request by patient or official, as well as posted on the WomanCare Acupuncture & Herbs website.

**6. Describe policy for frequency of review of this Safety Precaution Plan.**

This plan will be reviewed by me weekly during the official time of pandemic classification by NYS. Once this pandemic period is over, this plan will be reviewed annually in the fall of each year to prepare for the typical upcoming cold and flu season. This plan will be initialed and dated with each review and/or reprinted with a “Last reviewed” statement date on the plan for review documentation.

## **References used in this Safety Precaution Plan**

- NYS website: [New York Forward: NY Forward](#)
- CCAOM: [CCAOM Clinic Infection Control Advisory Emergence of COVID-19 What Acupuncture Clinics Should Do](#)
- CDC: [Information for Healthcare Professionals about Coronavirus \(COVID-19\)](#)
- County Health departments: [https://www.health.ny.gov/contact/contact\\_information/](https://www.health.ny.gov/contact/contact_information/)
- NYS Department of Health: [Novel Coronavirus \(COVID-19\) | Department of Health](#)
- ASNY: <https://asny.org/about/>
- ASA: <https://www.asacu.org/>
- NCCAOM: <https://www.nccaom.org/>
- CCAOM: <http://www.ccaom.org/>
  - CNT: [https://www.ccaom.org/ccaom/Clean\\_Needle\\_Technique.asp](https://www.ccaom.org/ccaom/Clean_Needle_Technique.asp)
  - CICA: <https://www.ccaom.org/images/ccaom/Documents/COVID-19/COVID-19%20Clinic%20Infection%20Control%20Advisory.pdf>

## **Attached Resources:**

- Cleaning Checklists for Treatment rooms
- Pre-Screening Checklist
- Day-of-Appointment Screening Checklist
- COVID 19 Treatment Waiver
- Entry Signage

\*This document is a living plan, intended to be reviewed regularly and subject to change according to the changes in the environment and local, state, and national regulations.

## **PRE-SCREEN SCRIPT AND CHECKLIST**

Telephone Script: Hello, my name is \_\_\_\_\_ and I am confirming your appointment on \_\_\_\_\_. I also have to do a quick COVID19 check before you come in. Thanks for your patience.

**In the past 14 days, have you experienced any newly developed signs of:**

*(indicate “yes” answers with a check or x)*

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Repeated shaking with chills
- Headache
- Loss of taste or smell
- Muscle pain
- Sore throat

**Y / N: Have you had close contact with someone diagnosed with COVID-19, or suspected to have COVID-19?** (Close contact means being within 6 feet of the person for at least 15 minutes, or being exposed to their cough or sneeze).

If a patient responds “yes” to any of the above symptoms (2 or more), or suspects they have COVID19, apologize and cancel their appointment, and ask them to see their primary care doctor ASAP.

If they failed, be sure to document on your prescreening checklist and put a red flag in their chart on the date of failure.

It is also helpful to note earliest allowable return date as well (3 weeks). As an example:

**Positive COVID Prescreen 5/4/20**

**Return Date Allowed 5/25/20**

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# **ATTENTION**

IF YOU HAVE A FEVER, COUGH,  
SHORTNESS OF BREATH, OR ARE SICK,  
**PLEASE DO NOT ENTER.**

**INSTEAD CALL US AT: (518) 288-8431.**

IF YOU ARE SICK, WE OFFER ONLINE  
TELE-HEALTH APPOINTMENTS.

FOR MORE INFORMATION, VISIT:  
[www.womancare-acupuncture.com](http://www.womancare-acupuncture.com)

**THANK YOU FOR WEARING A MASK  
AT ALL TIMES UPON ENTRY.**

# COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

***To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)***

I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.

I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.

I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office.

I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:  
\*Fever \*Dry Cough \*Sore Throat \*Shortness of Breath \*Runny Nose \*Loss of Taste or Smell

I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train.

I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.

I have been offered a copy of this consent form.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature & Date

Witness Signature & Date

Guardian/ Parent Signature & Date

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