WA State DOC COVID-19 Screening, Testing, and Infection Control Guideline

Version 22

The purpose of this guidance document is to allow the Washington State Department of Corrections (DOC) to better respond to the emerging COVID-19 outbreak. This document covers screening, assessment, testing and infection control of patients housed in Washington DOC facilities. New information is italicized.

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Screening

1) **Patients presenting with symptoms prior to Health Services contact**: Direct the patient to immediately don a surgical mask, place them in an isolated area and contact Health Services.
2) **Intersystem intakes (Patient arriving from other than a DOC facility)**: All intersystem intakes coming into DOC facilities will have a temperature taken and will be asked the two screening questions listed below as a. and b. If any of the three screening items are positive, the patient should immediately don a surgical mask and be place in an isolated area.
3) Intersystem intakes originating from the community, such as patients from community custody field offices, work release, or community custody violators in jails will be screened prior to transport. If the patient screens positive they should be transported by staff in PPE including an N95 mask per the **Transportation of patients with suspected or confirmed COVID-19 disease** section below.
4) **Patients presenting with symptoms in Health Services:** Patients with symptoms concerning for COVID-19 should immediately don a surgical mask and be placed in an isolated area.
5) **Intrasystem intakes (Patients transferring to another DOC facility):** All intrasystem intakes should have a temperature taken prior to boarding and upon exiting the transport bus. If the patient has temperature greater

than 100.4F immediately direct the patient to don a surgical mask, place them in an isolated area, and contact health services.

6) **Active screening of staff:** All staff entering DOC facilities will be screened for signs and symptoms of COVID-19 with questions and a temperature check. Staff screening positive will not be allowed entry to the facility and will have follow up through the secondary staff screening process.

7) **Active screening of patients prior to entering Health Services**: All patients entering Health Services areas for scheduled or unscheduled care will be screened for signs and symptoms of COVID-19 with questions and a temperature check. Patients screening positive will immediately don a surgical mask and be placed in an isolated area for evaluation, according to the Health Services Evaluation section below.

Health Services Evaluation

1) Any health care provider making contact with patients referred from the screening section above should don personal protective equipment listed below *before* the evaluation:
    a. Fit-tested N95 mask
    b. Gloves
    c. Eye protection defined as goggles or face shield
    d. Gown
    e. If not fit tested use PAPR instead of N95 *(if there is not an established procedure for disinfecting PAPR hoods at facility, the used hood should be disposed of).*
2) For instructions on proper donning and doffing of PPE see the following video and/or document. The purpose of this video is to demonstrate proper donning and doffing of PPE. For detailed guidance regarding appropriate PPE for each clinical situation, see the PPE matrix or the Infection Control and Prevention section of this document.
3) Nurse performs a clinical assessment, including temperature check, and asks the following 2 screening questions:
    a. Do you have a fever **OR** any new cough, shortness of breath, sore throat, diarrhea*, muscle aches that cannot be attributed to another cause*, or loss of taste/smell?
    b. Did you have contact with someone with possible COVID-19 in the previous 14 days?
4) If the answer to either screening questions is yes, or temperature is greater than 100.4F, notify a healthcare practitioner for further assessment:
    a. If a practitioner is available onsite, they will assess the patient clinically and decide whether symptoms are compatible with COVID-19 disease *or other influenza-like illness.* If yes, proceed to step C.
    b. If no practitioner is onsite, the nurse will discuss the patient's case with the practitioner.
    c. All patients screening positive for symptoms or fever who are placed in isolation should be tested for COVID-19 and other respiratory viruses as described in the Testing Procedure section below.
    d. Medical record should be reviewed to identify if the patient has any CDC designated high risk conditions
    e. The practitioner will determine the following:
        i. Level of care based on acuity
            1. To emergency department for severely ill patients
            2. To a negative pressure room for any non-severely ill patient if one is available and the patient requires IPU level care, under airborne medical isolation precautions.
            3. To a facility medical isolation unit for those with mild or moderate symptoms of influenza-like illness while awaiting test results.

4. *Symptomatic patients with influenza-like illness should NOT be transferred to a Regional Care Facility unless a positive COVID-19 test is confirmed.*

ii. Patients remaining in the facility will have the following diagnostic workup:

1. *During influenza season (October through the end of March) perform rapid influenza testing as available along with the first COVID-19 test*
2. *If the initial COVID-19 test and rapid influenza test is negative AND it is influenza season (October through the end of March) send a viral respiratory panel (Interpath # 2910) along with the second COVID-19 test*
3. Consider other diagnostic testing as clinically appropriate, i.e. chest x ray and *blood cultures for community acquired pneumonia and/or sepsis.*

iii. In the event that the patient is unable to be tested (for example if testing is declined) but for whom clinical suspicion remains, the patient should be isolated for presumptive COVID-19 disease.

iv. For further guidance on clinical care of patients with COVID-19 see National Institutes of Health COVID-19 Treatment Guidelines.

5) *Any patients presenting to Health Services for evaluation of influenza-like illness will not be charged a co-pay per the Washington DOC Health Plan.*

6) **For questions or consultation regarding evaluation or management of patients with suspected or confirmed COVID-19 call the DOC COVID medical duty officer phone: 564-999-1845**

Testing Procedure

1) *For influenza rapid point of care testing, follow test manufacturer testing instructions*
2) *For viral respiratory panel, follow Interpath lab testing instructions for test number 2910.*
3) COVID-19 Sample collection and testing:
   a) Upper respiratory samples appropriate for COVID-19 testing can include any of the following. Patient collected nasal anterior and mid-turbinate samples *are preferred.* All sampling techniques require synthetic tipped swabs, such as dacron, nylon, or polyester, without wooden handles:
      i) Nasopharyngeal (NP) swab:
         (1) NP swab sample collection is considered an aerosol generating procedure that requires the clinician to wear full PPE including an N95 mask.
         (2) Perform NP swab on both sides of the nasopharynx, with either one swab or two depending on composition of testing kit and swab availability
         (3) Please review the following nasopharyngeal swab sample collection guidance:
            (a) NP swab is clinician collected only
            (b) NP swab guidance document
            (c) NP swab demonstration video
      ii) Nasal mid-turbinate swab:
         (1) Nasal mid-turbinate swab can be clinician or patient collected.
         (2) Use a flocked tapered swab. Tilt patient's head back 70 degrees. While gently rotating the swab, insert swab less than one inch (about 2 cm) into nostril (until resistance is met at turbinates). Rotate the swab several times against nasal wall and repeat in other nostril using the same swab.
      iii) Anterior nares specimen swab:

(1) Anterior nares specimen swab can be clinician or patient collected.
(2) Using a flocked or spun polyester swab, insert the swab at least 1 cm (0.5 inch) inside the nares and firmly sample the nasal membrane by rotating the swab and leaving in place for 10 to 15 seconds. Sample both nares with same swab.

b) There are currently four options for COVID-19 testing:

i) **Washington State DOH/public health laboratory**:

(1) Refer to Washington DOH COVID-19 Specimen Collection and Submission Instructions for guidance on collecting, submitting, and shipping of test samples.
(2) When the decision is made to test patients for COVID-19 use the following lab testing equipment:
(a) Nasal swab (any of the three described above) in viral transport media testing tube is the preferred testing sample in all patients. Use only synthetic sterile swabs.
(b) Test sputum **if easily available** using a sterile specimen cup. Do not induce sputum in patients who are not producing sputum.
(3) Use the Washington State DOH Sample Submission Form to submit test samples to the state DOH lab.
(4) Write the provided PUI# on the submitter section of the submission form.
(5) Send samples via Federal Express pickup using supplied packaging that complies with the IATA/DOT regulations for shipping category B biological substances. Laboratory personnel can review the following guidance for more shipping information about shipping samples through Federal Express. Shipping labels will be provided for both testing laboratories.

ii) **Interpath Laboratory**:

(1) Testing through Interpath does not require specialized supplies for packaging and shipping as samples are picked up through the established Interpath lab courier.
(2) Collect COVID-19 specimen per Interpath Laboratories test collection guidance.

iii) **University of Washington Virology Lab**:

(1) Use the following testing instructions and the linked UW Virology COVID-19 test requisition.
(2) Send samples via Federal Express pickup using supplied packaging that complies with the IATA/DOT regulations for shipping category B biological substances. Laboratory personnel can review the following guidance for more shipping information about shipping samples through Federal Express. Shipping labels will be provided for both testing laboratories.

iv) **Northwest Pathology**:

(1) Enter the Northwest Pathology online portal, TestDirectly, to enter a testing order.
(a) Health Services staff must have pre-authorization to access this site. Contact Greg Miller to request site access.
(b) Fill out the online requisition form for patient testing.
(2) Collect COVID-19 specimen per Northwest Pathology test collection guidance.
(3) Ship test sample via FedEx. Pre-paid label, shipping containers and ice packs can be ordered in advance from the Washington Department of Health or by placing an order for shipping materials through the facility Logistics Section Chief. COVID-19 viral test kits should be ordered through the facility Logistics Section Chief.
(4) Test results are available through the Northwest Pathology online portal.

Infection control and prevention principles:

1) Definitions:

   a) **Medical isolation**: Separating a symptomatic patient with a concern for a communicable disease from other patients. Medical isolation status also applies to asymptomatic patients testing positive for COVID-19.

   b) **Quarantine**: Separating asymptomatic patients who have been exposed to a communicable disease from other patients through close contact.

   c) **Cohort**: Grouping patients infected with or exposed to the same agent together. Isolated and quarantined patients should NOT cohort together.

2) *The following recommendations should be made for prevention of COVID-19 :*

   a) All incarcerated individuals in facilities, including work releases, will wear DOC provided mandatory routine face coverings when out of cell or when within 6 feet of others

   b) Perform frequent hand hygiene

   c) Perform frequent cleaning of cell throughout the day

      (1) Highly <u>discourage</u> the use of bleach as this can exacerbate conditions for those patients with underlying lung disease

   d) Avoid contact of high-touch surfaces

   e) Limit movement in the facility

   f) Social distancing (staying at least 6 feet from others) should be maintained during Day Room, Yard, Gym, Dining Halls, Religious Services, Pill Line, and other areas where the incarcerated population congregates.

3) PPE <u>must</u> be changed between EVERY patient in isolation or quarantine any time there is close contact except in the following situations:

   a) Regional Care Facilities and tiers, units or pods of isolation units where ALL patients have a confirmed positive result for COVID-19:

      a) It is not necessary to change eye protection, mask/respirator, and gown between each patient.

      b) Hand hygiene and new gloves are still needed between each patient. This can be achieved by double gloving, removing the outer gloves, disinfecting the inner gloves, and putting on new outer gloves between patients.

      c) All PPE should be changed if visibly soiled.

4) Facility management of isolated/quarantined patients:

   a) If possible, cluster cases in medical isolation within in a single location/wing within the facility to help streamline ongoing assessments and delivery of services to the affected population

   b) If possible, medical isolation areas should not be located in units housing quarantined patients or general population individuals unless it has been confirmed by environmental analysis that isolation cells are under negative pressure and air is ventilated into the outdoors.

   c) If patients are in medical isolation or quarantine, allowances will be made to accommodate patients:

      a) Television, playing cards and/or other recreational activities will be provided

      b) There will be no cost to the patient for the duration of their stay

      c) All patients placed in medical isolation/quarantine will be issued hygiene kits and new clothing as needed

d) Provision of health care

   a) Routine health care will be provided at cell front.

   b) Medications will be given at cell front

   c) Insulin and other diabetic services will be given at cell front

   d) Routine mental health services will be provided at cell front

   e) Emergency medical needs will be assessed immediately by medical personnel, as required. Patient will be transported as deemed necessary if a higher level of medical care than can be delivered in the unit is required. There is not a medical indication for restraints during transport. Patient will don a surgical mask if it is not contraindicated.

e) Meals will be provided by Food Services and delivered to the cell.

   a) The Unit staff will notify Food Services at the beginning of each shift the number of meals that are needed

   b) Gloves will be worn when picking up used trays

f) Education Programs will be suspended

g) Phone Use in Medical Isolation and Quarantine:

   a) Phone Use in Medical Isolation and Quarantine for Areas WITH In-Cell Phone Use:

      (1) Staff shall don appropriate PPE:

         (a) Symptomatic patients with presumed or confirmed COVID-19: **N95 respirator, eye protection, gown, and gloves**

         (b) Asymptomatic patients with presumed or confirmed COVID-19: **surgical mask, eye protection, gown and gloves**

      (2) Staff shall cover the phone handset with a plastic sleeve and use tape/bands to cinch both ends to enclose the entire handset

      (3) Patient will wear a surgical mask, if they are medically able to do so

      (4) Staff shall pass the handset of the phone to the patient via the cuff port or an opening of the door if necessary

      (5) Staff shall have the patient wash his/her hands immediately after using the phone

      (6) Staff shall carefully remove the plastic sleeve from the phone and dispose of it in the garbage container

      (7) Staff shall remove PPE appropriately and then sanitize or wash hands as per protocol

      (8) Staff shall spray disinfectant over the entire phone, let it sit for 10 min., and put on new gloves before wiping it off

   b) Phone Use in Medical Isolation and Quarantine for Areas WITHOUT In-Cell Phone Use:

      (1) Facility will designate staff member to make weekly status update phone calls to person identified by patient

      (2) When a patient is placed into medical isolation, he/she shall be asked to provide the name and telephone number of a person for a weekly phone call, which will be provided to the designated staff person making the call

      (3) Designated staff will verify no current restrictions on contact exist prior to making call

(4) Designated staff will make call to identified person to notify of placement into medical isolation, as well as a weekly call to update on status

(5) Designated staff will note the call by placing a chrono in OMNI

h) **Showers in Medical Isolation and Quarantine**:

a) Patients in Medical Isolation and Quarantine will be allowed to maintain personal hygiene including showers according to the following:

(1) For patients in medical isolation showers should be offered starting on day 7 per custody unit schedule.

(2) For patients in quarantine, showers should be offered per custody unit schedule throughout duration of quarantine.

(3) These patients can be rotated, and must remain at least 6 feet apart.

(4) The patients must wear a **surgical mask** at all times while out of their cell.

(5) PPE for unit staff having close contact with patients:

(i) N95 mask, disposable gown, gloves, and eye protection

(6) The showers will need to be disinfected according to the manufacture's guidelines after each shower.

(7) Showers should not be vigorously scrubbed, deep cleaned, or power washed due to concern that these methods could cause virus to be aerosolized.

(8) PPE for staff or incarcerated individuals cleaning showers used by patients in Medical Isolation:

(a) surgical mask, disposable gown, gloves and eye protection

Infection Prevention and Control Categories:

Medical isolation:

1) Medical isolation status is indicated for patients in the following clinical situations:

a) Patients identified as having an influenza-like illness or other symptoms potentially caused by COVID-19.

b) Asymptomatic patients testing positive for COVID-19.

2) All patients placed into medical isolation for influenza-like illness will be tested for COVID-19

3) As soon as staff become aware that a symptomatic patient is suspected or confirmed as a COVID-19 case, staff should direct the patient to put on a surgical mask until the patient can be isolated.

a) Each housing unit and Shift Commander's office will maintain a supply of surgical masks

b) Surgical masks will be made available in clinic waiting rooms

c) Staff will work to isolate the patient and notify medical if they are identified outside the clinic

4) If the patient is off the living unit at the time COVID-19 symptoms are noted, staff working with the patient will notify the applicable housing unit that they are sending the patient back for single cell confinement until the patient can be assessed by medical

a) If a single room is not immediately available, confine the patient at least 6 feet away from others until they have been evaluated by medical

b) If the patient is already in the living unit, isolate the patient in their cell and notify medical

5) Droplet Precautions will be initiated:

a) Droplet Precaution Medical isolation signs will be hung outside the room at cell front

b) Proper PPE will be available outside the medical isolation cell or somewhere easily accessible

6) All staff must wash hands with soap and water or with alcohol sanitizer prior to entering a patient's cell and removing gloves.

7) All patients requiring medical isolation under this protocol who require ongoing use of aerosol generating medical treatments such as continuous positive airway pressure or nebulized bronchodilator treatment should be housed in negative pressure isolation rooms, if available, until release criteria have been met as described in Clinical Management of Medical Isolation Patients #3b below. If a negative pressure isolation room is not available, consult the COVID medical duty officer to discuss placement.

PPE for medical isolation:

1) In the following situations PPE will be comprised of an **N95 mask, eye protection, gown, and gloves:**
   a) Patients with suspected or lab confirmed COVID-19 while symptomatic with cough or sneezing.
   b) While performing diagnostic nasopharyngeal swab sample collection or any other potentially aerosol generating procedures.
2) In the following situations PPE will be comprised of a **surgical mask, eye protection, gown, and gloves:**
   a) When speaking with a symptomatic patient from outside of a medical isolation cell with an open door. Speaking to a patient from outside a medical isolation cell with the door closed does not require PPE other than general use face covering.
   b) Any patient who has tested negative for COVID-19 but remains in medical isolation and continues to be symptomatic
   c) Patients with suspected or lab confirmed COVID-19 without cough or sneezing.
   d) Asymptomatic patients who have tested positive for COVID-19.
3) All staff must wash hands with soap and water or with alcohol sanitizer after leaving a patient's cell and removing gloves.
4) A trash bin and bag, hand sanitizer, and gloves should be available immediately outside the cell or unit to assist staff in proper doffing of PPE.

Nursing and Unit Management of Patients on Medical Isolation Status:

1) Custody will work with medical staff to determine the best location to house patients on medical isolation status.
2) If single cell is not available, it is acceptable to cohort patients with COVID-19 together if they both/all have lab confirmed disease *and do not have* other communicable diseases concurrently (i.e. influenza or another viral respiratory disease).
3) Symptomatic isolated patients and asymptomatic COVID positive patients must be housed separately from asymptomatic exposed patients (quarantined).
4) If possible, avoid isolating patients with suspected or confirmed COVID-19 in cells with open bars.
5) As a general rule, isolated patients will not be allowed out of the cell unless security or medical needs require it
6) If an isolated patient needs to be out of their cell, they will don a surgical mask during the necessary movement
7) Staff will ensure that the patient goes where directed by communication between the sending and receiving area staff
8) Any pill line medications will be delivered by medical staff unless medical staff determines the need for a different protocol
9) A trash bin and bag, hand sanitizer, and gloves should be available immediately outside the cell or unit to assist staff in proper doffing of PPE.

Clinical management of medical isolation patients:

1) Patients isolated in a living unit with suspected or confirmed COVID-19 will have nursing assessments and vital signs at least every shift, *with consultation with* a practitioner as clinically indicated.
   a) Patients testing positive for COVID-19 who are symptomatic can be assessed once per day once they become asymptomatic for 24 hours. See #5 in this section for more information.
   b) Patients testing positive for COVID-19 who have never been symptomatic should be assessed twice per day throughout the isolation period. See #6 in this section for more information. If symptoms develop assess patient every shift as in number 1.a) above.
   c) For patients testing negative for COVID-19 once and positive for influenza refer to the Seasonal Influenza Protocol for continued management.
   d) For patients testing positive for both COVID-19 and influenza:
      i) The case should be discussed with the Facility Medical Director and COVID medical duty officer/infectious disease consultant
      ii) The patient should NOT be placed in a Regional Care Facility
      iii) The patient should remain in medical isolation for 14 days after becoming asymptomatic according to COVID-19 isolation criteria
      iv) Antivirals for influenza should be used if clinically appropriate
2) *Medical practitioners should document an assessment on all patients entering medical isolation for confirmed or suspected COVID-19 within one business day*
   a) If symptomatic, patients should be assessed by medical practitioner daily until asymptomatic for 24 hours.
   b) If asymptomatic, patients should be assessed by medical practitioner if there are any clinical concerns. Once the patient is thought to be symptomatic daily assessments by the medical practitioner should occur.
3) Patients with laboratory confirmed COVID-19 will remain in medical isolation until they have been asymptomatic for 14 days with the following exceptions:
   a) Patients with confirmed COVID-19 who are significantly immunocompromised may continue to shed contagious virus after the isolation period is complete. To prevent potential spread of COVID-19 disease from these patients additional time in medical isolation may be required.
      i) Any patient with significant immunocompromise by diagnosis or medication as determined by a medical practitioner will be discussed with the COVID medical group by calling the COVID medical duty officer phone prior to release from isolation in order to determine a strategy to ensure safe release from medical isolation.
   b) Patient with confirmed COVID-19 who require ongoing use of medical treatments that may aerosolize virus, such as nebulized bronchodilators and continuous positive airway pressure (CPAP) will require negative COVID testing prior to release from the negative pressure isolation room.
      i) Perform the first test on day 15 of medical isolation
      ii) The patient will remain in a negative pressure isolation room until they have tested negative for COVID-19 on two consecutive tests 48 hours apart. If the patient tests positive for COVID-19 retain in negative pressure isolation and repeat the test in 7 days.
4) Patients who tested negative for COVID-19, influenza, and other respiratory viruses will remain in medical isolation until:
   a) they have been asymptomatic for 14 days, unless they have a documented or confirmed alternative diagnosis that explains their symptoms, such as in the following example:
      i) Fever explained by infection at another site, such as UTI or cellulitis

b) **OR** they have been asymptomatic for at least 72 hours and have tested negative for COVID-19 twice with at least 48 hours between tests

5) Patients with symptoms isolated for suspected or confirmed COVID-19 disease who become asymptomatic:
   a) After an isolated patient is asymptomatic for 24 hours, the intensity of monitoring can be decreased to once daily temperature, *oxygen saturation*, and symptom checks at cell front. Patients with recurrence of symptoms should be evaluated by a medical practitioner.
   b) Recommended PPE for these asymptomatic medical isolation nursing checks will include **surgical mask, eye protection, gown, and gloves**.
   c) Unless transfer to a setting for a higher level of medical care is required, all medical care should be delivered in the patient's medical isolation cell.
6) Asymptomatic patients testing positive for COVID-19:
   a) Place in medical isolation for 14 days from the date of the positive test if the patient remains asymptomatic
   b) Continue nursing assessments two times per day, including temperature, oxygen saturation, and symptom checks at cell front to monitor for the development of symptoms.
   c) If the patient subsequently becomes symptomatic, follow the isolation criteria in Medical Isolation section below

Quarantine:

Patients who are asymptomatic but have been in close contact with confirmed or suspected COVID-19 patients should be placed on quarantine status.

PPE for staff interacting with quarantined patients:

1) Staff performing tier checks in open dorm style housing units should remain 6 feet away and have patients sit on their beds. PPE worn during these tier checks includes **gloves.**
2) Staff performing nursing or medical assessments on quarantined patients requiring close contact including in open dorm style housing units, should don the following PPE: **surgical mask, gown, eye protection and gloves.**
3) Staff interacting with quarantined patients in units with barred cells WITHOUT contact and staying at least 6 feet away do not require PPE other than a **routine face covering**.
4) Staff performing a temperature check through a closed cell door with an open cuff port should don the following PPE: **surgical mask, eye protection, and gloves**.

Nursing and Unit Management of Patients on Quarantine Status:

1) Quarantined patients can be housed alone or cohorted with other quarantined patients from the same exposure.
2) If the patient develops symptoms or fever, a full assessment should be done by entering the cell in PPE appropriate for symptomatic patients including full PPE with N95 mask.
3) Patients in quarantine should don a **surgical mask** anytime they leave their cell.
4) Any pill line medications will be delivered to the quarantined patient by medical staff unless medical staff determines the need for different protocol.
5) A trash bin and bag, hand sanitizer, and gloves should be available immediately outside the cell or unit to assist staff in proper doffing of PPE.
6) Unless transfer to a setting for a higher level of medical care is required, all medical care should be delivered in the patient's quarantine cell.
7) Signage indicating that the quarantine cells are under droplet precautions will be hung at the unit or tier level.

Clinical Management of Patients on Quarantine Status:

1) Asymptomatic patients are placed on quarantine status after being identified as a close contact of a symptomatic suspected or confirmed COVID-19 case, or an asymptomatic confirmed COVID-19 case.
2) Patients placed into quarantine status who are close contacts of confirmed (by a positive COVID test) cases will be tested for COVID-19 with a viral PCR test within *one business day* of the positive test result.
    a) Quarantine patients testing positive for COVID-19 or who become symptomatic will be transferred to medical isolation. Further management of these patients is described in the Asymptomatic Patients Testing Positive for COVID-19 section.
    b) Patients testing negative for COVID-19 will remain on quarantine status. They will be retested for COVID-19 on quarantine day #7.
        i) Patients testing negative for COVID-19 will remain on quarantine status until 14 days from the time of last contact with the index case has elapsed.
        ii) Patients who test positive for COVID-19 or become symptomatic will be transferred to medical isolation. Further management of these patients is described in the Asymptomatic Patients Testing Positive for COVID-19 section.
3) Close contacts of patients who test negative for COVID-19 may only be released from quarantine if the associated symptomatic patient tests negative for COVID-19 on two tests at least 48 hours apart:
    a) If repeat testing is not available, close contacts of patients testing negative once for COVID-19 may be released from quarantine 14 days after their last contact with the symptomatic patient per the Medical Isolation section above.
4) At a minimum, patients in quarantine will be assessed twice daily by nursing staff. The assessment will include a temperature check, oxygen saturation, and monitoring for development of any symptoms at a minimum. If the patient develops symptoms, fever, or oxygen desaturation while in quarantine, they will be assessed by a medical practitioner per Health Services Evaluation section step #3.
    a) For stand-alone camps, Health Services staff will determine scheduling to accommodate assessment of quarantined patients 7 days per week.
    b) If a quarantined patient develops symptoms of COVID-19, they will be immediately removed from quarantine, if they were housed with other asymptomatic patients, and placed into medical isolation. If cohorted with other asymptomatic patients, the quarantine period for those patients will be reset to day 0 of 14.
    c) If the symptomatic patient lived in dormitory-style housing, consider quarantining an entire dorm or wing of a housing unit. If multiple cases occur in the same living unit refer to the Outbreak Testing and Management section.
    d) Staff performing nursing assessments of patients in quarantine should do so by discussing development of symptoms and perform temperature check at the cell front after donning PPE outlined above. Assessments should be documented on 13-583 Influenza-Like Illness Assessment Flow Sheet.
        i) Disposable thermometers should be used by patients if available. If multi-use thermometers must be used, they should be disinfected in between patients.
5) Close contacts of patients who test positive for COVID-19 will remain in quarantine 14 days after the last exposure to the patient.
6) *All patients requiring quarantine under this protocol who require ongoing use of aerosol generating medical treatments such as continuous positive airway pressure or nebulized bronchodilator treatment should be housed*

in negative pressure isolation rooms, if available, until the quarantine period is completed. If a negative pressure isolation room is not available, consult the COVID medical duty officer to discuss placement.

Routine Pre-procedure COVID-19 Testing:

1) Community health care providers may require routine COVID-19 testing of asymptomatic patients prior to surgical or other procedures.
   a) Patients may be housed in their usual housing units without special quarantine or isolation procedures while awaiting test results.
   b) Staff interacting with these patients may do so without additional PPE other than a **routine face covering.**
   c) Patients testing positive should follow guidance above regarding asymptomatic COVID positive patients.

Intersystem Transfer Separation:

Intersystem transfer separation can include individuals entering or exiting DOC custody that require separation from the general population to reduce the potential risk of COVID spread

Intake separation:

1) This section applies to all intersystem intakes into DOC facilities, including:
   a) Community custody violators
   b) Patients arriving from county jails or other detention facilities
   c) Work release, GRE, or rapid reentry returns
2) Patients will be cohorted together based on day of arrival:
   a) After testing is initiated no new patients should be added to the cohort. The cohort should have no contact with other incarcerated individuals or other cohorts until the testing process is complete.
   b) If patients are added to arrival cohorts after the day of arrival the intake separation period resets to day 1 after the last addition to the cohort
3) Patients in these categories will be housed separate from the general population as a cohort after intake to the receiving facility
   a) Within 24 hours of arrival patients in intake separation will be tested for COVID-19
      i) If the COVID-19 test is negative and the patient is asymptomatic, the patient remains in intake separation and is re-tested on day 7 after intake. If the second test is negative, the patient can be released to the general population on day 10 post intake.
      ii) Patients becoming symptomatic or testing positive at either point will be transferred to medical isolation and managed according to protocol.
      iii) If a patient in an intake separation cohort tests positive for COVID-19, all patients testing negative from that cohort will be placed on quarantine status.
4) Additional PPE, other than a **routine face covering**, is not needed when interacting with asymptomatic patients in intake separation status.
5) If a patient in routine intake separation becomes symptomatic, they should enter medical isolation status and the remaining intake cohort should be placed in quarantine for 14 days.

Protective Separation

1) Housing units with a high concentration of individuals at high risk for severe COVID-19 may be placed on protective separation status in order to reduce the risk of introduction and transmission of virus.
   a) At the current time, the following units are on protective separation status:
      i) CRCC-Sage

ii) AHCC K unit
iii) All DOC facility inpatient units
iv) Other facilities or units if designated by Prisons Health Services Unified Command

2) Special direction to staff working on protective separation units:
   a) Only necessary and assigned staff should have access to this unit
   b) Staff must wash hands before entering and exiting the unit
   c) Staff will remove and store their routine face covering and don a new surgical mask prior to entering the unit.
   d) No staff interacting with quarantined and isolated individuals should be entering these units during their assigned shift
   e) Staff will wear a face shield over their surgical mask when in protective separation units
3) Special direction to incarcerated individuals living on special units:
   a) Individuals are restricted to their living unit
   b) Patients are provided a routine face covering for use at all times
   c) Patients are restricted from eating in main chow halls and meals are delivered to the living unit
   d) Individuals shall be given pill line at their cells
   e) Individuals should be allowed to self-quarantine if they choose
4) *All incarcerated individuals transferring into protective separation units, excluding facility inpatient units, will have 2 negative COVID-19 test results and a negative viral respiratory panel (no rapid influenza test is necessary). The second COVID test should be collected with the viral respiratory panel 7 days after the first COVID test.* The transfer should occur as soon as possible after the second test results are received. Incarcerated individuals should be screened the day of transfer utilizing the screening questions and temperature checks per protocol for intrasystem transfers.
   a) Patients transferring into *facility inpatient units* do not require testing prior to transfer:
      i) At arrival place transferring inpatients into single rooms if possible
      ii) After arrival patients should not have access to inpatient unit day rooms until they have had two negative COVID test results one week apart with one negative viral respiratory panel.

PPE Requirements for Prisons and Work Release Staff:

- **Tyvek suites** are not considered appropriate PPE for the purpose of this guideline and should not be used when contacting patients with suspected or confirmed COVID-19 or those on quarantine.
- Contact with asymptomatic individuals who are not on medical isolation or quarantine:
  a) **Gloves**
     i) Follow standard universal precautions
  b) **Routine face covering**
- Contact with individuals on medical isolation status:
  a) In the following situations **N95 mask, eye protection, gown, and gloves** should be worn:
     i) Contact with incarcerated individuals with suspected or lab confirmed COVID-19 while symptomatic with cough or sneezing
  b) In the following situations **surgical mask, eye protection, gown, and gloves** should be worn:
     i) When speaking with a symptomatic patient from outside of an medical isolation cell
     ii) Any contact with a patient who has tested negative for COVID-19 but remains on medical isolation

iii) Any contact with incarcerated individuals with suspected or lab confirmed COVID-19 without cough or sneezing.
iv) Any contact with incarcerated individuals who are asymptomatic but have tested positive for COVID-19.

c) In the following situations PPE will be comprised of **gloves**:
i) Passing items through a closed door cuff port and NO face to face contact
ii) If possible, avoid medical isolation in cells with open bars

- Contact with individuals on quarantine status:
  a) Open bay units:
     i) Close contact (ex. Temp check): **surgical mask, gown, gloves, eye protection**
     ii) No close contact (example walking through unit): **gloves**
  b) Dayroom/or other close quarters:
     i) Close contact (within 6 feet): **surgical mask, gown, gloves, eye protection**
     ii) No close contact (example walking through unit): **gloves**
  c) Pat searches:
     i) **Surgical mask, gown, gloves** (for every person pat searched), **eye protection**
  d) Closed door cells with *cuff port*:
     i) Passing items through cuff port and NO face to face contact: **gloves** only
     ii) No contact at all (talking through the door): **No PPE required**
     iii) Close contact: **surgical mask, gloves, eye protection**
  e) Bar cells:
     i) Close contact (ex. temp check): **surgical mask, gown, gloves, and eye protection**
- Staff active screening of patients or staff at entry into facilities, health services, or other :
  a) **Active screening without use of a protective barrier:**
     i) **Surgical mask, gown, gloves and eye protection**
     ii) **When an active screener should change PPE:** If a facility active screener comes within 6 feet of a staff member or patient that screens positive PPE should be removed and discarded, hand hygiene should be performed, and new PPE should be donned prior to resuming screening.
  b) **Active screening while using protective barrier:**
     i) PPE should consist of **gloves and routine face covering**
     ii) The screener should stand behind the protective barrier. Temperature should be taken by reaching around the barrier. The screener should ensure they are positioned so that the barrier blocks any potential respiratory droplets from the screened individual. If no contact was made between the screener and the screened individual, gloves do not need to be changed between screenings, unless they are visibly soiled or torn.
- All staff working in DOC locations must wear an approved face covering while on duty.
- Staff in protective separation units will wear a face shield over their surgical mask.
- Recommended personal protective equipment for both Health Services and Prisons/Work Release staff is summarized in the linked PPE matrix.

Environmental Cleaning

1) Enhanced frequency of cleaning and disinfection procedures of high touch surfaces is recommended for COVID-19 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.

2) Disinfectant must be:
   a) EPA-approved as a hospital/healthcare or broad spectrum disinfectant
   b) Contain quaternary ammonium
3) Management of laundry:
   a) Laundry from medical isolation or quarantine patients and cells will be placed in rice bags and transported in yellow bags. Contents should be washed/treated as infectious laundry.
4) Food service management:
   a) Meals for isolated and quarantined patients should be served in disposable clamshells. If trays are used, staff should wear gloves and wash hands before and after handling.
5) Medical waste from medical isolation and quarantined cells can be discarded using the regular waste disposal process.
6) Any individuals involved in cleaning rooms occupied by isolated suspected or confirmed COVID-19 cases, including DOC staff and employed incarcerated individuals, should wear the following PPE: **surgical mask, gown, eye protection and gloves**.
7) Any individuals involved in handling laundry and food services items of patients in medical isolation or quarantine, without entering the cell, should wear the following PPE:
   a) **Gown and gloves**
8) Rooms occupied by quarantined patients, who are moved prior to the complete 14-day period, should be similarly cleaned only by individuals wearing the following PPE: **surgical mask, gown, eye protection and gloves**.
9) Areas with potential COVID-19 exposure should not be scrubbed, deep cleaned, or power washed due to concern that these methods could cause virus to be aerosolized.
10) Areas with potential COVID-19 exposure should not be vacuumed due to the potential for vacuuming to aerosolize virus.

Outbreak Testing and Management:

This guidance describes management of COVID outbreaks in DOC facilities, including recommendations for mass testing and safe unit operation.

1) **Outbreak definition:** An outbreak within a DOC facility is defined as:

   a. Two or more confirmed cases of COVID in incarcerated individuals occurring within 14 days who reside in the same living area

   OR

   b. One or more confirmed cases of COVID in an incarcerated individual AND one or more confirmed cases of COVID in DOC staff working in proximity to the incarcerated individual case/cases occurring within 14 days

   c. Incarcerated individual COVID cases occurring in intake separation areas are not included in (a) above. Management of multiple cases in intake separation areas will be discussed with Prisons/Health Services Unified Command on a case by case basis.

2) *If two or more symptomatic patients test positive for influenza please refer to the Seasonal Influenza Protocol for ongoing management.*
    a. *If overlapping COVID-19 and influenza outbreaks occur in the same living area contact COVID medical duty officer or Infectious Diseases Consultant.*

3) **Contact tracing, quarantine, and testing:** Once an outbreak of COVID-19 has been identified the Infection Prevention Nurse (IPN), in cooperation with *the Occupational Nurse Consultant (ONC) and the facility mapping team, if staff cases are involved,* will perform contact tracing of suspected and confirmed COVID cases in order to identify close contacts and determine a recommendation for quarantining of individuals and living areas.
    a. This will be determined on a case-by-case basis considering environmental, clinical, and operational aspects of the scenario in coordination with Prisons/Health Services Unified Command.
    b. When contact tracing is complete the identified individuals and living areas will be placed on quarantine as indicated. This may occur at the unit level, multi-unit level or facility level, based on details of the contact tracing and potential for wider exposures throughout the facility.
    c. Patients testing positive for COVID will be moved to isolation or a Regional Care Facility (RCF) based on level of medical care needed.
    d. Testing of DOC staff should occur simultaneously with incarcerated individual testing in an outbreak setting to limit risk for re-introduction of COVID in populations that have tested negative.
    e. Staff working in outbreak areas will wear surgical mask and face shield at all times, unless the situation requires other PPE as directed elsewhere in this protocol, for example an N95 respirator replacing the surgical mask during close contact with a symptomatic patient.
    f. Patients in quarantined living areas will have symptom screening, temperature and oxygen saturation checks two times daily, and will be moved to isolation areas if they screen positive or become symptomatic.
    g. When symptomatic or COVID positive patients are moved to isolation from a quarantined unit, the remaining cohort will have its quarantine period reset to day 1.

4) **Unit operation and cohorting:** Incarcerated individuals in living areas on quarantine during an outbreak situation should be placed into distinct contact cohorts at the beginning of the quarantine period:
    a. Cohorts will be comprised of the smallest number of incarcerated individuals as is operationally feasible.
    b. Patients should not change cohorts through the duration of the quarantine period.
    c. Unit operations should be managed so that cohorts do not have contact with other cohorts in the quarantined unit or with any incarcerated individuals outside of the quarantined unit.
    d. If essential workers, such as porters, kitchen workers, or laundry workers from the quarantined unit/facility are needed to maintain prison operations the facility Incident Command Post (ICP) will discuss the situation with Prisons/Health Service Unified Command at the start of the quarantine to explore solutions for providing unit services while mitigating risk of transmission.
    e. Continuation of court-ordered programming, religious services and other prison movements outside of the quarantined area should be discussed with Prisons/Health Service Unified Command.
    f. No transfers should occur in or out of areas on quarantine during an outbreak.

5) Serial Testing and Outbreak resolution: In quarantined areas where COVID positive incarcerated individuals are identified from initial testing:
    a. Those testing negative initially will be re-tested as soon as initial test results are available, ideally within 48 hours.

b. Subsequent serial testing will be repeated every seven days until all incarcerated individuals in the quarantined area have two consecutive negative results.

c. Once serial testing results show that all incarcerated individuals in the living area have two negative tests AND they have been on quarantine status at least 14 days from their last contact with COVID positive or symptomatic patients, the living area can be removed from quarantine.

d. Prior to moving patients back into a quarantined living area during an outbreak situation, discuss with Prisons/Health Services Unified Command

Reuse of N95 Respirators:

Supplies of N95 respirators are in increased demand creating critical shortages during infectious diseases outbreaks. Existing CDC guidelines recommend a combination of approaches to conserve supplies while safeguarding health care workers in such circumstances. In these situations, existing guidelines recommend:

- Minimizing the number of individuals who need to use respiratory protection
- Using alternatives to N95 respirators where feasible
- Implementing practices allowing reuse of N95 respirators when acceptable during encounters with multiple patients

Reuse of N95 respirators:

1) Re-use can occur under the following conditions:
   a) N95 respirators must only be used by a single individual and should never be shared
   b) Use a full-face shield that covers entire extent of N95 respirator and/or surgical mask over an N95 to reduce surface contamination of the respirator. For aerosol generating procedures, both a face shield and surgical mask are necessary for re-use.
   c) N95 respirators can be reused up to five times before discarding.
   d) Keep used respirator in a clean dry paper bag between uses
   e) Write your name on the bag and elastic straps of the N95 so that the owner is clearly identified (Do not write on the actual mask)
   f) Use a new paper bag each time the respirator is removed
2) Always use clean gloves when donning a used N95 respirator and performing a user seal check.
3) Perform hand hygiene over gloves before touching or adjusting the respirator as necessary
4) Discard gloved after the N95 is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.
5) Perform hand hygiene. Anytime one touches the N95, perform hand hygiene again.

Do NOT reuse and DISCARD N95 respirators if:

1) The N95 respirator becomes visibly soiled with blood, respiratory or nasal secretions, or other bodily fluids
2) The N95 respirator becomes visibly damaged or difficult to breathe through
3) The straps are stretched out so they no longer provide enough tension for the respirator to seal to the face
4) The nosepiece or other fit enhancements are broken
5) If the inside of the respirator is touched inadvertently
6) The respirator was used during an aerosol generating procedure, except when the respirator is protected by a surgical mask as described below.

Donning and Doffing of N95 respirator:

Donning a NEW N95 respirator:

1) Perform hand hygiene
2) Remove routine face covering
3) Perform hand hygiene
4) Don gown
5) Don gloves
6) Don a new, fit-tested N95 respirator and adjust as necessary
7) Don a full face shield ensuring it fully covers both eyes and respirator
8) Perform patient care activities

Donning a USED N95 respirator:

1) Perform hand hygiene
2) Remove routine face covering
3) Perform hand hygiene
4) Don gloves
5) Remove the used N95 respirator from the paper bag by the straps
6) Don the respirator without touching the front of the mask
7) Sanitize gloves and adjust the mask for comfort and to ensure a good face seal
8) Remove gloves and perform hand hygiene
9) Don gown, new gloves, and full face shield

Doffing an N95 respirator:

1) When finished with patient care prior to leaving isolation area, remove gown and gloves and discard
2) Perform hand hygiene
3) Don new gloves
4) Leave isolation area
5) Immediately outside isolation area, remove gloves
6) Perform hand hygiene
7) Put on new gloves
8) Remove face mask by touching only the ear pieces
9) Remove respirator touching only the straps
10) Place respirator in a new, clean paper bag labeled with the user's name
11) Remove gloves
12) Perform hand hygiene
13) Put back on routine use mask

Release of Patients into the Community

1) Patients in medical isolation: For any patient with suspected or confirmed COVID-19 disease *or other influenza-like* illness in medical isolation who is releasing from a DOC facility, the Health Services Manager, Infection Prevention Nurse and Facility Medical Director will have a conference call with the COVID-19 medical duty officer (**564-999-1845)** prior to release for discussion of release planning.

2) Patients in quarantine: Upon release from DOC custody while on quarantine status, patients will be provided a surgical mask and will be directed to self-quarantine in their place of residence until the remainder of their 14-day quarantine period. Direction should be given that they should immediately report to their CCO via phone to arrange future reporting requirements.

Transportation of Patients with Suspected or Confirmed COVID-19 Disease

1) This section refers to transportation of patients under Washington DOC jurisdiction to or between DOC facilities who are confirmed or suspected (by a licensed medical provider) to have COVID-19 disease. This includes community custody violators, work release/GRE returns, and patients currently housed in DOC facilities.
2) No patient with confirmed COVID-19 disease will be transported into or between DOC facilities without approval of the CMO in consultation with the COVID-19 EOC.
3) When a unit or facility experiences an outbreak, transfers in and out of that unit will be suspended and the situation discussed with Prisons/Health Services Unified Command.
4) For any patients with confirmed or suspected (by a licensed medical provider) COVID-19 disease being transported into or between DOC facilities, custody officers, community custody officers, or other DOC staff in close contact with the patient will don the following personal protective equipment:
    a) A pair of disposable examination gloves
    b) Disposable medical isolation gown
    c) Any NIOSH-approved particulate respirator (i.e., N-95 or higher-level respirator)
    d) Eye protection
    e) If unable to wear a disposable gown or coveralls because it limits access to duty belt and gear, ensure duty belt and gear are disinfected after contact with individual.
5) Transportation staff should adhere to the following procedure when doffing PPE after transport of a patient with suspected or confirmed COVID-19:
    a) Transfer patient to custody of facility staff
    b) Doff PPE per protocol into nearest garbage can except for mask and sanitize hands
    c) Return to vehicle and don clean gloves
    d) Sanitize vehicle
    e) Doff PPE and sanitize hands
    f) Don routine face covering
6) The transport vehicle will be cleaned and disinfected after use.
7) For any patients on quarantine for contact with a suspected or confirmed COVID-19 case, DOC staff will don the following PPE:
    a) A pair of disposable examination gloves
    b) Disposable medical isolation gown
    c) Surgical mask
    d) Eye protection

1) Cases of suspected and confirmed COVID-19 will be thoroughly investigated by *the Infection Prevention Nurse (IPN) with assistance as needed from the facility mapping team to identify additional contacts within the facility for the IPN to further investigate:*

   a) Review the patient's cell and living unit location, job, classes, etc. to determine who could have been exposed and needs to be quarantined.

   b) If in the course of the contact tracing it is apparent that DOC staff may have had close contact with the confirmed or suspected COVID-19 case, the IPN will send an email with case details to the following Occupational Health email address: DOCoccupationalhealthandwellness@DOC1.WA.GOV

   c) The decision to classify a contact as close or high risk and requiring quarantine will be a clinical decision by the IPN taking into consideration the guidance described here. IPNs should strongly consider consultation with a *DOC Infectious Disease physician or designee* if any uncertainty exists regarding how to classify a contact with a suspected or confirmed COVID-19 case.

   d) A close, or high-risk, contact with potential COVID-19 cases will be defined as follows for the purpose of this guideline:

      *i) Department of Corrections (DOC) clinical leadership has updated our definition of close contact in consideration of the most recent CDC's update. Effective immediately, close contact is defined as being within 6 feet of someone with suspected or confirmed COVID-19 for a cumulative total of ten minutes within a twenty-four hour period, starting 2 days prior to symptom onset or test date (if asymptomatic).**

      ** Previously, the definition was ten consecutive minutes. With the new definition, close contact could include multiple, brief exposures to someone with suspected or confirmed COVID-19 that total a minimum of ten minutes.*

      ii) Having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

   e) Contact not considered close or high risk include briefly entering the patient room without having direct contact with the patient or their secretions/excretions, *brief conversation with a patient who was wearing a facemask.*

   f) Mitigating and exacerbating factors should be considered in determination of contact risk. For example, a suspected or confirmed COVID-19 case will be more likely to transmit disease if they are actively coughing during the contact, and less likely if they are wearing a facemask.

   g) Report the need to isolate a patient and the need to quarantine other patient/s as indicated to the Health Care Manager or designee who will then *notify the facility ICP*, Facility Medical Director, and Headquarters EOC.

   h) Enter the information about the case of suspected/confirmed COVID-19 and the information about the exposed patients on the Influenza like illness log.

   i) The results of contact investigations will be communicated to the facility ICP, Facility Medical Director, HSM, and facility Human Resources who will help ensure that people who have been exposed are identified, notified, and all appropriate infection control measures are put in place to reduce transmission (masking, quarantine, cohorting etc.)

2) All COVID-19 test results for DOC patients should be reported via phone to the COVID medical duty officer (phone **564-999-1845**), FMD, IPN, and facility COVID ICP immediately upon receipt from the testing lab.

   a) Notification of positive COVID tests should also be sent to the following email address: doccovid19cases@doc1.wa.gov.

   b) The IPN will update the contact investigation and review medical isolation/quarantine status of the tested and exposed patients after receipt of test results.

c) The IPN will report positive COVID cases to their local public health jurisdiction. If the patient was transferred to a second facility for medical isolation or care, the case should be reported to the local public health jurisdiction of the patient's original location.

d) Occupational Nurse Consultants will, in communication with the IPN, review the case for potential close contacts among DOC staff.

Guideline Update Log

03/06/2020

- Under Heath Services Evaluation, section 3.iii, added subsection 3 to include criteria for isolating patients who are suspected COVID-19 who cannot be tested.
- Under Infection control and Prevention section C.5, d. "COVID-19 patients will not be isolated in an IPU, unless they require IPU level of medical care." was deleted.
- Under Infection control and Prevention section C.9 added.
- Section Transportation of patients with suspected or confirmed COVID-19 disease added.

03/09/2020

- Section Contact Tracking and Case Reporting added
- Section Health Services Evaluation 3.3.2 changed to reflect updated DOH and CDC testing guidance

03/11/2020

- Section Health Services Evaluation part 2 added instruction for donning and doffing PPE.
- Section Contact Tracking and Case Reporting added guidance and definitions for determining risk of contact with suspected or confirmed COVID 19 cases.
- Section Contact Tracking and Case Reporting changed COVID-19 log to Influenza-like illness log.

03/12/2020

- Section Health Services Evaluation part 5 Testing Procedure updated

03/13/2020

- Section Testing Procedure information regarding testing through Interpath labs

03/17/2020

- Section Screening Intrasystem Intakes changed to require temperature screening at both boarding and exiting the transport bus.
- Section Health Services Evaluation 3A (screening question #1) changed from AND to OR
- Section Infection Control and Prevention changed to reflect updated PPE requirements for staff evaluating quarantined patients

03/18/2020

- Section Infection Control and Prevention changed the duration of medical isolation recommended
- Section Testing Procedure, deleted #3 regarding Interpath Labs, as they are no longer performing COVID testing
- Section Health Services Evaluation added information regarding when to order COVID testing in the context of influenza test results

03/19/2020

- Section Infection Control and Prevention, changed criteria for use of N95 mask when in contact with isolated patients.

03/20/2020

- Section Infection Control and Prevention, changed monitoring of isolated patients after they become asymptomatic to once daily at cell front

03/25/2020

- Section Patients at High Risk for Severe COVID-19 added
- Section Infection Control and Prevention added statement regarding release from quarantine requirements
- Section Health Services Evaluation added pharyngitis to screening questions
- Section Infection Control and Prevention, added PPE Requirements for Prisons and Work Release Staff

03/27/2020

- Section Testing Procedure- deleted reference to need for PUI number and approval prior to sending COVID tests to the Washington DOH public health lab
- Section Release of Patients into the Community added direction for patients on quarantine status at the time of release

04/03/2020

- Section Testing Procedure added NP swab demonstration video
- Section Infection Control and Prevention added eye protection to PPE needed for evaluation of quarantined patients
- Section Infection Control and Prevention, PPE for Work Release and Prisons Staff, added criteria for changing PPE for screeners

04/07/2020

- Section Clinical Care of Patients with Suspected or Confirmed COVID-19 added
- Section Screening added statements about active screening of staff and patients
- Section Infection Control and Prevention changed waste disposal from biohazard red bag/bin to regular trash bins.

04/15/2020

- All sections changed ‘isolation’ to ‘medical isolation’
- Section Clinical Care of Patients with Suspected or Confirmed COVID-19 added recommendation to use metered dose inhalers instead of nebulizers for administration of bronchodilators.
- Section Infection Control and Prevention added link to recommended PPE matrix.
- Section Release of Patients in the Community changed notification for patients releasing who are on medical isolation
- Section Clinical Care of Patients with Suspected or Confirmed COVID-19 changed criteria for starting supplemental oxygen to less than 96% on room air
- Section Testing Procedure added back Interpath Laboratory as they have resumed COVID-19 testing

- Section Testing Procedure added statement to perform NP swabs of both sides of the nasopharynx

04/21/2020

- Section Infection Control and Prevention added statement that Tyvek suites are not appropriate PPE for this purpose and should not be used.
- Section Infection Control and Prevention added statement that quarantined patients must don a surgical mask anytime they leave their cells.
- Section Infection Control and Prevention added statement regarding all staff wearing approved face coverings while on duty.
- Section Patients at High Risk for Severe Covid-19 changed interventions for high risk and very high risk patients
- Section Contact Tracing and Case Reporting changed positive COVID test result reporting to include COVID medical duty officer and COVID cases email box.
- Section Health Services Evaluation added diarrhea and loss of taste/smell to screening questions.
- Section Infection Control and Prevention added statement regarding droplet precaution signs in quarantine units
- Section Infection Control and Prevention added subsections h. and i. regarding phone use in medical isolation

04/24/2020

- Section Infection Control and Prevention subsection PPE requirements for Prisons and Work Release Staff added use instructions and PPE for staff using barriers during active screening
- Section Health Services Evaluation linked PPE video
- Section Testing Procedure added information regarding anterior nasal and nasal mid-turbinate swab sample collection
- Section Health Services Evaluation eliminated influenza testing and added statement regarding testing for influenza during influenza season

05/06/2020

- Section Testing Procedure added statement that patient collected nasal swabs should be preferred if N95 masks are in short supply and removed preference for NP swabs in all testing situations
- Section Infection Prevention and Control added statement regarding mandatory use of routine face coverings by incarcerated individuals.
- Section Health Services Evaluation added statement that all patients entering isolation will be tested for COVID-19.
- Section Infection Control and Prevention added subsection Post-isolation Convalescent Housing
- Section Infection Control and Prevention added two negative tests at least 48 hours apart as new criteria for release from isolation and associated quarantine
- Section Infection Control and Prevention added subsection Routine Pre-procedure COVID-19 Testing
- Section Patients at High Risk for COVID-19 Disease deleted ‘very high risk’ section
- Section Infection Control and Prevention added subsection Asymptomatic Patients Testing Positive for COVID-19
- Section Infection Control and Prevention added subsection Showers in Medical Isolation
- Section Infection Control and Prevention added subsection Routine Intake Separation

- Section Infection Control and Prevention added subsection Protective Isolation Prior to Work Release Transfer

05/15/2020

- Section Infection Control and Prevention added information for each care situation regarding when to change PPE
- Section Infection Control and Prevention added subsection Protective Separation
- Section Reuse of N95 Respirators added
- Section Health Services Evaluation changed testing criteria for viral respiratory panel
- Section Infection Control and Prevention subsections Routine Intake Separation and Separation Prior to Work Release Transfer were combined into Intersystem Transfer Separation and the period of pre-work release separation was changed to 14 days

06/29/2020

- Section Infection Control and Prevention added eye protection to PPE requirement for close contact with asymptomatic confirmed COVID patients
- Section Infection Control and Prevention – Environmental Cleaning corrected placement of laundry to: placed in rice bags and transported in yellow bags.
- Section Contact Tracing and Case Reporting added requirement for reporting confirmed COVID cases to the patient's local public health jurisdiction
- Section Infection Control and Prevention subsection Facility Management of Isolation/Quarantine, added statement that medical isolation and quarantine areas should not be located in the same unit
- Section Infection Control and Prevention subsection Clinical Management of Quarantine Patients revised to require COVID-19 testing of all patients placed on quarantine status who are close contacts of confirmed COVID 19 cases
- Section Infection Control and Prevention added statement recommending against deep cleaning, scrubbing, or power washing due to concerns over aerosolized virus.
- Section Infection Control and Prevention added oxygen saturation monitoring to quarantine nursing assessments

07/20/2020

- Section Infection Control and Prevention Categories, Quarantine, Clinical Management of Patients on Quarantine Status, changed #2 to 'Patients placed into quarantine status who are close contacts of confirmed (by a positive COVID test) cases will be tested for COVID-19 with a viral PCR test within 24 hours.'
- Section Infection Control and Prevention Categories, Medical Isolation- Clinical Management of Medical Isolation Patients- added #3b: Any patient with significant immunocompromise by diagnosis or medication as determined by a medical practitioner will be discussed with the COVID medical group prior to release from isolation
- Section Transportation of Patients with Suspected or Confirmed COVID-19 Disease #4 added describing procedure for donning and doffing PPE before and after disinfection of the transport vehicle.
- Section Infection Control and Prevention- Environmental Cleaning- added #10 'Areas with potential COVID-19 exposure should not be vacuumed due to the potential for vacuuming to aerosolize virus.'
- Section Infection Control and Prevention Categories- Medical Isolation- added #7 requiring patients on medical isolation who use CPAP or nebulizer treatments to be housed in negative pressure isolation rooms.

- Section Infection Control and Prevention Categories- Medical Isolation- Clinical Management of Medical Isolation Patients- added #3a regarding patients with confirmed COVID-19 using CPAP or nebulizers requiring 2 negative COVID-19 tests 48 hours apart prior to release from isolation.
- Section Infection Control and Prevention Categories- Intake Separation added COVID-19 testing process for intersystem intakes (added to version 19)
- Section Infection Control and Prevention Categories- Post Isolation Convalescent Housing was deleted
- Section Infection Control and Prevention Categories- Quarantine- Intake Separation- changed #3 to 'Patients in these categories should be separated from the general population at the receiving facility for 14 days after arrival if COVID-19 testing is not available or is not feasible due to the patient's length of stay'
- Section Infection Control and Prevention Categories, Separation Prior to Work Release Transfers was deleted
- Section Transportation of Patients with Suspected or Confirmed COVID-19 Disease- added #3 'When two or more cases of confirmed COVID-19 are present within a 30 day time period in a facility's housing unit transfers in and out of that unit will be suspended and the situation discussed with Prisons/Health Services Unified Command.'

09/8/20

- Section Outbreak Testing and Management added
- Section Transportation of Patients with Suspected or Confirmed COVID-19 Disease- changed #3 to 'When the outbreak definition, as defined in the Outbreak Testing and Management section, is met, transfers in and out of that unit will be suspended and the situation discussed with Prisons/Health Services Unified Command.'
- Section Infection Control and Prevention- PPE Requirements for Prisons and Work Release Staff, added #7 'Staff working in or passing through protective separation units will wear a face shield over their face covering.
- Section Infection Control and Prevention- Protective Separation- added 1.a.iii/iv, 2.e, and 4
- Section Infection Control and Prevention- Intake Separation- added #2
- Section Infection Control and Prevention- Intake Separation- deleted #3: Patients in these categories should be separated from the general population at the receiving facility for 14 days after arrival if testing is not available
- Section Clinical Care of Patients with Suspected and Confirmed COVID-19 deleted
- Section Health Services Evaluation- added 4.d.iv: For further guidance on clinical care of patients with COVID-19 see National Institutes of Health COVID-19 Treatment Guidelines.
- Section Testing Procedure 1.b added iv. Northwest Pathology to the list of labs for COVID-9 testing.

10/06/20

- *Section Health Services Evaluation- added #1. e.*
- *Section Health Services Evaluation- #3. a. added 'muscle aches that cannot be attributed to another cause.'*
- *Section Health Services Evaluation- #4. a. added 'or other influenza-like illness'.*
- *Section Health Services Evaluation- added #4. d.*
- *Section Health Services Evaluation- #4 e. i. and ii. SIGNIFICANT CHANGES PLEASE REVIEW CAREFULLY*
- *Section Health Services Evaluation- added #5.*

- *Section Testing Procedure- added #1 and #2*
- *Section Testing Procedure- #3. a. added 'Patient collected anterior nares and mid-turbinate samples are preferred'.*
- *Section Infection Control and Prevention/Infection Control and Prevention Principles- added #2.*
- *Section Infection Control and Prevention/Infection Control and Prevention Principles- added #4. h. 2. Regarding showers in quarantine.*
- *Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation/Clinical Management of Patients in Medical Isolation- #1 and #2 contain extensive revisions please review section. #5 added 'oxygen saturation'. #6 added b.*
- *Section Infection Control and Prevention/Infection Control and Prevention Categories/Quarantine/Clinical Management of Patients in Quarantine/ #2 changed 'within 24 hours' to 'within one business day'. Added #6.*
- *Section Infection Control and Prevention/Infection Control and Prevention Categories/Protective Separation- #4 added viral respiratory panel testing to intake separation testing procedure.*
- *Section Outbreak Testing and Management- added #2 regarding influenza outbreaks and #3 added 'facility mapping team'.*
- *Section Reuse of N95 Respirators- added #1. c.*
- *Section Transportation of Patients with Suspected or Confirmed COVID-19 Disease- added #7. d. adding eye protection to PPE for transportation staff*
- *Section Contract Tracing and Case Reporting 1. d. i. updated definition of close contact, and 1. g. added notification for new isolation and quarantine patients to facility ICP.*