



COVID-19

DPSCS Guidance for Maryland Correctional
Facility Health Care and Public Health
Providers

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INTRODUCTION

Coronavirus disease 2019 (COVID-19) is caused by the novel corona virus SARS-CoV2-It was first identified in Wuhan, China during an outbreak, in December 2019. It spread by person to person via droplets. On March 11, 2020, the World Health Organization recognized COVID-19 to be a pandemic.

This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities during this global pandemic.

This guidance is based on the currently available information about COVID-19. This approach will be refined and updated as more information becomes available and as response needs change in the United States. It is important to stay informed about COVID-19 to prevent introduction and minimize spread of COVID-19 in correctional facility.

This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes.

The guidance may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions.

DEFINITIONS OF COMMONLY USED TERMS

Airborne Infection Isolation Rooms (AIIRs) are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted to the outside or be filtered through a high-efficiency particulate air (HEPA) filter. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.

Close Contact of a COVID-19 case (Person Under Investigation (PUI)) – an individual is considered a close contact if they have:

- a) Been within approximately 6 feet of a COVID-19 case for a prolonged period of time or
- b) Had direct contact with infectious secretions from a COVID-19 case (e.g. have been coughed on).

Data to inform the definition of close contact are limited.

Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

Cohorting – the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group. Ideally, cases should be isolated individually, and close contacts should be quarantined individually. However, some correctional facilities and detention centers do not have enough individual cells to do so and must consider cohorting as an alternative.

Community Transmission of COVID-19 – This occurs when individuals acquire the disease through contact with someone in their local community, rather than through travel to an affected location. Once community transmission is identified in a particular area, correctional facilities and detention centers are more likely to start seeing cases inside their walls.

Confirmed vs. Suspected COVID-19 case

- A confirmed case has received a positive result from a COVID-19 laboratory test, with or without symptoms.
- A suspected case shows symptoms of COVID-19 but either has not been tested or is awaiting test results.

Healthcare Personnel (HCP) refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including:

- Body substances
- Contaminated medical supplies, devices, and equipment
- Contaminated environmental surfaces
- Contaminated air

Medical Isolation – Refers to confining a confirmed or suspected COVID-19 case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission.

Quarantine – Refers to the practice of confining individuals who have had close contact with a COVID-19 case to determine whether they develop symptoms of the disease. Quarantine for COVID-19 should last for a period of 14 days. They should be monitored for sign and symptoms.

Social Distancing – Social distancing is the practice of increasing the space between individuals and decreasing the frequency of contact to reduce the risk of spreading a disease (ideally, to maintain at least 6 feet between all individuals, even those who are asymptomatic).

Although social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19.

Staff – Refers to all public sector employees as well as those working for a private contractor within a correctional facility (e.g. custody, private healthcare or food service).

STAFF PRECAUTIONS AND RESTRICTIONS DURING THE PANDEMIC

- Correctional facilities should have signage posted at entry points in English and Spanish alerting staff and visitors that if they have fever and respiratory symptoms, they should not enter the facility.
- Instruct staff to report fever and/or respiratory symptoms at the first sign of illness.
- Staff with respiratory symptoms should stay home or be advised to go home if they develop symptoms while at work. Ill staff should remain at home until their provider to return to work clears them.
- Advise visitors who have fever and/or respiratory symptoms to delay their visit until they are well.
- Consider temporarily suspending visitation or modifying visitation programs, when appropriate.
- Initiate other social distancing procedures, if necessary (e.g. halt volunteer and contractor entrance, discourage handshaking).
- Post signage and consider population management initiatives throughout the facility encouraging vaccination for influenza.

Respiratory Hygiene, Cough Etiquette, and Hand Hygiene

- Post visual alerts in high traffic areas in both English and Spanish instructing patients to report symptoms of respiratory infection to staff.
- Encourage coughing patients with respiratory symptoms to practice appropriate respiratory hygiene and cough etiquette (e.g. cover your cough, sneeze into your sleeve, use a tissue when available, dispose of tissue appropriately in designated receptacles, and hand hygiene).
 - Additionally, coughing patients should not remain in common or waiting areas for extended periods and should wear a surgical or procedure mask and remain 6 feet from others.
- Ensure that hand hygiene and respiratory hygiene supplies are readily available.
- Encourage frequent hand hygiene.

COVID-19 PPE and Healthcare Personnel

Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

- Receive comprehensive training on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- Demonstrate competency in performing appropriate infection control practices and procedures.

Preferred PPE Includes:

- N95 or Higher Respirator is preferred.
- N95 mask or higher when respirators are not available, use the best available alternative, like a facemask.
- One pair of clean, non-sterile gloves
- Face shield or goggles
- Isolation gown

Doffing and Donning PPE

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical.

A step-by-step process:

Donning (Putting on the Gear):

1. Identify and gather the proper PPE to don. Ensure choice of gown size is correct (based on training).
2. Perform hand hygiene using hand sanitizer.
3. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by another HCP.
4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented.

Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.

Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.

5. Put on eye protection. Eye protection includes a face shield or goggles. Face shields provide full-face coverage. Goggles also provide excellent protection for eyes, but fogging is common.

Put on eye protection upon entry to the patient room or care area.

6. Perform hand hygiene before putting on gloves. Gloves should cover the cuff (wrist) of gown.
7. HCP may now enter patient room.

DOFFING (Taking Off the Gear):

1. Remove gloves.

Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).

2. Remove gown.

Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.

3. HCP may now exit patient room.

4. Perform hand hygiene.

5. Remove Eye Protection - face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.

- Reusable eye protection (e.g. goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
- Disposable eye protection should be discarded after use.

6. Remove and discard respirator (or facemask if used instead of respirator)

** Do not touch the front of the respirator or facemask.*

Respirator:

Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.

Facemask:

Carefully untie (or unhook from the ears) and pull away from face without touching the front.

7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.

Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices

Limited Supply of PPE

During times of limited access to respirators or facemasks, facilities could consider having HCP remove only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator or facemask (i.e., extended use).

Risk of transmission from eye protection and facemasks during extended use is expected to be very low.

HCP must take care not to touch their eye protection and respirator or facemask.

HCP should strictly follow basic infection control practices between patients (e.g., hand hygiene, cleaning and disinfecting shared equipment).

INFECTION PREVENTION AND ENVIRONMENTAL CONTROL

Limit how COVID-19 can enter and travel through the facility by:

- Cancelling elective procedures
- Using telemedicine when possible
- Limiting points of entry and manage visitors
- Screening patients for respiratory symptoms
- Encouraging patient respiratory hygiene using alternatives to facemasks (e.g. tissues to cover cough)
- Isolating symptomatic patients as soon as possible
- Setting up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with door closed and private bathroom (as possible),
- Prioritizing AIIRs for patients undergoing aerosol-generating procedures.
- Protecting healthcare personnel
- Emphasizing hand hygiene
- Installing barriers to limit contact with patients at triage
- Cohorting COVID-19 patients
- Limiting the numbers of staff providing care, and
- Prioritizing respirators and AIIRs for aerosol-generating procedures.
- If a hemodialysis facility is dialyzing more than one patient with suspected or confirmed COVID-19, consideration should be given to cohorting these patients and the HCP caring for them together in the section of the unit and/or on the same shift.

Equipment

- Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies consistently and correctly.

Disinfectants

- For a list of EPA - registered disinfectant products that have qualified for use against SARSCoV-2, the novel coronavirus that causes COVID-19, go to:

<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2> .

- If an EPA-registered disinfectant is not available, use a fresh chlorine bleach solution at a 1:10 dilution. • Focus on cleaning and disinfection of frequently touched surfaces in common areas (e.g., faucet handles, phones, countertops, and bathroom surfaces).
- If bleach solutions are used, change solutions regularly and clean containers to prevent contamination.

Cleaning and Disinfection Procedures

- Routine cleaning and disinfection procedures should be used. Studies have confirmed the effectiveness of routine cleaning (extraordinary procedures not recommended at this time).
- Routine cleaning and disinfection means to:
 - Pre-cleaning surfaces to remove pathogens,
 - Rinse with water, and
 - Follow with an EPA - registered disinfectant to kill coronavirus. Follow the manufacturer's labeled instructions and always follow the product's dilution ratio and contact time.
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures. Special handling and cleaning of soiled linens, eating utensils, and dishes is not required, but should not be shared without thorough washing.
- Linens (e.g., bed sheets and towels) should be washed by using laundry soap and tumbled dried on a hot setting. Staff should not hold laundry close to their body before washing and should wash their hands with soap and water after handling dirty laundry.
- Follow standard procedures for handling waste.

REPORTING AND COMMUNICATION

Communicate and collaborate with public health authorities.

Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.

Communicate and collaborate within the institution.

Implement mechanisms and policies that promote situational awareness for facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known or suspected COVID-19 patients and facility plans for response.

Communicate information about known or suspected COVID-19 patients to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

When a patient with fever and respiratory symptoms is identified, notify the Infection Control Coordinator (ICC).

Laboratory confirmed COVID-19 cases and suspect cases of COVID-19 shall immediately be reported to ICC or ICC alternate.

Confirmed COVID-19 cases should be immediately reported to the DOC officials and the Local Health Department.

Response to an Outbreak

When one or more laboratory confirmed cases of COVID-19 have been reported, surveillance should be conducted throughout the institution to identify contacts. A standardized approach to stop COVID-19 transmission is necessary by identifying people who have been exposed to a laboratory confirmed COVID-19 case.

Initial Notifications

If healthcare or custody staff become aware of or observe symptoms consistent with COVID-19 in a patient, staff, or within the institution, they should immediately notify institutional leadership:

- The Regional Medical Director over the facility and Director of Operations should follow the attached DPSCS Communication Cascade see attached form.

- The manager or institutional leadership should notify the Infection Control Nurse and the local health department.

Reporting and Notification

As soon as outbreak is suspected follow the DPSCS Communication Cascade protocols by telephone, text, then by email within 24 hours. Complete the Preliminary Report of Infectious Disease or Outbreak form (PORS).

Communication with the Institution

Activate the Central Command Center. The central command center includes: Regional Medical Director, Director of Nurses (DON), Infection Control Nurse (ICN), Warden, and key custody staff. Call for an Exposure Control meeting with the Warden site provider, Facilities Captains, Department Heads and Employee multi-vendor and state staff (psychology, social work) to inform them of outbreak, symptoms of disease, number of patients affected and infection control measures.

Containment

Stopping transmission will require halting movement of exposed patients. The goal is to keep patients who are ill or who have been exposed to someone who is ill from mingling with patients from other areas of the prison, from food handling and duties in healthcare settings.

- Close as many affected buildings/units as needed to confine the outbreak.
- Remind patients not to share eating utensils, food or drinks.
- Stop large group meetings such as religious meetings and social events.
- Patients who are housed in the same affected building/unit may have pill line or yard time together.

COVID-19

Currently, there are no approved vaccine or medication treatments for COVID-19. Treatment is supportive, especially for respiratory distress.

Mild to Moderate Disease

Patients with a mild clinical presentation (absence of viral pneumonia and hypoxia) may not require hospitalization,

Many patients will be able to manage their illness at the prison.

Most of them require supportive care only.

Severe Disease

Some patients with COVID-19 will have severe disease requiring hospitalization for management.

Reinfection

- There are no data concerning the possibility of reinfection.
- Viral RNA shedding declines with resolution of symptoms, and may continue for days to weeks.
- However, the detection of RNA during convalescence does not necessarily indicate the presence of viable infectious virus.
- Clinical recovery has been correlated with the detection of IgM and IgG antibodies that signal the development of immunity.

Transmission

Person-to-person transmission most commonly happens during close exposure to a person infected with COVID-19, primarily via respiratory droplets produced when the infected person coughs, sneezes, or talks.

Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity.

People who are infected but do not have symptoms likely spread of COVID-19.

Except with the risk of exposure from aerosol generating procedures, airborne transmission is not the main route of transmission.

However, airborne transmission from person-to-person over long distances is unlikely.

Community spread means people have been infected with the virus in an area, including some who are not sure how or where they became infected.

People are thought to be most contagious when they are symptomatic.

Although transmission of SARS-CoV-2 from asymptomatic or pre-symptomatic persons has been reported, risk of transmission is thought to be greatest when patients are symptomatic.

Viral RNA shedding is greatest at the time of symptom onset and declines over the course of several days.

The exact degree of SARS-CoV-2 viral RNA shedding that confers risk of transmission is not yet clear.

Incubation Period

The incubation period for COVID-19 is thought to extend to 14 days, median time of 4-5 days from exposure to symptoms onset.

One study reported that 97.5% of persons with COVID-19 who develop symptoms would do so within 11.5 days of SARS-CoV-2 infection.

Clinical Manifestations

The signs and symptoms of COVID-19 present at illness onset vary.

Over the course of the disease, most persons with COVID-19 will experience the following:

- Fever (83–99%)
- Cough (59–82%)
- Fatigue (44–70%)
- Anorexia (40–84%)
- Shortness of breath (31–40%)
- Sputum production (28–33%)
- Myalgias (11–35%)

Atypical presentations have been described and older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.

Some persons with COVID-19 have experienced gastrointestinal symptoms such as diarrhea and nausea prior to developing fever and lower respiratory tract signs and symptoms.

- Anosmia or ageusia preceding the onset of respiratory symptoms has been anecdotally reported.
- Approximately 80% of laboratory confirmed patients have had mild to moderate disease. Most of these patients are expected to recover completely.
- Approximately 15% of laboratory confirmed patients have severe disease (dyspnea, respiratory rate ≥ 30 /minute, blood oxygen saturation $\leq 93\%$, and/or lung infiltrates $>50\%$ of the lung field within 24-48 hours).
- Approximately 5% of laboratory confirmed patients are critical (respiratory failure, septic shock, and/or multiple organ dysfunction/failure).
- Asymptomatic infection has been reported, but the majority of the relatively rare cases who were asymptomatic on the date of identification/report, went on to develop disease.
- SARS-CoV-2 infection is demonstrated in patients who never develop symptoms (asymptomatic) and in patients not yet symptomatic (pre-symptomatic).
- As many as 13% of RT-PCR-confirmed cases of SARS-CoV-2 infection in children were asymptomatic.
- Skilled nursing facility residents infected with SARS-CoV-2 from a healthcare worker demonstrated that half were asymptomatic or pre-symptomatic at the time of contact tracing evaluation and testing.
- Patients may have abnormalities on chest imaging before the onset of symptoms.

Other Laboratory Findings

Lymphopenia is the most common lab finding in COVID-19 and is found in as many as 83% of hospitalized patients.

Lymphopenia, neutrophilia, elevated serum alanine aminotransferase and aspartate aminotransferase levels, elevated lactate dehydrogenase, high CRP, and high ferritin levels may be associated with greater illness severity.

Elevated D-dimer and lymphopenia have been associated with mortality.

Procalcitonin is typically normal on admission, but may increase among those admitted to the ICU.

Patients with critical illness had high plasma levels of inflammatory makers, suggesting potential immune dysregulation.

Radiologic Findings

Chest radiographs of patients with COVID-19 typically demonstrate bilateral air-space consolidation, though patients may have unremarkable chest radiographs early in the disease.

Chest CT images from patients with COVID-19 typically demonstrate bilateral, peripheral ground glass opacities.

Chest CT imaging pattern is non-specific

Chest radiograph or CT alone is not recommended for the diagnosis of COVID-19.

The American College of Radiology also does not recommend CT for screening or as a first-line test for diagnosis of COVID-19.

Progression of the Disease

Among patients who developed severe disease, the median time to dyspnea ranged from 5 to 8 days, to acute respiratory distress syndrome (ARDS) ranged from 8 to 12 days, and to ICU admission ranged from 10 to 12 days.

Clinicians should be aware of the potential for some patients to rapidly deteriorate one week after illness onset.

Among hospitalized patients, 26% to 32% of patients were admitted to the ICU.

Among all patients, 3% to 17% developed ARDS compared to a range of 20% to 42% for hospitalized patients and 67% to 85% for patients admitted to the ICU.

Mortality among patients admitted to the ICU ranges from 39% to 72%.

The median length of hospitalization among survivors was 10 to 13 days.

Differential Diagnosis

Viral pneumonia can be caused by many respiratory pathogens. When Influenza is present, it is the likely cause of influenza-like illness (ILI).

Patients with influenza or another etiology are unlikely to be co-infected with COVID-19 related virus. Therefore, COVID-19 testing is unnecessary if influenza is confirmed.

Infectiousness of COVID-19 Patients

A patient with a confirmed or suspected case of COVID-19 is considered to be infectious from the 48-72 hours before the time of symptom onset and until symptoms resolve.

Risk Factors for Severe Illness

Age is a strong risk factor for severe illness, complications, and death.

The case fatality rate was highest among older persons:

≥85 years (range 10%–27%),

3%–11% for ages 65–84 years,

1%–3% for ages 55–64 years, and

<1% for ages 0–54 years.²⁹

Patients with no reported underlying medical conditions had an overall case fatality of 0.9%, but case fatality was higher for patients with comorbidities:

10.5% for those with cardiovascular disease,

7.3% for diabetes, and

6% each for chronic respiratory disease, hypertension, and cancer.

Heart disease, hypertension, prior stroke, diabetes, chronic lung disease, and chronic kidney disease have all been associated with increased illness severity and adverse outcomes.

Management of Contacts to Contacts

CDC does not recommend testing, symptom monitoring, quarantine, or special management for people exposed to asymptomatic people who have had high-risk exposures to COVID-19, (e.g., Contacts to Contacts).

CLINICAL MANAGEMENT AND TREATMENT

Diagnostic Testing

Testing for influenza and SARS-CoV-2 is important for establishing the etiology of influenza like illness (ILI). ILI can be defined by any combination of fever or cough.

- Diagnosis of COVID-19 requires detection of SARS-CoV-2 RNA by reverse transcription polymerase chain reaction (RT-PCR).
 - Lower respiratory samples may have better yield than upper respiratory samples.
 - SARS-CoV-2 RNA has also been detected in stool and blood.
 - Detection of SARS-CoV-2 RNA in blood may be a marker of severe illness.
 - Viral RNA shedding may persist over longer periods among older persons and those who had severe illness requiring hospitalization. (Median range of viral shedding among hospitalized patients 12–20 days).
1. Priority for COVID-19 testing should be given to symptomatic individuals who are ≥ 60 years or have chronic medical conditions and/or an immunocompromised state that may put them at higher risk for poor outcomes (e.g., diabetes, heart failure, cerebrovascular disease, chronic lung disease, chronic kidney disease, cancer, liver disease, and pregnancy).
 2. Patients who have had close contact with an infectious case of COVID-19 and if the contact develops symptoms, they should be tested for COVID-19 immediately.
 3. Early identification of a COVID-19 outbreak may be key to mitigating its impact on staff, patients, and the surrounding community.

For initial diagnostic testing for COVID-19, the preferred specimen is any nasal swab, or oropharyngeal swabs should be collected in transport media.

- Only one swab is needed.
- NP specimen has the best sensitivity.
- Specimens should be collected as soon as possible, regardless of the time of symptom onset. **Please note:**
 - Sputum inductions are not recommended as a means for sample collection.
 - Collection of sputum should only be done for those patients with productive coughs.

- Testing policy may change as CDC recommendations change.

Collection of Respiratory Specimen

When collecting diagnostic respiratory specimens from a possible COVID-19 patient, the following should occur:

- HCP in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown.
- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support.
- Specimen collection should be performed in a normal examination room with the door closed.
- Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control.

Precaution When Performing Aerosol-Producing Procedures (AGPs)

Some procedures performed on patient with known or suspected COVID-19 could generate infectious aerosols.

In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible.

If performed, the following should occur:

- HCP in the room should wear an N95 or higher-level respirator, eye protection, gloves, and a gown.
- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.
- AGPs should ideally take place in an AIIR.
- Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

Medical Hold and Contact Investigation

When a patient with a suspected or confirmed case of COVID-19 is identified:

- The patient should be placed on a medical **hold by the provider**;
- A contact investigation should be conducted; and
- All patients housed in the same unit, and any other identified close contacts, should be placed on a medical hold as part of quarantine measures.

Management of Suspected and Confirmed Cases of COVID-19

- Immediately mask patients when COVID-19 is suspected. Surgical or procedure masks are appropriate for patients.
- Patient Placement: The RMD Provider will determine placement as it relates to isolation, Negative airflow room, infirmary, and hospital offsite.
- For patients with COVID-19 or other respiratory infections, evaluate need for hospitalization or placement in the infirmary.
- If admitted, place a patient with known or suspected COVID-19 in a single-person room with the door closed.
- The patient should have a dedicated bathroom.
- Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients who will be undergoing aerosol-generating procedures
- It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens will likely be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room.

Transporting COVID-19 Patients

- Limit transport and movement of the patient outside of the room.
- Patients shall only be transported for emergent medically necessary procedures or transfers.
- Consider providing portable x-ray equipment in patient cohort areas to reduce the need for patient transport.
- Patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- Patients should wear a facemask to contain secretions during transport.
- If patients cannot tolerate a facemask or one is not available, they should use tissues to cover their mouth and nose.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles
- After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.
- When possible, assign dedicated health care staff to provide care to suspected or confirmed cases.

Monitoring Patients Suspected or Confirmed With COVID-19

- Patients with suspected COVID-19 require a minimum of twice daily nursing assessment, including, but not limited to:
 - Temperature monitoring twice daily
 - Pulse oximeter monitoring
 - Blood pressure checks
 - Lung auscultation
 - Assessing for signs and symptoms of dehydration (rapid pulse, sluggish skin turgor; dry mucous membranes, sunken eyes, confusion)
- Monitor patients for complications of COVID-19 infection, including respiratory distress and sepsis:
 - Fever and chills
 - Rapid pulse
 - Rapid breathing
 - Labored breathing
 - Low blood pressure
 - Low oxygen saturation
 - Altered mental status or confusion.

Patients with abnormal findings should be immediately referred to a provider for further evaluation.

Management of Asymptomatic Contacts of COVID-19

Patients with exposure to a confirmed or suspected COVID-19 case shall be placed in quarantine.

Isolation

Isolation housing requires a medical order (place a mask on the inmate while getting the order)

Promptly separate patients who are sick with fever and lower respiratory symptoms from well-patients. Patients with these symptoms should be isolated until they are no longer infectious and have been cleared by the health care provider.

- The preference is for isolation in a negative pressure room; second choice would be isolation in private room with a solid, closed door.

- When a negative pressure room or private, single room is not available, cohorting symptomatic patients who meet specific criteria is appropriate. Groups of symptomatic patients can be cohorted in a separate area or facility away from well patients. Possible areas to cohort patients could be an unused gym or section of a gym or chapel. When it is necessary to cohort patients in a section of a room or area with the general population of well-patients (e.g., dorm section) there should be at least 6 feet between the symptomatic patients and the well patient population. Tape can be placed on the floor to mark the isolation section with a second line of tape 6 feet away to mark the well-patient section which can provide a visual sign and alert well-employees and patients to remain outside of the isolation section unless they are wearing appropriate PPE.
 - Patients with influenza like illness (ILI) of unknown etiology should be isolated alone. If they cannot be isolated alone, they should be isolated with other sick patients from the same housing unit.
 - Patients with confirmed COVID-19 or influenza can safely be isolated in a cohort with other patients who have the same confirmed diagnosis.
- Correctional facilities should review their medical isolation policies, identify potential areas for isolation, and anticipate how to provide isolation when cases exceed the number of isolation rooms available.
- If possible, the isolation area should have a bathroom available for the exclusive use of the identified symptomatic patients. When there is no separate bathroom available, symptomatic patients should wear a surgical or procedure mask when outside the isolation room or area, and the bathroom should be sanitized frequently.
- A sign should be placed on the door or wall of an isolation area to alert employees and patients. All persons entering the isolation room or areas need to follow the required transmission-based precautions.
- When possible, assign dedicated health care staff to provide care to suspected or confirmed cases.

Quarantine

Placing an Inmate in Quarantine Housing Requires a Medical Order.

The criteria for imposing quarantine in a correctional facility will remain a dynamic process with possible re-direction and re-strategizing of disease control efforts based on recommendations from Authorities. Quarantine should be implemented for patients who are contacts to a COVID-19 case and are not ill.

- **ALL Quarantined patients shall be placed on medical hold. A medical decision regarding quarantine housing will be made in collaboration with**

the RMD statewide medical director and Infectious Disease Consultant and notification to facility hierarchy.

- Transport of patients in quarantine **should be limited**. If transport becomes necessary, assign dedicated staff to the extent possible. Patients under quarantine, and those transporting quarantined patients, must use appropriate PPE (quarantined patient should wear a surgical or procedure mask, transport staff should wear an N-95 respirator or other approved respirator).
- Quarantine does not include restricting the patient to his own cell for the duration of the quarantine without opportunity for exercise or yard time. Quarantined patients can have yard time as a group but should not mix with patients not in quarantine.
- Nursing staff must conduct twice-daily surveillance on quarantined patients for the duration of the quarantine period to identify any new cases. If new case(s) are identified, the symptomatic patient must be masked and evaluated by a health care provider as soon as possible.
- Quarantined patients may be given meals in the hall as a group if:
 - They do not congregate with other non-quarantined patients,
 - They are the last group to get meals, and
 - The dining room can be cleaned after the meal.If these parameters cannot be met in the chow hall, the patients shall be given meals in their cells.
- In the event of a more severe outbreak, involving multiple suspected or confirmed cases or involving neighboring community, consider prison lockdown.

Patient Surveillance While In Quarantine

Correctional nursing leadership is responsible for assigning nursing teams to conduct surveillance to identify new suspected cases. Twice daily surveillance rounds and the evaluation of well patients who have been exposed must be done in all housing units that have housed one or more patients with suspected or confirmed COVID-19.

- Surveillance Rounds must be conducted twice daily on quarantined patients.
- All quarantined patients shall be evaluated on a twice daily basis, including weekends and holidays.
- Using the electronic Surveillance Rounds form in EHRS, temperatures and any respiratory symptoms must be recorded.
- Patients with symptoms should be promptly masked and escorted to a designated clinical area for medical follow up as soon as possible during the same day symptoms are identified, including weekends and holidays.

Discontinuation of Precautions for Patient with Confirmed COVID-19

1. *Test-based strategy.*

- Resolution of fever without the use of fever-reducing medications and
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens)

2. *Non-test-based strategy.*

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
- At least 14 days have passed prior to first *symptoms appeared*.

Discontinuation of Precautions for Patient Suspected of Having COVID-19.

Discontinuation of precautions for a suspected COVID-19 patient requires a medical order and notification to the facility management prior to executing the order.

Negative results from at least one FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2.

- If a higher level of clinical suspicion for COVID-19 exists, consider maintaining Transmission-Based Precautions and performing a second test for SARS-CoV-2.
- If a patient suspected of having COVID-19 is never tested, the decision to discontinue Transmission-Based Precautions can be made based upon using the *non-test-based strategy* described above.

Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determines whether to continue or discontinue empiric Transmission-Based Precautions.

- Educate all patients about signs and symptoms of respiratory illness, possible complications, and the need for prompt assessment and treatment. Instruct patients to report respiratory symptoms at the first sign of illness.

- Surveillance may uncover patients in housing units with respiratory symptoms but without fever and who do not meet the case presentation for COVID-19. Consult with the treating provider and/or CME to determine if these patients should be isolated.

Release from Quarantine

Release from quarantine requires medical order and communication to the facility management prior to release

The period of quarantine is 14 days from the last date of exposure, because 14 days is the longest incubation period seen for similar coronaviruses. Someone who has been released from COVID-19 quarantine is not considered a risk for spreading the virus to **others because they have not developed illness during the incubation period.**

Quarantine must be extended by 14 days for every new exposure.

REFERENCES

<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>

<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).