# WA State DOC COVID-19 Screening, Testing, and Infection Control Guideline Version 13

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.

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## Screening:

1) **Patients presenting with symptoms prior to Health Services contact**: Direct the patient to immediately don a surgical mask and 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.
    A) 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.
3) **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.

4) **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.
5) **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.
6) **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 first contact with patients referred from the screening section above should don personal protective equipment listed below *before* the evaluation:
    1. Fit-tested N95 mask
    2. Gloves
    3. Eye protection: goggles or facemask
    4. Gown
    5. If not fit tested use PAPR instead of N95

2) For instructions on proper donning and doffing of PPE see the following video and/or 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, or pharyngitis?

    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. If yes proceed to step C.
    B. If no practitioner is onsite the nurse will discuss the patient's case with the practitioner.
    C. The practitioner will determine the following:
        1. Level of care based on acuity
            a. To emergency department for severely ill patients
            b. To a negative pressure room for any non-severely ill patient if one is available and the patient requires IPU level care, under airborne isolation precautions.
            c. Living unit isolation with contact and droplet precautions for patients with mild illness.
                - Patients isolated in a living unit with suspected or confirmed COVID-19 will have nursing assessments and vital signs at least every shift
        2. Patients remaining in the facility will have the following diagnostic workup:
            a. Perform rapid influenza test:

i. If the rapid influenza test is negative send a viral respiratory panel (Interpath #2470) NP swab and COVID-19 test according to the testing procedure below, and isolate the patient.
ii. If the rapid influenza test is positive and illness is mild a COVID-19 test is not needed and the patient can be isolated according to the influenza protocol
iii. If the rapid influenza test is positive and illness is moderate or severe send a COVID-19 test according to testing procedure below

b. Consider other diagnostic testing as clinically appropriate, i.e. chest x ray for community acquired pneumonia

3. In the event that the patient is unable to be tested but for whom clinical suspicion remains, the patient should be isolated for presumptive COVID-19 disease.
4. Treat supportively based on symptoms and clinical evaluation.
5. Record and file rapid influenza test on the In-House Lab Results Form 13-415

## Testing procedure:

1) There are currently two 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. Nasopharyngeal swab 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. Please review the following nasopharyngeal swab sample collection guidance:
   i. NP swab guidance document
   ii. NP swab demonstration video
4. Use the Washington State DOH Sample Submission Form to submit test samples to the state DOH lab.
5. Write the provided PUI# on the submitter section of the submission form.
6. 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. 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.

2) Notify facility Infection Prevent Nurse, Facility Medical Director, and Health Services Manager

## Patients at High Risk for Severe COVID-19:

1) Patients with underlying conditions and those with advanced age are at higher risk for severe disease and complications if they acquire COVID-19. Patients with the following conditions should be considered at high risk:

A) Aged 50 years** or older
B) COPD or moderate to severe asthma
C) Cardiovascular disease
D) Patients who are immunosuppressed based on diagnosis or due to medication
E) Cancer
F) Morbid obesity (BMI >40)
G) Diabetes, particularly if poorly controlled
H) Chronic kidney disease including those with ESRD on dialysis
I) Hepatic cirrhosis
J) Pregnancy or the immediate post-partum period

**National Institute of Corrections recognizes that incarcerated population ages 50 and above are considered elderly

2) The following recommendations should be made for patients identified as high risk :

A) Encourage self-quarantine in cell
B) Wear a surgical mask if leaving cell
C) Perform frequent hand hygiene
D) Perform frequent cleaning of cell throughout the day
    - highly discourage the use of bleach as this can exacerbate conditions for those patients with underlying lung disease
E) Avoid contact of high-touch surfaces
F) Limit movement in the facility
G) Social distancing (stay 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) For those patients identified as “very high risk” for severe disease, the Facility Medical Director may choose to write an HSR for medication and meal delivery to the patient’s cell front on a case by case basis.

## Clinical Care of Patients with Suspected or Confirmed COVID-19:

1) **Triage for appropriate care setting of suspected or confirmed COVID-19 patients**:
    a. COVID-19 can display a very wide range of disease severity, from asymptomatic and mild upper respiratory symptoms to severe lower respiratory tract disease with ARDS and multiple organ

failure. Therefore triage to the appropriate care setting and subsequent monitoring are important aspects of clinical care for patients with COVID-19.

b. Risk factors for severe disease and mortality include the following:
    i. Lung disease including COPD and asthma
    ii. Cardiovascular disease including hypertension and cardiomyopathy
    iii. Diabetes
    iv. Immunosuppression due to diagnosis or medication
        1. History of Transplant
        2. HIV with CD4 <200 or detectable viral load
        3. Immune modulators or immunosuppressive medications including corticosteroid treatment at the equivalent of 20 mg of oral prednisone or more daily
    v. Cancer
    vi. Chronic kidney disease
    vii. Cirrhosis
    viii. Age 50 years old or greater
c. Patients with one or more of the risk factors above should be considered at high risk for clinical deterioration and should be monitored closely regardless of initial care setting.
d. Patients with confirmed or suspected COVID-19 disease can be triaged into the following groups based on the clinical evaluation:
    i. Mild disease: Patients with mild disease may have fever, cough, upper respiratory tract symptoms, myalgias, and fatigue without significant dyspnea or hypoxia (oxygen saturation 96% or greater).
    ii. Moderate to severe disease: Patients with significant dyspnea, hypoxia (oxygen saturation less than 96%) or other clinical evidence for severe disease should be triaged to a higher level of care.
        1. If hypoxia is mild (92-95% on room air) and the patient is otherwise clinically stable admission to an inpatient unit or other unit with 24 hour nursing coverage, with on-site diagnostic evaluation may be considered:
            a. In addition to the diagnostic testing described in the Health Services Evaluation section above, at a minimum perform a chest x ray and the following lab studies:
                i. CBC with differential
                ii. CMP
                iii. CRP
                iv. LDH (Interpath #1018)
                v. INR
                vi. D-dimer (Interpath #2657)
                vii. Creatine kinase (CK) (Interpath #1015) and troponin (Interpath #2688)
                viii. lactic acid (Interpath #2092)
            b. Patients in this group with risk factors for severe disease are at high risk for rapid clinical deterioration. Consider emergency department evaluation as indicated based on clinical judgement.
        2. If hypoxia is severe (<92% on room air) or there is other clinical evidence of severe disease, including sepsis, cardiac complications, or coagulopathy, the patient should be transferred to the emergency department for further diagnostic evaluation and treatment.

2) **Treatment and monitoring of outpatients with suspected or confirmed COVID-19 and mild disease as defined above:**
    a. Treatment for patients with mild disease is supportive:
        i. Patients with mild disease will be isolated in a living unit and will have nursing assessments every shift. Signs of clinical deterioration that should provoke transfer to a higher level of care or further diagnostic assessment include:
            1. Hypoxia with oxygen saturation less than 96% on room air
            2. Development of significant dyspnea
            3. Inability to tolerate oral intake
            4. Clinical evidence for sepsis, cardiac complications, or coagulopathy.
        ii. Supportive care can include oral hydration, anti-emetics if indicated, and analgesics/antipyretics:
            1. Prefer acetaminophen for fever and myalgias
            2. Anecdotal reports initially suggested NSAIDs may have been associated with worsening COVID-19 disease in some patients. Currently there is no evidence to support either harm or safety for use of NSAIDs in patients with confirmed or suspected COVID-19. In the face of this uncertainty acetaminophen should be used preferentially for pain and fever in this patient group, however NSAIDs can be used intermittently based on clinical judgement on a case by case basis if no contraindications are present.
        iii. For patients in the mild disease category be aware that early experience with COVID-19 cases suggests the potential for clinical deterioration **five to ten days after illness onset**, including the onset of respiratory failure, sepsis, and cardiac complications.
        iv. There are no data to suggest a link between ACE inhibitors and ARBs with worse COVID-19 outcomes. These medications should be continued unless the clinical picture warrants holding them (ex. hypotension).

3) **Treatment and monitoring of the COVID-19 patient admitted to an inpatient unit setting:**
    a. Patients initially triaged to an inpatient unit care setting or another unit with 24 hour nursing coverage, or admitted to one after return from an emergency department evaluation or hospitalization for COVID-19:
        i. Admit to negative pressure room with airborne isolation precautions if available
        ii. Until further evidence for benefit and safety is available anti-viral agents are not recommended.
        iii. Supportive care ordered as described above for patients with mild illness
        iv. Supplemental oxygen by nasal cannula to keep oxygen saturation > 92%
        v. Close monitoring for clinical deterioration including worsening hypoxia, with awareness of the potential for severe disease to develop 5-10 days after illness onset.
        vi. Clinical factors that should provoke consideration for transfer to a higher level of care:
            1. Need for greater than 2L supplemental oxygen to maintain saturation above 92%
            2. Bilateral infiltrates on chest x ray suggesting moderate to severe pneumonia
            3. Elevated D Dimer > 1000 ng/ml
            4. Elevated CRP > 100
            5. LDH >245
            6. CPK > 2x ULN or elevated troponin
            7. Elevated AST and ALT

8. Significant lymphopenia or neutrophilia:
    a. Calculate absolute neutrophil to absolute lymphocyte ratio: if 3.0 or greater the patient should be considered at high risk for clinical deterioration

    OR

    b. Absolute lymphocyte count <0.8
9. Lactate > 4
10. New creatinine elevation
11. Other clinical findings based on clinical judgement of medical team

vii. Consider monitoring diagnostic studies recommended above through the course of illness until clear clinical improvement is seen.

viii. Patient may transfer back to living unit isolation for the remainder of the isolation period after clinical improvement is seen and the risk for deterioration has passed.

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

## Infection Control and Prevention:

A) Definitions:

1. Isolation: Separating a symptomatic patient with a concern for a communicable disease from other patients.
2. Quarantine: Separating asymptomatic patients who have been exposed to a communicable disease from other patients.
3. Cohort: Grouping patients infected with or exposed to the same agent together. Isolated and quarantined patients should NOT be cohorted together.

B) Patients suspected of COVID-19 and their cellmates are immediately isolated and quarantined respectively until they can be evaluated by a medical provider.

**C) Isolation of symptomatic confirmed or suspected COVID-19 cases:**

1. 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

2. 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

3. If the patient is already in the living unit, isolate the patient in their cell and notify medical

4. Droplet Precautions will be initiated

   a. Droplet Precaution Isolation signs will be hung outside the room at cell front

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

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

   d. In the following situations PPE will be comprised of an **N95 mask, eye protection, gown, and gloves:**

      i. Patients with suspected or lab confirmed COVID-19 while symptomatic with cough or sneezing.

      ii. While performing diagnostic nasopharyngeal swab sample collection or any other potentially aerosol generating procedures

   e. In the following situations PPE will be comprised of a **surgical mask, eye protection, gown, and gloves:**

      i. When speaking with a symptomatic patient from outside of an isolation cell

      ii. Any patient who has tested negative for COVID-19 but remains in isolation and continues to be symptomatic

      iii. Patients with suspected or lab confirmed COVID-19 without cough or sneezing.

   f. All staff must wash hands with soap and water or with alcohol sanitizer after leaving a patient's cell and removing gloves.

   g. A red 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.

   h. If possible avoid isolating patients with suspected or confirmed COVID-19 in cells with open bars.

   i. Patients in isolation should don a surgical mask if staff enters the cell for any reason.

5. Isolation of patients with suspected or confirmed COVID-19

   a. Custody will work with medical staff to determine the best location to house patients on isolation status.

   b. If single cell not available, it is acceptable to cohort patients with COVID-19 together if they both/all have lab confirmed disease and are not thought to have other communicable diseases concurrently (i.e influenza or another viral respiratory disease).

   c. Sick isolated patients must be housed separately from asymptomatic exposed patients (quarantined).

6. As a general rule, isolated patients will not be allowed out of the cell unless security or medical needs require it

    a. If an isolated patient needs to be out of their cell, they will don a surgical mask during the necessary movement

    b. Staff will ensure that the patient goes where directed by communication between the sending and receiving area staff

7. Any pill line medications will be delivered by medical staff unless medical staff determines the need for a different protocol

8. Patients isolated in a living unit with suspected or confirmed COVID-19 will have nursing assessments and vital signs at least every shift, with referral to a practitioner as clinically indicated.

9. Medical practitioners should document an assessment on patients in isolation for confirmed or suspected COVID-19 each business day until they are asymptomatic for 24 hours.

10. Patients with laboratory confirmed COVID-19, or who were not tested but are suspicious for COVID-19, will remain in isolation until they have been asymptomatic for 14 days.

11. Patients who tested negative for COVID-19 will remain in isolation until 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 examples:

    a. Mild respiratory illness with a positive influenza test

    b. Fever explained by infection at another site, such as UTI or cellulitis

12. Close contacts of patients who test negative for COVID-19 will remain in quarantine 14 days after the last exposure to the patient unless there is a documented or confirmed alternative diagnosis that explains their symptoms.

13. Close contacts of patients who test positive for COVID-19 will remain in quarantine 14 days after the last exposure to the patient.

14. Patients 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 and symptom checks at cell front. Patients with recurrence of symptoms should be evaluated by a medical practitioner.

    b. Recommended PPE for these asymptomatic isolation nursing checks will include **surgical mask, gown, and gloves**.

15. Unless transfer to a setting for a higher level of medical care is required, all medical care should be delivered in the patient's isolation cell.

**D) Quarantine of exposed patients**

1. Patients who are asymptomatic but have been in close contact with confirmed or suspected COVID-19 patients should be quarantined. Quarantined patients can be housed alone or cohorted with other quarantined patients from the same exposure.

    a. If a quarantined patient develops symptoms of the COVID-19, they will be immediately removed from quarantine if they were housed with other asymptomatic patients, and placed into isolation. If cohorted with other asymptomatic patients the quarantine period for those patients will be reset to day 0 of 14.

    b. If the symptomatic patient lived in dormitory-style housing, consider quarantining an entire dorm or wing of a housing unit, especially if multiple cases

        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 in open dorm style housing units on quarantined patients should don the following PPE: **surgical mask, gown, eye protection and gloves.**

    c. Staff performing nursing or medical assessments in units with barred cells

2. 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 the following PPE: **surgical mask, gown, eye protection and gloves**. Disposable thermometers should be used by patients if available. If multi-use thermometers must be used they should be disinfected in between patients.

3. 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.

4. Exposed patients will remain in quarantine for COVID-19 for 14 days from the date of last contact with the symptomatic patient, or until symptoms develop.

5. Patients in quarantine will be assessed twice daily by nursing staff. The assessment will include a temperature check and development of any respiratory symptoms. If the patient develops symptoms 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.

6. Any pill line medications will be delivered to the quarantined patient by medical staff unless medical staff determines the need for different protocol.

7. 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.

8. 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.

E) **Facility management of isolated/quarantined patients:**

1. If possible, cluster cases in isolation within in a single location/wing within the facility to help streamline ongoing assessments and delivery of services to the affected population
2. If patients need to be isolated/quarantined in a living unit, allowances will be made to accommodate patients in this location
    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
3. All patients placed in isolation/quarantine will be issued hygiene kits and new clothing as needed
4. 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.
5. 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
6. Education Programs will be suspended

**F) PPE Requirements for Prisons and Work Release Staff:**

1. Contact with asymptomatic individuals who are not on isolation or quarantine:
    a. **Gloves** (follow normal practice)
2. Contact with individuals on isolation (symptomatic):

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 (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 isolation cell

    ii. Any contact with a patient who has tested negative for COVID-19 but remains on isolation

    iii. Any contact with incarcerated individuals with suspected or lab confirmed COVID-19 without cough or sneezing.

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 isolation in cells with open bars

3. Contact with quarantined (asymptomatic) individuals:

    i. Open bay units:

        1. Close contact (ex. Temp check): **surgical mask, gown, gloves**
        2. No close contact (example walking through unit): **gloves**

    ii. Dayroom/or other close quarters:

        1. Close contact (within 6 feet): **surgical mask, gown, gloves**
        2. No close contact (example walking through unit): **gloves**

    iii. Pat searches:

        1. **Surgical mask, gown, gloves** (for every person pat searched)

    iv. Closed door cells with *cuff port*:

        1. Passing items through cuff port and NO face to face contact: **gloves** only
        2. No contact at all (talking through the door): **No PPE required**
        3. Close contact: **surgical mask, gloves, goggles/face shield**

    v. Bar cells:

        1. Close contact (ex. temp check): **surgical mask, gown, gloves**

4. Staff active screening of patients or staff at entry into facilities, health services, or other :
    **i. Surgical mask, gown and gloves**

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 resumption of screening.

**G) 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 isolation or quarantine patients and cells will be placed in yellow bags and transported in rice 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 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 isolation or quarantine, without entering the cell, should wear the following PPE:
   **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 PPE listed above in #4.

## Release of patients into the community

1) Patients in isolation: For any patient with suspected or confirmed COVID-19 disease who releasing from a DOC facility, the Infection Prevention Nurse or designee in conjunction with the facility Psychiatric Social Worker will contact their local health jurisdiction for appropriate placement guidance prior to the patient's release.

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 the community 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) 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:
    i. A pair of disposable examination gloves
    ii. Disposable isolation gown or single-use/disposable coveralls
    iii. Any NIOSH-approved particulate respirator (i.e., N-95 or higher-level respirator)
    iv. Eye protection (i.e., goggles or disposable face shield)
    v. 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.
4) The transport vehicle will be cleaned and disinfected after use.
5) For any patients on quarantine for contact with a suspected or confirmed COVID-19 case DOC staff will don the following PPE:
    i. A pair of disposable examination gloves
    ii. Disposable isolation gown or single-use/disposable coveralls
    iii. Surgical mask

## Contact Tracking and Case Reporting:

1. Cases of suspected and confirmed COVID-19 will be thoroughly investigated by the Infection Prevention Nurse (IPN):
    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. 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 local/state public health departments if any uncertainty exists regarding how to classify a contact with a suspected or confirmed COVID-19 case.
    c. A close, or high risk, contact with potential COVID-19 cases will be defined as follows for the purpose of this guideline:
        i. Being within approximately 6 feet of a person with confirmed or suspected COVID-19 for a prolonged period of time, defined as at least several minutes. Examples include caring for or visiting the patient or sitting within 6 feet of the patient in a healthcare waiting room.

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).

d. 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 not wearing a facemask.
e. 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.
f. 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 Superintendent at the facility, Facility Medical Director, and headquarters EOC.
g. Enter the information about the case of suspected/confirmed COVID-19 and the information about the exposed patients on the Influenza like illness log.
h. The results of contact investigations will be communicated to the Facility Medical Director, HSM, facility Human Resources and infectious disease consultant 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 CMO, FMD, and IPN immediately upon receipt from the testing lab.
    a. The CMO will report test results to the COVID-19 EOC, who will forward to Human Resources for updating of any staff who were identified as potentially exposed through the contact investigation.
    b. The IPN will update the contact investigation and review isolation/quarantine status of the tested and exposed patients after receipt of test results.

## Guideline Update Log:

1) 3/6/20: 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.
2) 3/6/20: 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.
3) 3/6/20: Under Infection control and Prevention section C.9 added.
4) 3/6/20: Section Transportation of patients with suspected or confirmed COVID-19 disease added.
5) 3/9/20: Section Contact Tracking and Case Reporting added
6) 3/9/20: Section Health Services Evaluation 3.3.2 changed to reflect updated DOH and CDC testing guidance
7) 3/11/20: Section Health Services Evaluation part 2 added instruction for donning and doffing PPE.
8) 3/11/20: Section Contact Tracking and Case Reporting added guidance and definitions for determining risk of contact with suspected or confirmed COVID 19 cases.
9) 3/11/20: Section Contact Tracking and Case Reporting changed COVID-19 log to Influenza-like illness log.
10) 3/12/20: Section Health Services Evaluation part 5 Testing Procedure updated
11) 3/13/20: Section Testing Procedure information regarding testing through Interpath labs

12) 3/17/20: Section Screening Intrasystem Intakes changed to require temperature screening at both boarding and exiting the transport bus.
13) 3/17/20: Section Health Services Evaluation 3A (screening question #1) changed from AND to OR
14) 3/17/20: Section Infection Control and Prevention changed to reflect updated PPE requirements for staff evaluating quarantined patients
15) 3/18/20: Section Infection Control and Prevention changed the duration of isolation recommended
16) 3/18/20: Section Testing Procedure, deleted #3 regarding Interpath Labs, as they are no longer performing COVID testing
17) 3/18/20: Section Health Services Evaluation added information regarding when to order COVID testing in the context of influenza test results
18) 3/19/20: Section Infection Control and Prevention, changed criteria for use of N95 mask when in contact with isolated patients.
19) 3/20/20: Section Infection Control and Prevention, changed monitoring of isolated patients after they become asymptomatic to once daily at cell front
20) 3/25/20: Section Patients at High Risk for Severe COVID-19 added
21) 3/25/20: Section Infection Control and Prevention added statement regarding release from quarantine requirements
22) 3/25/20: Section Health Services Evaluation added pharyngitis to screening questions
23) 3/25/20: Section Infection Control and Prevention, added PPE Requirements for Prisons and Work Release Staff
24) 3/27/20: Section Testing Procedure- deleted reference to need for PUI number and approval prior to sending COVID tests to the Washington DOH public health lab
25) 3/27/20: Section Release of Patients into the Community added direction for patients on quarantine status at the time of release
26) 4/3/20: Section Testing Procedure added NP swab demonstration video
27) 4/3/20: Section Infection Control and Prevention added eye protection to PPE needed for evaluation of quarantined patients
28) 4/3/20: Section Infection Control and Prevention, PPE for Work Release and Prisons Staff, added criteria for changing PPE for screeners
29) 4/7/20: Section Clinical Care of Patients with Suspected or Confirmed COVID-19 added
30) 4/7/20: Section Screening added statements about active screening of staff and patients
31) 4/7/20: Section Infection Control and Prevention changed waste disposal from biohazard red bag/bin to regular trash bins.