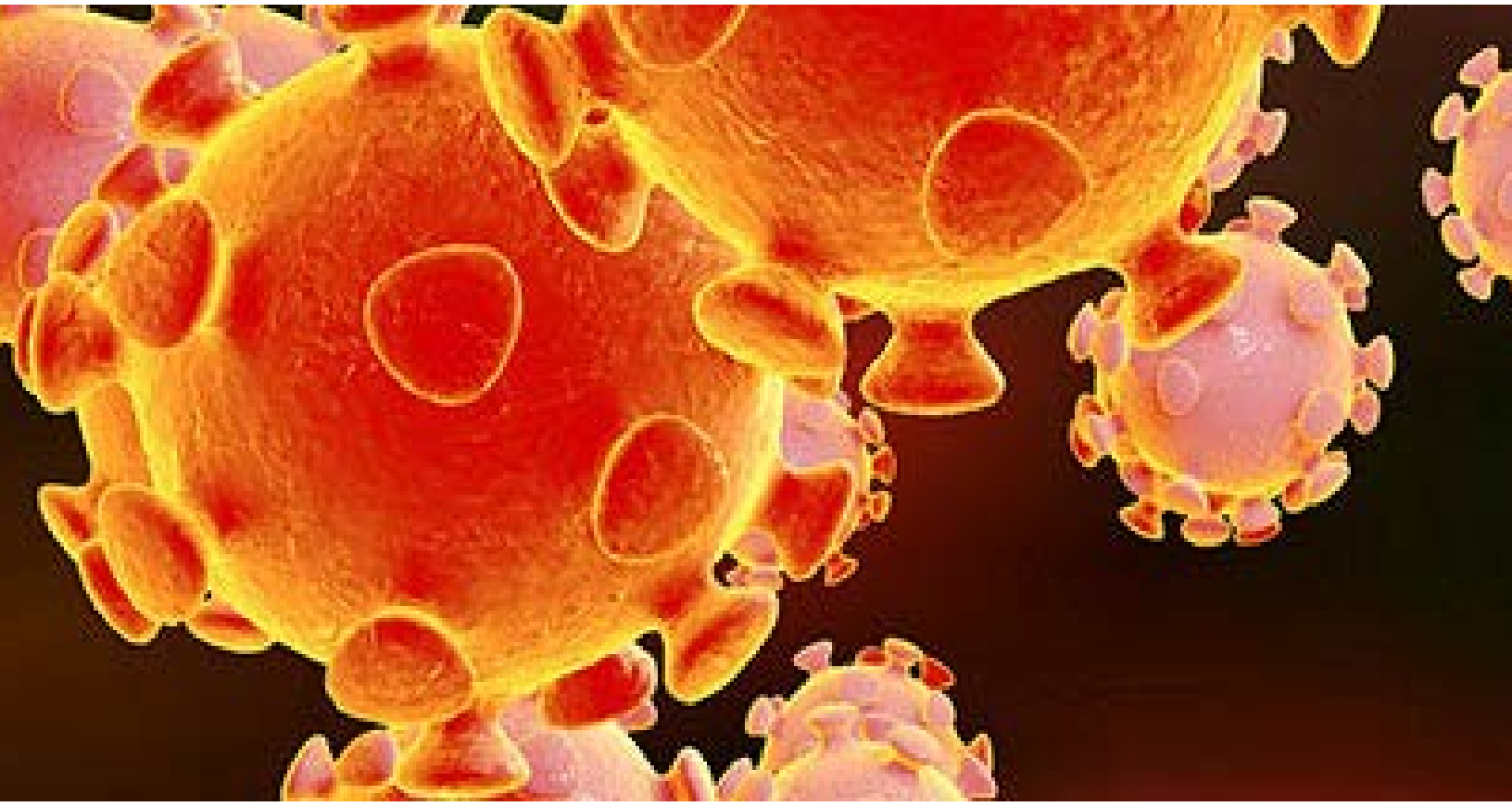
COVID-19: Interim Guidance for Health Care and Public Health Providers



Public Health Nursing Program

Version 1.0

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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Record of Change

Date	Change	Approved By

INTRODUCTION

Coronaviruses are a large family of viruses that are common in many different species of animals; some coronaviruses cause respiratory illness in humans. Coronavirus disease 2019 (COVID-19) is caused by the novel (new) coronavirus SARS-CoV-2. It was first identified during the investigation of an outbreak in Wuhan, China, in December 2019. Early on, many ill persons with COVID-19 were linked to a live animal market indicating animal to person transmission. There is now evidence of person to person spread, as well as community spread (i.e., persons infected with no apparent high risk exposure contact). On March 11, 2020, the World Health Organization recognized COVID-19 to be a pandemic.

This guidance supersedes the Seasonal Influenza Guidance except where noted.

CLINICAL MANIFESTATIONS OF COVID-19

People with COVID-19 generally develop signs and symptoms, including respiratory symptoms and fever, average 5 days, range 2-14 days after infection.

Typical Signs and Symptoms

- **Common:** Fever, dry cough, fatigue, shortness of breath.
- **Less common:** sputum production, sore throat, headache, myalgia or arthralgia, chills.
- **<5% occurrence:** nausea, vomiting, diarrhea, nasal congestion

Mild to Moderate Disease

Approximately 80% of laboratory confirmed patients have had mild to moderate disease, which includes non-pneumonia and pneumonia cases. Most people infected with COVID-19 related virus have mild disease and recover.

Severe disease

Approximately 14% of laboratory confirmed patients have severe disease (dyspnea, respiratory rate ≥30/minute, blood oxygen saturation ≤93%, and/or lung infiltrates >50% of the lung field within 24-48 hours).

Critical disease:

Approximately 6% 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.

DIFFERENTIAL DIAGNOSIS

Viral pneumonia can be caused by many respiratory pathogens. When Influenza is present (e.g., the height of seasonal influenza), it is the likely cause of influenza-like illness (ILI). Regardless of the known disease signs, symptoms, and epidemiology that

may distinguish influenza or other viral respiratory infections from COVID-19, no clinical factors can be relied upon to rule out COVID-19. Hence, laboratory testing is required.

DIAGNOSTIC TESTING

Testing for influenza and the virus that causes COVID-19 is important for establishing the etiology of ILI. **During the COVID-19 pandemic, testing for respiratory pathogens shall be ordered by providers as part of the evaluation of all patients with ILI.**

To be inclusive of both influenza and COVID-19 in the differential, ILI can be defined by any combination of fever or cough; sore throat is more common with influenza whereas difficulty breathing is more common with COVID-19.

Two approaches can be taken to testing: concurrent COVID-19 and influenza testing; or a tiered approach using a point of care influenza test followed by COVID-19 testing if the influenza test is negative.

Clinicians should use their judgment in testing for other respiratory pathogens.

Respiratory syncytial virus (RSV) Testing is indicated if it will affect clinical management. Consider testing for RSV in vulnerable populations, including those with heart or lung disease, bone marrow and lung transplant recipients, frail older adults, and those with multiple underlying conditions.

Additional considerations:

1. Patients of Concern: Because early diagnosis may improve clinical outcomes, priority for COVID-19 testing should be given to symptomatic individuals who are **older (age ≥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. COVID-19 Contacts: Patients who have had close contact with an infectious case of COVID-19 are at increased risk of developing the disease. If a contact develops symptoms of COVID-19, they should be tested for COVID-19 immediately.
3. Outbreaks of ILI: Early identification of a COVID-19 outbreak may be key to mitigating its impact on staff, patients, and the surrounding community (including community hospitals). Therefore, if a cluster of ILI occurs and the Rapid Influenza Diagnostic Test (RIDT) is not available, use concurrent testing for subset of patients (a sentinel approach).
4. Influenza No Longer Prevalent: When influenza is no longer prevalent in the community, it is less likely to be the cause of ILI. Until California Department of Public Health (CDPH) downgrades influenza transmission to “sporadic” for the region where your institution is located, assume influenza is prevalent (see CDPH

Weekly Influenza Report). In 2019, influenza remained widespread through early April, regional in mid-April, and sporadic in May.

Rapid Influenza Diagnostic Test (CLIA waived)

While influenza remains prevalent, Rapid Influenza Diagnostic Testing (RIDT) may be used to quickly identify influenza infections. 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.

1. If RIDT is available at your facility and influenza prevalence is high, test symptomatic patients.
    a. RIDT is only useful for ruling in influenza when prevalence is high. When the CDPH specifies that **influenza transmission has downgraded to "sporadic" for your institution's geographic area, DO NOT USE the RIDT tests** any longer and instead use only the RT-PCR. CDPH Weekly Influenza Report
    b. Headquarters Public Health Branch (PHB) will send notification of when RIDT is no longer useful due to decreased prevalence in your geographic area.
2. Due to unreliable sensitivity, if the RIDT result is negative, further testing is always indicated, order the influenza A/B RNA Qualitative PCR and COVID-19 RNA Qualitative PCR (see below).

COVID-19 Testing

For initial diagnostic testing for COVID-19, **the preferred specimen is a nasopharyngeal (NP) swab**. NP or oropharyngeal (OP) swabs should be collected in multi microbe media (M4), VCM medium (green-cap provided by Quest) tube or equivalent (UTM). Only one swab is needed and the NP specimen has the best sensitivity. Testing both NP and OP also increases sensitivity. If collecting both a NP and OP swab, they both can be put in the same VCM tube. 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.

Please note: **A different order will be needed if or when collecting a specimen for any other tests, e.g., influenza, use a different swab and the swab goes into a different tube.**

Quest is accepting specimens for SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR testing (Quest Test Code: 39433).

1. Preferred specimen: NP swab or OP swab collected in multi microbe media (M4), VCM medium (green-cap) tube or equivalent (UTM). If collecting two swabs, both can be put in one tube.
2. Separate NP/OP Swab: Collect sample using a separate NP or OP swab for other tests (i.e., influenza test) requiring NP or OP swab. **DO NOT COMBINE swabs in one tube for both COVID-19 and influenza test.**
3. Storage and Transport: COVID-19 specimens must be refrigerated. Refrigerated stability is up to 72 hour.
4. Follow standard procedure for storage and transport of refrigerated samples.
5. Cold packs/pouches must be utilized if samples are placed in a lockbox.
6. COVID-19 is not a STAT test and a STAT pick-up cannot be ordered.
7. Turnaround time (TAT), published as 3-4 days, may be delayed initially due to high demand
8. The induction of sputum is not recommended.

SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR- Quest Test Code 39433:

Test Purpose: Aids in presumptive detection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) RNA

Collect via Nasopharyngeal (NP) Swab or Oropharyngeal (OP) swab

Collected in multi microbe media (M4), VCM medium (green-cap) tube or equivalent (UTM) (one swab per tube)

Testing policy may change as CDC recommendations change. See: CDC Guidelines for Collecting, Handling and Testing Clinical Specimens

PRECAUTIONS FOR SPECIMEN COLLECTION:

- When collecting diagnostic respiratory specimens (e.g., NP swab) from a possible COVID-19 patient or conducting RIDT, the Heath Care Personnel (HCP) in the room should wear an N-95 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. 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. CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

TREATMENT

Currently, there is no approved vaccine or medication treatments for COVID-19. Treatment is supportive, especially for respiratory distress. Experimental drugs may be available through compassionate use or clinical trials. See: CDC Confirmed Case Management

TRANSMISSION

- The virus that causes COVID-19 seems to be spreading easily and sustainably in the community ("community spread") in some affected geographic areas. 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.
- The virus is thought to spread mainly from person-to-person (airborne, contact or droplet transmission), between people who are in close contact with one another (within 6 feet).
- People are thought to be most contagious when they are most symptomatic (the sickest).
- Except with the risk of exposure from aerosol generating procedures, airborne transmission is not the main route of transmission.
- Infectious respiratory droplets can land in the mouths or noses of people who are nearby and possibly be inhaled into the lungs.
- It may be possible that a person can get COVID-19 by touching a contaminated surface and then touching their own mouth, nose, or their eyes. Research shows longevity of viable virus particles on fomites, but infectiousness of this modality is unclear at this time.
- Symptoms of COVID-19 may appear in as few as two days or as long as 14 days after exposure (mean six days, median five days).
- Fecal shedding after symptom resolution has been found; however, the infectiousness of the fecal viral particles is unclear.

COVID-19 RELATED PUBLIC HEALTH DEFINITIONS

CASE DEFINITIONS

CONFIRMED COVID-19 CASE
A positive laboratory test for the virus that causes COVID-19 in at least one respiratory specimen. The tests no longer need to be confirmed by CDC.

CONFIRMED INFLUENZA CASE
A positive point-of-care or laboratory test for an influenza virus in respiratory specimen in a patient with influenza-like illness.

SUSPECTED COVID-19 / INFLUENZA CASE
HIGH SUSPECT: Any fever, respiratory symptoms, or evidence of a viral syndrome in a patient who had close contact with a confirmed case of COVID-19 within 14 days of onset **OR** linkage to a high risk group defined by public health during an outbreak (for example: an affected dorm, housing unit, or yard) but without a test result for COVID-19.

LOW SUSPECT: Fever and cough or shortness of breath (dyspnea) with evidence of a viral syndrome (ILI) of unknown etiology in a person without test results for COVID-19 or influenza and without high-risk exposure.

NON-CASE DEFINITIONS

ASYMPTOMATIC CONTACT OF COVID-19
A person who has had close (within 6.6 feet [2 meters]) and prolonged (generally ≥30 minutes) contact with the COVID-19 patient **OR** direct contact with secretions with a confirmed case of COVID-19 within the past 14 days, who has had no symptoms of COVID-19 and who has had no positive tests for COVID-19. Asymptomatic contacts should be monitored for symptoms; ideally, two times daily, and containment measures should be in place [e.g., housing with a cohort of asymptomatic contacts, “Confined To Quarters” (CTQ), etc.]

ASYMPTOMATIC CONTACT OF INFLUENZA
A person who has had close contact (within 6 feet) with an infectious influenza case within the past five days.

CONTACT OF A CONTACT
The contact of an asymptomatic contact is NOT to be included in the exposure cohort. The patient does not need to wear a mask. Health care workers do not need PPE.

ISOLATION
Separation of ill persons who have a communicable disease (confirmed or suspected) from those who are healthy. People who have different communicable diseases (e.g., one

patient with COVID-19 and one with influenza), or who may have different diseases should not be isolated together. Isolation setting depends on the type of transmission-based precautions that are in effect. For airborne precautions, an airborne infection isolation room (AIIR) is the ideal setting; a private room with a solid, closed door is an alternative. Precautionary signs and PPE appropriate to the level of precautions should be placed outside the door to the isolation room.

QUARANTINE

The separation and restriction of movement of well persons who may have been exposed to a communicable disease. Quarantine facilitates the prompt identification of new cases and helps limit the spread of disease by preventing new people from becoming exposed. In CDCR, patients who are quarantined are not confined to quarters, but they do not go to work or other programs. They may go to chow as a group and go to the yard as a group, but not mix with others who are not quarantined.

MEDICAL HOLD

Prohibition of the transfer of a patient to another facility except for legal or medical necessity. In CDCR, medical holds are employed for both isolation and quarantine.

REPORTING

- When a patient with fever and respiratory symptoms is identified, institutional processes for notification to the Public Health Nurse (PHN) and/or PHN alternate must be established for ongoing surveillance and reporting. The PHN and/or PHN alternate is responsible for reporting of respiratory illness and outbreaks.
- Laboratory confirmed COVID-19 cases and suspect cases of COVID-19 shall immediately be reported to the PHN or PHN alternate.
- Confirmed COVID-19 cases should be immediately reported to the Local Health Department (LHD). Outbreaks of COVID-19 should also be immediately reported to the LHD. Follow usual guidelines for reporting influenza to the LHD. The LHD is responsible for reporting to CDPH.
- During the COVID-19 pandemic:
  - Notify CCHCS Public Health Branch (PHB) immediately at CDCRCCHCSPublicHealthBranch@cdcr.ca.gov if there are significant developments at the institution (e.g., first time the institution is monitoring one or more contacts, first confirmed case at the institution, first COVID-19 contact investigation at the institution.)
  - The following require same-day reporting to the COVID-19 SharePoint: https://cdcr.sharepoint.com/sites/cchcs_ms_phos
    - **All new suspected and confirmed COVID-19 cases.**
    - **All new COVID-19 contacts.**

  - For previously reported cases: new lab results, new symptoms, new hospitalizations, transfers between institutions, discharges/paroles, releases from isolation, deaths.
  - For previously reported contacts: new exposures, transfers between institutions, discharges/paroles, releases from quarantine.

- Single or hospitalized cases of COVID-19, outbreaks of ILI, and influenza should be reported to the PHB via the Public Health Outbreak Response System (PhORS) http://pors/. Single cases of lab-confirmed influenza and single cases of ILI that result in hospitalization or death should be reported to PhORS.

INFECTIOUSNESS OF PATIENTS BY CASE TYPE

A patient with a confirmed or suspected case of COVID-19 is considered to be infectious from the time of symptom onset until symptoms resolve AND they are cleared by the local health department for release from isolation. See Criteria for Release from Isolation section of this document.

A patient with a confirmed or suspected case of influenza is considered infectious for seven days after the onset of symptoms or for 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.

An asymptomatic contact is not considered to be infectious.

PRECAUTIONS

Standard, contact, and airborne precautions, plus eye protection are required for any patient with suspected or confirmed COVID-19, or any asymptomatic contact to COVID-19.

For patients with confirmed influenza, **standard, contact, and droplet precautions** are required.

Standard precautions are sufficient for the patient who is a contact of a contact.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Gloves

- Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated.
- Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.

Gowns

- Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for

waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use.

Respiratory Protection for Airborne Precautions

- Use respiratory protection that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering face piece respirator before entry into the patient room or care area.
- Disposable respirators (e.g., N95s) should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator. In cases of N95 respirator shortage, extended N95 use may be implemented per CDC and National Institute for Occupational Safety and Health (NIOSH) parameters. (https://www.cdc.gov/niosh/ topics/hcwcontrols/recommendedguidanceextuse.html)
- If reusable respirators, such as powered air purifying respirator (PAPR) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
- Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard (29 CFR 1910.134 Respiratory Protection). Staff should be medically cleared and fit-tested if using respirators with tight-fitting face pieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.

Respiratory Protection for Droplet Precautions

- Staff should wear a surgical mask when entering the room or area of a patient with confirmed influenza (where COVID-19 has been ruled out). After leaving the patient's room or area staff should remove the mask, dispose of the mask in a waste container, and perform hand hygiene.

Eye Protection

- Put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Remove eye protection before leaving the patient room or care area. 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.

For further information on standard, contact, and airborne precautions, refer to Health Care Department Operational Manual, Chapter 3 Article 8, Communicating Precautions from Health Care Staff to Custody Staff.

SUMMARY TABLE OF TRANSMISSION-BASED PRECAUTIONS

Type of case or Non-Case	Isolation or Quarantine	Precautions	PPE Recommendations
Confirmed COVID-19 Case	ISOLATION (AIIR if available) alone or with other confirmed cases of COVID-19	Standard, contact, droplet, and airborne	**Health Care Worker (HCW):** N95 Respirator, gloves, gown, face shield or other eye protection **Patient:** surgical or procedure mask
Confirmed Influenza Case	ISOLATION alone or with other confirmed cases of influenza	Standard, contact, and droplet	**HCW:** surgical mask, gloves, gown **Patient:** surgical or procedure mask
Suspected Case (ILI of unknown etiology)	ISOLATION alone	Standard, contact, droplet, and airborne	**HCW:** N95 Respirator, gloves, gown, face shield or other eye protection **Patient:** surgical or procedure mask
Asymptomatic Contact to a COVID-19 Case (Non-Case)	QUARANTINE alone or with others who had the same exposure	Standard, contact, droplet, and airborne	**HCW:** N95 Respirator, gloves, gown, face shield or other eye protection **Patient:** surgical or procedure mask for transport or interactions with HCW
Asymptomatic Contact to an Influenza Case (Non-Case)	QUARANTINE alone or with others who had the same exposure	Standard, contact, and droplet	**HCW:** Surgical Mask, Gloves, Gown **Patient:** Surgical or Procedure Mask for transport
Asymptomatic Contact of a Contact (Non-Case)	NO INTERVENTION	Standard	**HCW:** No PPE **Patient:** No Mask

SUMMARY FIGURE OF INTERVENTIONS

MANAGEMENT OF SUSPECTED AND CONFIRMED CASES OF COVID-19

For management of confirmed cases of influenza, see CCHCS Seasonal Influenza Infection Prevention and Control Guidance

- Immediately mask patients when COVID-19 is suspected. Surgical or procedure masks are appropriate for patients.
- Patients should be placed in AIIR as soon as possible. If AIIR is not immediately available, the patient shall be placed in a private room with the door closed. Appropriate signage indicating precautions should be visible outside the patient's room.
- Standard, contact, and airborne precautions plus eye protection should be implemented immediately (see PPE section).
- When possible, assign dedicated health care staff to provide care to suspected or confirmed cases.
- Ensure staff caring for or transporting patients with respiratory symptoms meeting criteria for COVID-19 utilize appropriate PPE: N95 respirator or PAPR, gloves, gown, and face shield or goggles.
- Limit movement of designated staff between different parts of the institution to decrease the risk of staff spreading COVID-19 to other parts of the facility.
- Patients shall only be transported for emergent medically necessary procedures or transfers, and shall wear a surgical or procedure mask during transport. Limit number of staff that have contact with suspected and/or confirmed cases.
- Assess and treat as appropriate soon-to-be released patients with suspected COVID-19 and make direct linkages to community resources to ensure proper isolation and access to medical care.

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
  - Pulse oximeter monitoring
  - Blood pressure checks
  - Lung auscultation
  - Assessing for signs and symptoms of dehydration (rapid pulse, sluggish skin tugor; dry mucous membranes, sunken eyes, confusion)
- Monitor patients for complications of COVID-19 infection, including respiratory distress and sepsis:
  - Fever and chills
  - Low body temperature
  - 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.

ISOLATION

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 (see below). 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 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.
- If a patient with ILI or confirmed COVID-19 or influenza must be moved out of isolation, ensure a surgical or procedure mask is worn during transport. Staff shall wear an appropriate respirator during transport of these patients.

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,
- 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.

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.

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.

Communication within the Institution: Establish a central command center to include Chief Medical Executive (CME), PHN, Chief Nurse Executive (CNE), Director of Nurses (DON), Infection Control Nurse (ICN), Warden and key custody staff. Call for an Exposure Control meeting with the Warden, CME, Facilities Captains, Department Heads and Employee Union Representatives to inform them of outbreak, symptoms of disease, number of patients affected and infection control measures.

Reporting and Notification: As soon as outbreak is suspected, contact your Statewide Public Health Nurse Consultant by telephone or email within 24 hours. Complete the Preliminary Report of Infectious Disease or Outbreak form (PORS). Report outbreak by telephone to the Local Health Department as soon as possible to assist with contact investigation, if needed. If your facility is considering halting all movement in and out of your institution, please consult with the PHB warmline at (916) 691-9901.

Tracking: For the duration of the outbreak, collect patient information systematically to ensure consistency in the data collection process. Assign back up staff for days off, to be responsible for tracking cases and reporting.

INITIAL NOTIFICATIONS

- If health care or custody staff become aware of or observe symptoms consistent with COVID-19 in a patient, staff, or visitor to the institution, they should immediately notify institutional leadership: a supervisor, manager or AOD (Administrative Officer of the Day). Institutional leadership should notify the Public Health Nurse (PHN) or PHN alternate (often the Infection Control Nurse) and the local health department.
- Institutional leadership is responsible for notifying the Office of Employee Health and Wellness (OEHW) and Return to Work Coordinator (RTWC) of the possibility of employees exposed to COVID-19.

CRITERIA FOR RELEASE FROM ISOLATION

1. Individuals with laboratory-confirmed COVID-19 who have are asymptomatic:
    a. Discontinue isolation when at least seven days have passed since the date of their first positive COVID-19 diagnostic test and remain asymptomatic.
2. Individuals with symptomatic COVID-19 under isolation, considerations to discontinue Transmission-Based Precautions include:
    a. Resolution of fever, without use of antipyretic medication; **AND**

b. Improvement in illness signs and symptoms; **AND**

c. While ample testing supplies and laboratory capacity are available, negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive sets of paired nasopharyngeal and throat swabs specimens collected ≥24 hours apart (total of two negative specimens).

Check for updates: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

MANAGEMENT OF ASYMPTOMATIC CONTACTS OF COVID-19

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

QUARANTINE

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 the LHD, CDPH, CCHCS PHB and Chief Medical Executive (CME). **Quarantine should be implemented for patients who are contacts to a COVID-19 case and are not ill.**

- Quarantined patients shall be placed on medical hold.
- 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 chow hall as a group;
  - If they do not congregate with other non-quarantined patients,
  - 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, visitor entry and patient visits for well patients may be greatly restricted or even temporarily halted, if necessary.
- If one or more patients in quarantine develops symptoms consistent with COVID-19 infection, follow recommendations for isolation for ill patient(s). Separate the ill patients from the well quarantined patients.

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 to identify influenza-like illness (temperature > 100°F [37.8°C], cough,).
- 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.
- 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.
- Each correctional facility should ensure the PHN (or designee) is aware of any patients with ILI, and any suspected or confirmed COVID-19 cases. PHNs should be notified by phone and via the Electronic Health Record System (EHRS) Message Center.

RELEASE FROM QUARANTINE

For COVID-19, 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.**

Check for updates From CDC:
https://www.cdc.gov/coronavirus/2019-ncov/faq.html#basics

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.

STAFF AND VISITOR PRECAUTIONS AND RESTRICTIONS DURING THE PANDEMIC

See COVID-19: Infection Control for Health Care Professionals

- 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.
- Visitor web sites and telephone services are updated to inform potential visitors of current restrictions and/or closures before they travel to 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 they are cleared by their provider to return to work.
- 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.
- Visitor signage and screening tools are available from the CCHCS PHB and can be distributed to visiting room staff.
- 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 AND COUGH ETTIQUETTE

- 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 of time 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.

ENVIRONMENTAL INFECTION CONTROL

- Routine cleaning and disinfection procedures should be used. Studies have confirmed the effectiveness of routine cleaning (extraordinary procedures not recommended at this time).
- After 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. (for a list of EPA- registered disinfectant products that have qualified for use against SARS-CoV-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, bathroom surfaces).
- If bleach solutions are used, change solutions regularly and clean containers to prevent contamination.
- 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 Waste Handling.

For further sanitation information: Communicating Precautions from Health Care Staff to Custody Staff HCDOM, Chapter 3, Article 8 - Communicating Precautions from Health Care Staff to Custody Staff.

RESOURCES

For additional COVID-19 information refer to the following internal and external resources:

CCHCS: COVID-19 Lifeline Page

CDC Websites:

https://www.cdc.gov/coronavirus/2019-nCoV/hcp

https://www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-personnel-checklist.html

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

REFERENCES

1. Influenza and Other Respiratory Viruses Weekly Report. California Influenza Surveillance Program. https://www.cdph.ca.gov/programs/cid/dcdc/cdph%20document%20library/immunization/week2019-2009_finalreport.pdf
2. CDC Tests for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/about/testing.html
3. Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
4. Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html
5. California Department of Corrections and Rehabilitation California Correctional Health Care Services, Health Care Department Operations Manual. Chapter 3, Article 8; 3.8.8: Communication Precautions from Health Care to Custody Staff. http://lifeline/PolicyandAdministration/PolicyandRiskManagement/IMSPP/HCDOM/HCDOM-Ch03-art8.8.pdf
6. Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings: https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html
7. United States Department of Labor, Occupational Safety and Health Administration https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134
8. Public Health Outbreak Response System (PhORS) http://phuoutbreak/
9. Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19 https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

10. Centers for Disease Control Coronavirus Disease 2019 (COVID-19) Healthcare Professionals: Frequently Asked Questions and Answers https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html
11. Centers for Disease Control Coronavirus Disease 2019 (COVID-19) Healthcare Professionals: Frequently Asked Questions and Answers About: **When can patients with confirmed COVID-19 be discharged from the hospital?** https://www.cdc.gov/coronavirus/2019-ncov/faq.html#basic
12. List N: Disinfectants for Use Against SARS-CoV-2: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

APPENDIX 1: CORONAVIRUS DISEASE 2019 (COVID-19) CHECKLIST

1. RECOGNITION, REPORTING, AND DATA COLLECTION	
	a. Be on alert for patients presenting with fever or symptoms of respiratory illness.
	b. Report suspect cases to institutional leadership, local health department, and the Public Health Branch.
2. INFECTION PREVENTION AND CONTROL MEASURES	
	a. Isolate symptomatic patients immediately in airborne infection isolation room (AIIR). Implement Standard, Contact, and Airborne Precautions, plus eye protection.
	b. Educate staff & patients about outbreak. Emphasize importance of hand hygiene, respiratory etiquette, and avoiding touching eye, nose, or mouth. Post signage about the outbreak in high traffic areas.
	c. Increase available of hand hygiene supplies in housing units and throughout the facility.
	d. Separate patients identified as contacts from other patients and implement quarantine as appropriate.
	e. Increase cleaning schedule for high-traffic areas and high-touch surfaces (faucets, door handles, keys, telephones, keyboards, etc.). Ensure available cleaning supplies.
3. CARING FOR THE SICK	
	a. Implement plan for assessing ill patients. Limit number of staff providing care to ill patients, if possible.
	b. Ensure Personal Protective Equipment is available and accessible to staff caring for ill patients.
4. POSSIBLE ADMINISTRATIVE CONTROLS DURING OUTBREAKS	
	a. Institute screening for respiratory symptoms.
	b. Encourage patients to report respiratory illness.
	c. Halt patient movement between affected and unaffected units.
	d. Screen for respiratory illness in patient workers in Food Service and Health Services; exclude from work if symptomatic.
	e. Minimize self-serve foods in Food Service (e.g., eliminate salad bars).
	f. Do controlled movement by unit to chow hall (cleaning between units), or feed on the units.
	g. Temporarily discontinue group activities, e.g., recreation, chapel, activity therapy groups, education.
	h. Schedule daily status meetings involving custody and medical leadership; other stakeholders should attend as appropriate.
	i. Do controlled movement by unit to pill line, or administer medication on the units.
	j. Encourage ill staff to stay home until symptoms resolve and/or they are cleared to return to work by their provider.
	k. Post visitor notifications regarding outbreak. Advise visitors with respiratory symptoms to not enter the facility (If large outbreak, consider suspending visits).
	l. During large outbreaks, consider halting patient movement in and out (in consultation with local health department).