

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

Version 27

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

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Contents

Screening	2
Initial Evaluation	3
Case Reporting	4
Infection Control and Prevention	5
Infection control and prevention principles:	5
Infection Prevention and Control Categories:	9
Medical isolation:.....	9
Quarantine:	12
Routine Pre-procedure COVID-19 Testing:	15
Intersystem and Intrasystem Separation:.....	16
Protective Separation for Prisons	18
PPE Requirements for Prisons and Work Release Staff:	19
Environmental Cleaning.....	20
Outbreak and Cluster Testing and Management	22
Release of Patients into the Community	24
Transportation of Patients with Suspected or Confirmed COVID-19 Disease	26
Contact Tracing	27
Serial Testing in Work Release	28
Testing Procedures	28
Reuse of N95 Respirators:	31
Reuse of N95 respirators:	31
Do NOT reuse and DISCARD N95 respirators if:.....	31
Donning and Doffing of N95 respirator:	32
Donning a NEW N95 respirator:.....	32
Donning a USED N95 respirator:.....	32
Doffing an N95 respirator:	32

Guideline Update Log.....	32
03/06/2020	32
03/09/2020	33
03/11/2020	33
03/12/2020	33
03/13/2020	33
03/17/2020	33
03/18/2020	33
03/19/2020	33
03/20/2020	33
03/25/2020	33
03/27/2020	34
04/03/2020	34
04/07/2020	34
04/15/2020	34
04/21/2020	34
04/24/2020	35
05/06/2020	35
05/15/2020	35
06/29/2020	36
07/20/2020	36
09/08/2020	37
10/06/2020	37
12/2/2020	38
01/25/2021	39
03/22/2021	40
06/25/2021	42
07/13/2021	42

Screening

- 1) **Patients presenting with symptoms in a work release (WR) or prior to Health Services contact in a prison:**
 Direct the patient to immediately don a surgical mask if not already wearing one, place them in an isolated area within the facility and contact the WR COVID Officer/designee or Health Services respectively.

- 2) **Intersystem intakes arriving from a non-DOC facility:** These intersystem intakes arriving at DOC facilities from other facilities will have a temperature taken and will be asked the COVID-19 screening questions immediately upon arrival. If any of the screening items are positive, the patient should immediately don a surgical mask if not already wearing one and be placed in an isolated area.
- 3) **Intersystem intakes originating from the community via DOC transport** (e.g. patients from community custody field offices, work release, or community custody violators): These intersystem intakes will be screened prior to transport. If the patient screens positive they should be transported by staff in PPE per the [Transportation of patients with suspected or confirmed COVID-19 disease](#) section below.
- 4) **Patients presenting with symptoms to Health Services:** Patients with symptoms concerning for COVID-19 should immediately don a surgical mask *if not already wearing one* and be placed in an isolated area.
- 5) **Intrasystem intakes (Patients transferring between DOC facilities):** 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 if not already wearing one, place them in an isolated area, and contact health services.
- 6) **Active screening of residents in Work Release:** Work Release residents screening positive due to presence of symptoms or a temperature >100.4F upon return to the facility will immediately don a surgical mask if not already wearing one and be placed on medical isolation in a room alone if they do not require immediate medical attention via 911.
- 7) **Active screening of patients prior to entering Prison 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 if not already wearing one and be placed in an isolated area for evaluation, according to the [Health Services Evaluation](#) section below.

Initial Evaluation

- 1) For instructions on proper donning and doffing of PPE see the following [video](#) and/or [document \(Spotter guide\)](#). For detailed guidance regarding appropriate PPE for each clinical situation, see the [PPE matrix](#) or the [Infection Control and Prevention](#) section of this document.
 - a. If a health care provider is unable to be fit tested, they can use a PAPR instead of an N95 respirator (if there is not an established procedure for disinfecting PAPR hoods at facility, the used hood should be discarded after use).
- 2) Work release staff escorting an individual who had a positive screening should ask the individual to wait outside or 6 feet away until they put on appropriate PPE
 - a. If possible, escort the patient while maintaining 6 feet of distance to a room to be by themselves for medical isolation
 - b. Any surfaces touched during the escort should be disinfected, including doors.
 - c. Once the resident is in medical isolation, work release staff should assess temperature and then immediately notify the WR COVID Officer. The WR COVID Officer will contact the Work Release Medical Consultant or if not available or after hours, the COVID Medical Duty Officer.
- 3) In prison, any health care provider making close contact with symptomatic patients referred from the screening section above should don personal protective equipment before the evaluation, including a fit-tested N95 mask, gloves, face shield, and gown. Given the COVID-19 status of a patient is unknown when responding to a medical emergency, PPE should be worn that assumes the patient may have COVID until the situation is further evaluated.
 - a. Nurse performs a clinical assessment, including temperature check, and asks the following screening questions:

- i. Do you have a fever, new cough, shortness of breath, sore throat, diarrhea, or muscle aches that cannot be attributed to another cause (e.g. muscle aches if COVID-19 vaccination within the past 48 hours), or loss of taste/smell?
 - ii. Did you have contact with someone with possible COVID-19 in the previous 14 days?
 - b. If the answer to either screening questions is yes, or temperature is greater than 100.4F, notify a healthcare practitioner for further assessment:
 - i. If a practitioner is available onsite, they will assess the patient clinically and decide whether symptoms are compatible with COVID-19 disease or other influenza-like illness. If yes, proceed to step C.
 - ii. If no practitioner is onsite, the nurse will discuss the patient's case with the practitioner via telephone.
- 4) Medical record should be reviewed to identify if the patient has any [CDC designated high risk conditions](#) or uses any aerosol generating equipment (e.g. CPAP, BiPAP, nebulizer).
- 5) The practitioner will determine the following:
 - a. Level of care based on acuity
 - i. To emergency department for severely ill patients
 - ii. To a negative pressure room, if one is available, under airborne medical isolation precautions for any non-severely ill patient that requires IPU level care
 - iii. To a facility or community medical isolation unit for those with mild or moderate symptoms of influenza-like illness while awaiting test results.
 - iv. Symptomatic patients with influenza-like illness should NOT be transferred to a Regional Care Facility unless a positive PCR COVID-19 test is confirmed. Until the results have been confirmed by a COVID-19 PCR test, patients with only a positive rapid COVID-19 antigen test should not be housed with other symptomatic or COVID-19 positive individuals.
- 6) All patients screening positive for symptoms or fever who are placed in medical isolation should be tested for COVID-19 and other respiratory viruses as described in the Testing Procedure section below.
- 7) For further guidance on clinical care of patients with COVID-19 see [National Institutes of Health COVID-19 Treatment Guidelines](#), the [DOC Use of Casirivimab + Imdevimab for COVID-19 protocol](#), and the [DOC Use of Remdesivir protocol](#).
- 8) Any patients presenting to Health Services for evaluation of influenza-like illness will not be charged a co-pay per the Washington DOC Health Plan.
- 9) For questions or consultation regarding evaluation or management of patients with suspected or confirmed COVID-19 call the DOC COVID medical duty officer phone.

Case Reporting

- 1) Notification of isolated patients with known COVID-19 in prisons or WR should be sent by email to doccovid19cases@doc1.wa.gov and for WR also send to the WR Medical Consultant at docdlworkrelmedcons@DOC1.WA.GOV.
- 2) All positive COVID-19 test results for DOC residents in WR should be phoned to the Work Release Medical Consultant and the DOC COVID medical duty officer phone after hours as needed.
- 3) Other notifications should occur as per the [mapping checklist](#).
- 4) The IPN or WR Medical Consultant or designee will report positive COVID cases to their local public health jurisdiction. If the patient was transferred to a second facility for medical isolation or care, the case should be

reported to the local public health jurisdiction of the patient's original location. Do not use regular email to communicate health protected information with outside agencies. Personal identifying information may only be reported via an encrypted email (encrypt by putting [SECURE] at the beginning of the email subject line), fax or by phone.

- 5) The IPN and WR Medical Consultant will enter the information about the case of suspected/confirmed COVID-19 and the information about the exposed patients on a COVID-19 specific log or on the Influenza-Like Illness (ILI) Log found on SharePoint Health Services. To access the ILI log, go to SharePoint Health Services, select medical, under the Infection Prevent Library on the left hand side choose the option that states "Influenza-Like Illness Log".
- 6) The COVID-19 Prison Facility Data Manager will assist the IPN in tracking facility COVID-19 data and reporting daily to the COVID-19 EOC.
- 7) Patient rapid antigen test results will be reported per the section [Testing Procedures](#) #4 below

Infection Control and Prevention

Infection control and prevention principles:

- 1) Definitions:
 - a) **Medical isolation:** Separating a symptomatic patient with a concern for a communicable disease from other patients. Medical isolation status also applies to asymptomatic patients testing positive for COVID-19.
 - b) **Quarantine:** Separating asymptomatic patients who have been exposed to a communicable disease from other patients through close contact.
 - c) **Cohort:** Grouping patients infected with or exposed to the same agent. Isolated and quarantined patients should NOT cohort together. Cohorting helps minimize transmission outside the defined group, but it may not eliminate the need to quarantine individuals outside the group. Cohorting also does not eliminate the need for individuals within a cohort to socially distance.
- 2) The following recommendations should be made for prevention of COVID-19:
 - a) All incarcerated individuals in prison or WR facilities will wear DOC provided surgical mask when out of their cell/room unless instructed otherwise.
 - b) Perform frequent hand hygiene
 - c) Perform frequent cleaning of cell/room throughout the day, especially high touch areas
 - (1) Highly discourage the use of bleach as this can exacerbate conditions for those patients with underlying lung disease
 - d) Avoid contact of high-touch surfaces
 - e) Cohort when feasible
 - f) Social distancing (staying at least 6 feet from others) should be maintained during Day Room, Yard, Gym, Dining Halls, Religious Services, Pill Line, and other areas where the incarcerated population congregates. Recommend signage to help identify where people should stand or sit when in these areas, the direction of the flow of movement through choke points and the maximum capacity based on distancing in these areas as appropriate (i.e. dayrooms and dining areas).
 - g) Consider barriers when social distancing and/or cohorting is not feasible.
 - h) Maximize airflow and air filtration as possible.

- 3) PPE must be changed between EVERY patient in medical isolation or quarantine any time there is close contact except in the following situations:
- a) Regional Care Facilities and tiers, units or pods of medical isolation units where ALL patients have a confirmed positive result for COVID-19:
 - a) It is not necessary to change eye protection, mask/respirator, and gown between each patient.
 - b) Hand hygiene and new gloves are still needed between each patient. This can be achieved by double gloving, removing the outer gloves, disinfecting the inner gloves, and putting on new outer gloves between patients.
 - c) All PPE should be changed if visibly soiled.
 - b) If wearing a face shield for eye protection, then it may not be necessary to change mask/respirator between each patient as long as the shield covers the extent of the mask/respirator. More detail in the N-95 reuse section.
- 4) Facility management of isolated, quarantined, intake/transfer separation patients:**
- a) If possible, cluster cases in medical isolation within in a single location/wing within the facility to help streamline ongoing assessments and delivery of services to the affected population
 - b) If possible, medical isolation areas should not be located in units housing quarantined patients or general population individuals unless it has been confirmed by environmental analysis that medical isolation cells are under negative pressure and air is ventilated into the outdoors.
 - c) Refer to section Facility Management of Patients on Medical Isolation Status and Facility Management of Patients on Quarantine Status below under Infection Prevention and Control Strategies.
 - d) If patients are in medical isolation or quarantine, allowances will be made to accommodate patients:
 - a) Television, playing cards and/or other recreational activities will be provided
 - b) There will be no cost for COVID-19 related medical evaluations or assessments of the patient for the duration of their stay
 - c) All patients/residents placed in medical isolation/quarantine will be issued hygiene kits and new clothing as needed
 - d) Access to personal property
 - e) Management of patients receiving outpatient hemodialysis on-site at Monroe Correctional Complex will be managed as follows:
 - (1) Universal source control measures
 - (a) While in the MCC dialysis unit with patients not on quarantine or isolation, staff should wear a surgical mask, face shield, gown and gloves.
 - (b) ALL patients should wear a surgical mask at all times while they are in the dialysis unit.
 - (c) Patients who are not on isolation or quarantine status should never cohort with quarantine or isolation patients in the dialysis unit.
 - (d) Clean and disinfect dialysis unit and machines after patient use per current protocols.
 - (e) Screen patients at entry to the dialysis unit per current Washington DOC COVID-19 protocol, if positive at screening refer to sections 2 below as clinically appropriate
 - (f) Adequate supplies for hand sanitizing should be placed within reach of dialysis chairs for patient use.
 - (g) Maintain 6 feet of distance between all patients regardless of COVID status at all times while in the dialysis unit.
 - (h) Patients should move to the dialysis unit in a manner that avoids all possible close contacts with each other and with other patients and staff in the MCC WSR Health Services and IPU area.

- (2) COVID quarantine and isolation patients requiring dialysis
 - (a) While in the dialysis unit with patients on quarantine or isolation status staff should wear the following PPE at all times, and this PPE should be changed between patients after any close contact: Fit-tested N95 respirator, face shield, gown, and gloves
 - (b) Quarantine patients can be cohorted together during dialysis sessions with strict physical distancing maintained.
 - (c) Quarantine patients should never be cohorted with medical isolation patients in the dialysis unit.
 - (d) Isolation patients can be cohorted together during dialysis sessions with strict physical distancing maintained.
 - (e) If multiple groups of patients, based on their COVID status, require dialysis on the same day the groups should be scheduled in the following order from earliest to latest in the day:
 - (i) Patients not on COVID quarantine or isolation status
 - (ii) Patients on quarantine status
 - (iii) Patients on isolation status
- (3) Disinfection of the hemodialysis unit [SEE section on Environmental Cleaning below]
- f) Provision of health care
 - a) Routine health care will be provided at cell front and non-urgent issues may be deferred.
 - b) Medications will be given at cell front and in alternative living units
 - c) Insulin and other diabetic services will be given at cell front and in alternative living units
 - d) Routine mental health services will be provided at cell front
 - e) Emergency medical, dental, and mental health needs will be assessed immediately by health service 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 anytime they are outside their cell/room.
- f) In Work Release:
 - (1) Should a resident on medical isolation or quarantine need to be transported by WR staff, follow the instructions in section [Transportation of Patients with Confirmed or Suspected COVID-19 Disease](#)
 - (2) Notify the WR Medical Consultant if a patient in medical isolation or quarantine is on CPAP, BiPAP or uses a nebulizer machine.
 - (3) Notify the WR Medical Consultant if a patient who will be transferred to a community medical Isolation/Quarantine Facility is on a pill line medication.
- g) Meals will be provided by Food Services and delivered to the cell/room.
 - a) The Unit staff will notify Food Services at the beginning of each shift the number of meals that are needed
 - b) PPE per the matrix will be worn when picking up used trays
- h) Education Programs will be suspended
- i) Phone Use in Medical Isolation and Quarantine:
 - a) Phone Use in Prison Medical Isolation and Quarantine for Areas WITH In-Cell Phone Use:
 - (1) Staff shall don appropriate PPE for patients based on their COVID status per the [PPE Matrix](#)
 - (2) Staff shall cover the phone handset with a plastic sleeve and use tape/bands to cinch both ends to enclose the entire handset
 - (3) Patient will wear a surgical mask, if they are medically able to do so

- (4) Staff shall pass the handset of the phone to the patient via the cuff port or an opening of the door if necessary
 - (5) Staff shall have the patient wash his/her hands immediately after using the phone
 - (6) Staff shall carefully remove the plastic sleeve from the phone and dispose of it in the garbage container
 - (7) Staff shall remove PPE appropriately and then sanitize or wash hands as per protocol
 - (8) Staff shall spray disinfectant over the entire phone, let it sit for 10 min., and put on new gloves before wiping it off
- b) Phone Use in WR Medical Quarantine or Medical Isolation for areas with available mobile phones:
- (1) Mobile phones should preferentially be used for patients in medical isolation if there is limited availability
 - (2) One phone should be issued to each individual for the duration of their medical isolation or quarantine and the phone number should be recorded in the WR COVID-19 SharePoint through the Incident Recorder.
 - (3) If limited phones are available, the phone must be disinfected between each patient by **staff** spraying a rag with disinfectant and wiped down completely (Do not spray the phone directly) and wait the designated time for proper disinfection according to the manufacturer's guidelines.
- c) Phone Use in Medical Quarantine for Areas WITHOUT phones available in-cell/room for use:
- (1) Patients in quarantine will wear a surgical mask when out of their cell/room, including for the full duration of the phone call
 - (2) Patients should be cohorted for phone use, so that they are outside their cell/room with the same patients each time
 - (3) If 6 feet of distance does not exist between phones, then either some phones will not be available for use in order to create distance or physical barriers will be placed between each pay phone
 - (4) Disinfectant and a clean rag will be available for the patient to wipe down the phone hand-set before and after use (Do not spray the phone directly)
- d) Isolated patients should have access to in cell/room phone use and should not need to come out to use the phone
- j) **Showers in Medical Isolation and Quarantine:**
- a) Patients in Medical Isolation and Quarantine will be allowed to maintain personal hygiene including showers according to the following:
 - (1) For patients in medical isolation showers should be offered starting on day 7 per custody unit/house schedule. However, if a housing unit is only housing patients with confirmed COVID-19 by PCR, showers can be per normal unit operations without delay as long as staff are able to maintain safe distancing during the process.
 - (2) For patients in quarantine, showers should be offered per custody unit/house schedule throughout duration of quarantine.
 - (3) Quarantined and intake/transfer separation patients should be cohorted and must remain at least 6 feet apart for showering.
 - (4) Patients must wear a **surgical mask** at all times while out of their cell.
 - (5) The showers will need to be disinfected according to the manufacture's guidelines after each shower.

- (6) Showers should not be vigorously scrubbed, deep cleaned, or power washed due to concern that these methods could cause virus to be aerosolized.
- (7) PPE for staff or incarcerated individuals cleaning showers used by patients in Medical Isolation or Quarantine will wait at least 15 minutes prior to cleaning and wear proper PPE.

Infection Prevention and Control Categories:

Medical isolation:

- 1) Medical isolation status is indicated for patients in the following clinical situations:
 - a) Patients identified as having an influenza-like illness or other symptoms potentially caused by COVID-19, even if they have previously been diagnosed with COVID-19
 - b) Asymptomatic patients testing positive for COVID-19.
- 2) 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 if not already wearing one until the patient can be isolated in a cell/room.
 - a) Each WR, field office, housing unit and Shift Commander's office will maintain a supply of surgical masks
 - b) Surgical masks will be made available in prison clinic waiting rooms
- 3) Staff will don PPE, then escort the patient/resident to area of isolation in a cell/room by themselves. Once the resident is in medical isolation, notify Prison Medical if they are identified outside the prison clinic. WR staff should assess temperature and then immediately notify the WR COVID Officer. The WR COVID Officer will contact the Community Corrections Supervisor and WR Medical Consultant) or if not available or after hours, the COVID Medical Duty Officer.
 - a) If the patient/resident is off the living unit or out of the WR at the time COVID-19 symptoms are noted, staff working with the patient/resident will notify the applicable housing unit or work release staff on shift and WR COVID Officer that they are sending the patient/resident back for single cell/room confinement until the patient can be assessed by medical or WR staff
 - b) If a single room is not immediately available, confine the patient at least 6 feet away from others until they have been evaluated by or discussed with medical
 - c) If the patient is already in the living unit or WR, isolate the patient in their cell/room
- 4) Droplet Precautions will be initiated and Droplet Precaution medical isolation signs will be hung outside the room at cell/room front
- 5) All patients requiring medical isolation under this protocol who require ongoing use of aerosol generating medical treatments such as continuous positive airway pressure (CPAP), BiPAP, or nebulized bronchodilator treatment should be housed in negative pressure isolation rooms, if available, until release criteria have been met as described in Clinical Management of Medical Isolation Patients #3b below. If a negative pressure isolation room is not available at the facility, consult the COVID Medical Duty Officer to discuss placement.

PPE for medical isolation:

- 1) Wear PPE in medical isolation as per the PPE Matrix.
- 2) All staff must wash hands with soap and water or with alcohol sanitizer after leaving a patient's cell and removing gloves.
- 3) 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.

Facility Management of Patients on Medical Isolation Status:

- 1) Custody will work with medical staff to determine the best location to house patients on medical isolation status.
- 2) If single cell is not available, it is acceptable to cohort patients with COVID-19 together if they both/all have lab confirmed disease by PCR testing and do not have other communicable diseases concurrently (i.e. influenza or another viral respiratory disease). Do NOT place an isolated patient diagnosed with COVID-19 by rapid antigen testing with another patient with COVID-19 unless confirmed with a PCR test. This can include patients who have been tested by rapid antigen outside our system, like in a jail or community hospital or emergency room
- 3) Patients in medical isolation must be housed separately from asymptomatic exposed patients (quarantined).
- 4) If possible, avoid isolating patients with suspected or confirmed COVID-19 in cells with open bars.
- 5) As a general rule, isolated patients will not be allowed out of the cell unless security or medical needs require it
- 6) If an isolated patient needs to be out of their cell, they will don a surgical mask during the necessary movement
- 7) Staff will ensure that the patient goes where directed by communication between the sending and receiving area staff
- 8) Any pill line medications will be delivered by medical or WR staff unless medical staff determines the need for a different protocol
- 9) Patients in WR will be issued a cell phone so that they can contact staff as needed without leaving their room. The phone number of the phone given to the resident should be sent to the WR COVID Liaison so that staff can also contact the resident as needed.

Clinical management of medical isolation patients:

- 1) Symptomatic patients placed in isolation at a prison or work release facility will have the following diagnostic workup:
 - a) All patients will be tested for COVID-19 by PCR if they have never had confirmed COVID-19 before, unless the patient refuses.
 - i) COVID-19 nasal PCR testing will be repeated in 48 hours, if negative or not yet back
 - b) If the patient previously had COVID-19 within the past 180 days, testing for COVID-19 will be by rapid antigen testing in place of the PCR testing and similarly repeated in 48 hours, if negative.
 - c) If it is greater than 180 days since the patient had a positive COVID-19 test, then standard COVID-19 PCR testing will be done as above.
 - d) COVID-19 vaccination history does not change the need or protocol for isolating and testing symptomatic patients.
 - e) In the event that the patient is unable to be tested (for example if testing is declined) but for whom clinical suspicion remains, the patient should be isolated for presumptive COVID-19 disease for up to 20 days.
 - f) Patients in prison will have additional on-site work-up:
 - i) During influenza season (October through the end of March) perform rapid influenza testing as available (based on [Washington State Surveillance Data](#)) along with the first COVID-19 test if the patient has respiratory symptoms
 - ii) If the initial COVID-19 test and rapid influenza test are negative, send a viral respiratory panel (Interpath # 2910) along with the second COVID-19 test if the patient has respiratory symptoms
 - iii) Consider other diagnostic testing as clinically appropriate, i.e. CBC with differential, complete metabolic panel, D-dimer, chest x ray and blood cultures for community acquired pneumonia and/or sepsis.

- 2) Symptomatic patients isolated in WR or a living unit in prison with suspected or confirmed COVID-19 will be checked on at least every shift.
 - a) WR staff will:
 - i) Check temperature using a no-touch thermometer. Residents can self-check their temperature and hand back the thermometer for the staff to read
 - ii) Screen for COVID-19 symptoms either at the door maintaining 6 feet of distance or via their issued mobile phone
 - iii) Discuss with the WR Medical Consultant or if not available, the COVID Medical Duty Officer (564-999-1845), initially and then if any temperature of 100.4°F or higher or any report of concerning symptoms
 - b) Prison nursing will:
 - i) Conduct assessment, including complete vital signs
 - ii) Consult with a facility practitioner as clinically indicated .
- 3) Patients testing positive for COVID-19 who are initially symptomatic can be checked by WR staff or assessed by nursing once per day once they become asymptomatic for 24 hours.
 - a) Daily checks will include temperature and symptom checks at cell front or in room doorway. Nursing will also check oxygen saturation and disinfect saturation monitor between patients. Patients with recurrence of symptoms should be evaluated by a medical practitioner or discussed with the WR Medical Consultant.
 - b) Unless transfer to a setting for a higher level of medical care is required, all medical care should be delivered in the patient's medical isolation cell or room.
- 4) Patients testing positive for COVID-19 who have never been symptomatic should be checked by WR staff or assessed by nursing twice per day throughout the medical isolation period. If symptoms develop assess patient every shift as in number 2. above.
 - a) Asymptomatic patients testing positive for COVID-19 are placed in medical isolation for 14 days from the date of the positive test if the patient remains asymptomatic
 - b) Twice daily checks will include temperature and symptom checks at cell front or in room doorway. Nursing will also check oxygen saturation and disinfect saturation monitor between patients.
- 5) For patients testing negative for COVID-19 once and positive for influenza refer to the Seasonal Influenza Protocol for continued management.
- 6) For patients testing positive for both COVID-19 and influenza:
 - a) The case should be discussed with the Facility Medical Director or WR Medical Consultant as well as the COVID medical duty officer/infectious disease consultant immediately for instructions on how to manage.
 - b) The patient should NOT be placed in a Regional Care Facility or shared room at a community Isolation/Quarantine Facility
 - c) The patient should remain in medical isolation according to COVID-19 isolation criteria
 - d) Antivirals for influenza should be used if clinically appropriate
- 7) Patients isolated in WR with suspected or confirmed COVID-19
 - a) Any time staff or the resident themselves feel the resident requires a higher level of care, 911 should be called without delay and the WR Medical Consultant (509-318-3498) should be notified as soon as possible.
 - b) Transfer to a community medical Isolation/Quarantine Facility or Regional care facility will be in discussion with the WR Medical Consultant.
- 8) For further guidance on clinical care of patients with COVID-19 see [National Institutes of Health COVID-19 Treatment Guidelines](#), the [DOC Use of Casirivimab + Imdevimab for COVID-19 protocol](#), and the [DOC Use of Remdesivir protocol](#). For questions or consultation regarding evaluation or management of patients with suspected or confirmed COVID-19 call the DOC COVID medical duty officer phone.

- 9) Prison medical practitioners should document an assessment on all patients entering medical isolation for confirmed or suspected COVID-19 within one business day
 - a) If symptomatic, patients should be assessed by medical practitioner daily until asymptomatic for 24 hours.
 - b) If asymptomatic, patients should be assessed by medical practitioner if there are any clinical concerns. Once the patient is thought to be symptomatic daily assessments by the medical practitioner should occur.
 - c) If there is clinical concern about placement of symptomatic patients, the practitioner will discuss with the Facility Medical Director and Deputy Chief Medical Officer or COVID Medical Duty Officer as indicated to determine if transfer to a Regional Care Facility is appropriate. Transfers to a higher level of care in the community are made at the facility level.
- 10) Patients with laboratory confirmed COVID-19 will remain in medical isolation until they have been asymptomatic for 14 days OR until they have been in medical isolation for 20 days from COVID-19 test date as long as their symptoms are improving and they have been afebrile (without fever reducing medication) for 72 hours with the following exceptions:
 - a) Patients with confirmed COVID-19 who are significantly immunocompromised may continue to shed contagious virus after the usual medical isolation period is complete. The practitioner will discuss any patient with significant immunocompromise by diagnosis or medication with the COVID Medical Duty Officer prior to release from medical isolation to determine if it is necessary to conduct rapid COVID-19 antigen testing to confirm two negative tests at least 24 hours apart prior to return to general population.
 - b) For patients in isolation who require ongoing use of medical treatments that may aerosolize virus, such as nebulized bronchodilators and continuous positive airway pressure (CPAP or BiPAP) should be housed in negative pressure isolation rooms, if available until the isolation period is completed. If a negative pressure isolation room is not available, notify the Facility Medical Director, CMO, deputy CMO, COVID Medical Duty Officer or the WR Medical Consultant to discuss placement. After completing isolation, it will require two negative COVID-19 rapid antigen tests at least 24 hours apart prior to release from the negative pressure isolation room.
- 11) Removal of patients from medical isolation status requires review by the Infection Prevention Nurse or designee or WR Medical Consultant or designee for prisons and WR respectively.
- 12) Patients who tested negative for COVID-19, influenza, and other respiratory viruses will remain in medical isolation until:
 - a) they have been asymptomatic for 14 days, unless they have a definitive confirmed alternate diagnosis that explains their symptoms, such as in the following example:
 - i) Fever explained by infection at another site, such as UTI or cellulitis
 - b) **OR** they have been asymptomatic for at least 72 hours and have tested negative for COVID-19 twice with at least 48 hours between tests

Quarantine:

Patients who are asymptomatic, but have been in close contact with confirmed or suspected COVID-19 patients should be placed on quarantine status. If a facility goes on outbreak status, follow the section Outbreak Testing and Management below regarding who and how to quarantine.

PPE for staff interacting with quarantined patients:

- 1) Whenever possible, staff should avoid close contact with patients in quarantine. For example, in an open dorm style housing unit, have patients sit on their bed during tier checks.

- 2) Wear proper PPE based on quarantine status according to the [PPE Matrix](#).

Facility Management of Patients on Quarantine Status:

- 3) Custody will work with medical staff to determine the best location to house patients on quarantine status. Quarantined patients ideally should be housed alone or cohorted when determined by medical to be necessary with other quarantined patients from the same exposure.
- 4) If possible, avoid quarantining patients with suspected or confirmed COVID-19 in cells with open bars.
- 5) If the patient develops symptoms or fever while on quarantine
 - a) Prison health services will perform a full assessment upon entering the cell in appropriate PPE for symptomatic patients with suspected COVID-19.
 - b) WR staff will call the WR Medical Consultant to discuss any reported symptoms or fever without the need to enter the room. Staff will call 911 as clinically appropriate.
 - c) The patient should be moved to medical isolation as appropriate
- 6) Patients in quarantine should don a surgical mask anytime they leave their cell.
- 7) Any pill line medications will be delivered to the quarantined patient by medical or WR staff unless staff determines the need for different protocol.
- 8) A trash bin and bag, hand sanitizer, and gloves should be available immediately outside the cell/room or unit/house to assist staff in proper doffing of PPE.
- 9) 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 in prison.
- 10) Signage indicating that the quarantine areas are under droplet precautions will be hung at the cell/room, unit, or tier level.
- 11) Patients in WR will be issued a cell phone so that they can contact staff as needed without leaving their room. The phone number of the phone given to the resident should be sent to the COVID Liaison so that staff can also contact the resident as needed.

Clinical Management of Patients on Quarantine Status:

- 1) Asymptomatic patients are placed on quarantine status after being identified as a close contact of a symptomatic suspected COVID-19 case or a confirmed COVID-19 case. In WR the close contact can occur in the house or in the community.
- 2) Asymptomatic patients who previously tested positive for COVID-19 within the past 90 days do not need to quarantine even if they have had a close contact with a confirmed case. Quarantine is still necessary after COVID-19 vaccination or if it has been 90 days or more since testing positive for COVID-19.
- 3) All patients placed into quarantine status who are close contacts of confirmed (by a positive COVID test) cases will be tested for COVID-19 within one business day of the positive test result unless the patient refuses.
 - a) Patients testing negative for COVID-19 will remain on quarantine status. They will be retested for COVID-19 between quarantine days #7-#10.
 - i) Patients testing negative for COVID-19 will remain on quarantine status until 14 days from the time of last contact with the index case has elapsed.
 - b) Patients who test positive for COVID-19 or become symptomatic will be transferred to medical isolation. Further management of these patients is described in [Medical Isolation](#) section.
 - c) If a patient has never had confirmed COVID-19 before or if it has been >180 days since testing positive for COVID-19, then testing in quarantine will be with a standard COVID-19 PCR test.

- d) If the patient on quarantine previously had COVID-19 91-180 days ago, testing for COVID-19 will be by rapid antigen testing.
 - e) In the event that the patient is unable to be tested (for example if testing is declined), the patient should be quarantined for up to 24 days based on the maximum period of time during which the patient remains at risk for developing COVID-19 infection.
- 4) Close contacts of patients who test negative for COVID-19 may only be released from quarantine if the associated symptomatic patient tests negative for COVID-19 on two tests at least 48 hours apart:
- a) If repeat testing is not available, close contacts of patients testing negative once for COVID-19 may be released from quarantine 14 days after their last contact with the symptomatic patient.
- 5) At a minimum, patients in quarantine in WR or prison will be checked on twice daily.
- a) WR staff will:
 - i) Check temperature using a no-touch thermometer. Residents can self-check their temperature and hand back the thermometer for the staff to read.
 - ii) Screen for COVID-19 symptoms either at the door maintaining 6 feet of distance or via their issued mobile phone.
 - iii) Discuss with the WR Medical Consultant or if not available, the COVID Medical Duty Officer, initially and then if any temperature of 100.4°F or higher or any report of any clinical symptoms or concerns.
 - iv) If a quarantined patient develops symptoms of COVID-19, they will be immediately removed from quarantine, if they were housed with other asymptomatic patients, and placed into medical isolation in discussion with the WR Medical Consultant and if not available, the COVID Medical Duty Officer.
 - v) Transfer to a community medical Isolation/Quarantine Facility or Regional care facility will be in discussion with the WR Medical Consultant
 - vi) If multiple cases occur in the same work release refer to the [Outbreak Testing and Management](#) section.
 - b) Prison nursing will:
 - i) Conduct assessment, including a temperature check, oxygen saturation, and monitoring for development of any symptoms at a minimum. *Disinfect all equipment, including oxygen saturation monitor, between patients.*
 - ii) For stand-alone camps, Health Services staff will determine scheduling to accommodate assessment of quarantined patients 7 days per week.
 - iii) If the patient develops symptoms, fever, or oxygen desaturation while in quarantine, they will be assessed by a medical practitioner per Health Services Evaluation section step #3.
 - iv) If a quarantined patient develops symptoms of COVID-19, they will be immediately removed from quarantine, if they were housed with other asymptomatic patients, and placed into medical isolation.
 - v) If the symptomatic patient lived in dormitory-style housing, consider quarantining an entire dorm or wing of a housing unit. If multiple cases occur in the same living unit refer to the [Outbreak Testing and Management](#) section.
 - vi) Staff performing nursing assessments of patients in quarantine should do so by discussing development of symptoms and perform temperature check at the cell front after donning PPE outlined above. Assessments should be documented on [13-583 Influenza-Like Illness Assessment Flow Sheet](#).
 - (1) Disposable thermometers should be used by patients if available. If multi-use thermometers must be used, they should be disinfected in between patients.
- 6) Close contacts of patients who test positive for COVID-19 will remain in quarantine 14 days after the last exposure to the patient.

- a) When a quarantined patient develops symptoms of COVID-19 and is placed into medical isolation, the quarantine period for the rest of their cohort will be reset to day 0 of 14.
- 7) All patients in quarantine who require ongoing use of aerosol generating medical treatments such as continuous positive airway pressure (CPAP or BiPAP) or nebulized bronchodilator treatment should be housed in negative pressure isolation rooms, if available, until the quarantine period is completed. If a negative pressure isolation room is not available, notify the Facility Medical Director, CMO, deputy CMO, COVID Medical Duty Officer or the WR Medical Consultant to discuss placement.
- 8) Removal from quarantine status requires review by Infection Prevention Nurse or designee or Work Release Medical Consultant or designee in prisons and work releases respectively.

Routine Pre-procedure COVID-19 Testing:

- 1) Health care providers may require routine COVID-19 testing of asymptomatic patients prior to surgical, dental, or other aerosolizing procedures.
 - a) Patients may be housed in their usual housing units without special quarantine or medical isolation procedures while awaiting test results.
 - b) Staff interacting with these patients may do so without additional PPE other than a **routine surgical mask**.
 - c) Test the patient with a COVID--19 [rapid antigen test](#) within 24 hours of the planned procedure as described in the Testing Procedure section below, including test result documentation and reporting.
 - d) For patients testing positive with the rapid antigen test:
 - i) Place patient alone in cell in a medical isolation unit that does not have contact with other COVID-19 positive patients
 - ii) Confirm the positive test using COVID-19 PCR testing as described in the Testing Procedure section
 - (1) If confirmatory PCR is positive, the patient can be housed with other confirmed COVID-19 cases
 - (2) If confirmatory PCR is negative, repeat PCR testing should be sent. The patient should remain in a single cell in medical isolation while awaiting results
 - (a) If the second COVID-19 PCR test is negative, the patient is considered COVID-19 negative and can be removed from isolation if remaining asymptomatic
 - (b) If the second COVID-19 PCR test is positive, the patient is considered a POSSIBLE COVID-19 case and should remain in a single cell in medical isolation to complete the isolation period.
 - iii) Notify the onsite or offsite consultant or their office staff that the patient tested positive and reschedule procedure after isolation is completed.
 - e) For patients testing negative with rapid antigen test:
 - i) The patient is considered COVID-19 negative and can proceed with the planned procedure
 - f) For on-site pulmonary function testing (PFTs) or nebulizer treatments in the outpatient clinic:
 - i) Perform testing/treatment in a negative pressure isolation room if available or a room with a free-standing HEPA filter adequate for the room size.
 - ii) Conduct pre-procedure rapid antigen testing as above
 - iii) Discard tubing and mouthpieces between patients and disinfect machine as per manufacturer instructions.
 - iv) Staff should don proper PPE for an aerosolizing procedure if remaining in the room with the patient, including an N95 respirator, eye protection, gown and gloves.
- 2) Patients in WR can be tested on site or can arrange COVID-19 rapid antigen testing in the community on their own at any of the available testing sites with the help of their community provider.

- 3) If rapid antigen testing is not available or unacceptable to the community provider, standard COVID-19 PCR testing can be done on-site 48-72 hours prior to the procedure, unless the patient has had COVID-19 within the past 180 days (antigen testing indicated in this situation), in order to get the results back in time.

Intersystem and Intrasystem Separation:

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

Intake Separation for Prisons:

- 1) This section applies to all intersystem intakes into DOC facilities, including:
 - a) Individuals arrested on community custody violations
 - b) Patients arriving from county jails or other detention facilities
 - c) Work release, GRE, or rapid reentry returns
 - d) *Patients returning from the hospital (ONLY if returning to an IPU) or court after being out of the facility at least overnight*
- 2) Patients will be cohorted together based on day of arrival:
 - a) Patients will be housed separate from the general population as a cohort after intake to the receiving facility
 - b) After testing is initiated no new patients should be added to the cohort. The cohort should have no contact with other incarcerated individuals or other cohorts until the testing process is complete.
 - c) If patients are added to arrival cohorts after the day of arrival the intake separation period resets to day 1 after the last addition to the cohort
- 3) Intake separation is not necessary if the patient has had a confirmed diagnosis of COVID by PCR within the past 90 days.
- 4) Within 24 hours of arrival, patients in intake separation will be tested for COVID-19
 - a) All patients will be tested for COVID-19 by PCR if they have never had known confirmed COVID-19 before, unless the patient refuses.
 - i) If negative, COVID-19 nasal PCR testing will be repeated on day #7.
 - ii) If the second test is negative, the patient can be released to the general population on day 10 post intake.
 - b) If the patient is known to have previously had COVID-19 in the past 91-180 days, testing for COVID-19 will be by rapid antigen testing.
 - c) If it is greater than 180 days since the patient had a known positive COVID-19 test, then standard COVID-19 PCR testing will be done as above Patients becoming symptomatic or testing positive at either point will be transferred to medical isolation and managed according to protocol.
 - i) If a patient in intake separation is put into medical isolation and is released from medical isolation after testing negative, they will return to intake separation status until 10-14 days have passed since arrival at the facility depending on test dates
- 5) Proper PPE for intake separation as per [PPE Matrix](#)
- 6) If a patient in routine intake separation becomes symptomatic, they should enter medical isolation status and the remaining intake cohort should be placed in quarantine for 14 days.
- 7) Removal on intake separation status requires review with the Infection Prevention Nurse or designee in prisons.
- 8) If the patient is already on isolation at intake, due to a positive rapid antigen test prior to arrival, the test needs to be confirmed with a COVID-19 standard PCR test prior to placing the patient around other positive patients.
- 9) Refer to Quarantine section regarding the proper handling of laundry, meals, medications, phone calls, etc.

Transfer Mitigation for Prisons and Work Release:

- 1) This section applies to all intrasystem transfers between DOC facilities, including:
 - a) Between two prison facilities
 - b) From prison to work release
- 2) As per the Screening section above, ALL individuals, regardless of vaccine status, will undergo active screening before departing the sending facility and upon arrival at the receiving facility.
- 3) Transfer separation and testing strategies are NOT necessary if the patient is fully vaccinated for COVID-19 (≥ 14 days since J&J vaccine or second Moderna/Pfizer vaccine) or if the patient has had confirmed diagnosis of COVID within the past 90 days.
- 4) Unvaccinated individuals will undergo a transfer testing strategy:
 - a) A COVID-19 PCR test will be conducted at the sending facility within 72 hours of the planned transfer.
 - i) *For patient who have had COVID-19 90-180 days ago, a rapid antigen test will be used instead of PCR.*
 - ii) *If 72 hours prior to a planned transfer falls on a weekend or holiday, COVID-19 PCR testing can be done up to 96 hours prior to transfer.*
 - iii) *If it is not possible to do COVID-19 testing within the 72-96 hour timeframe and get results prior to transfer due to a weekend or holiday, then a COVID-19 rapid antigen test can be done 2 days prior to transfer. This will be done only if the above options are not possible.*
 - b) Upon arrival at the receiving facility, the patient will undergo COVID-19 rapid antigen testing prior to entry.
 - c) *If both tests are negative, the patient can be placed directly in general population or other planned housing destination.*
- 5) Transfer separation is still necessary for:
 - a) All individuals, regardless of vaccine status, transferring from a facility on Limited Area Outbreak or Cluster status (Of Note: transfers are stopped within the outbreak areas).
 - b) Emergency transfers (when there is not time to test prior to transfer) to IPU, COA or IMU, and can be done at the receiving facility in those units.
 - c) *Patients who refuse COVID-19 testing*
- 6) *Transportation during transfers:*
 - a) *Vaccinated individuals and individuals testing negative at the sending facility can ride together on the transfer bus.*
 - b) *Patients not tested prior to transfer for any reason (emergent transfer, test refusal) should be transported separately and then placed in transfer separation on arrival.*
- 7) Transfer separation housing:
 - a) Patients can be cohorted together based on day of arrival and sending facility:
 - b) Patients will be housed separate from the general population as a cohort before or after transfer to the receiving facility
 - c) After testing is initiated no new patients should be added to the cohort. The cohort should have no contact with other incarcerated individuals or other cohorts until transfer separation complete.
 - d) If patients are added to arrival cohorts after the day of arrival the transfer separation period resets to day 1 after the last addition to the cohort
 - e) If a patient in routine transfer separation becomes symptomatic, they should enter medical isolation status and the remaining intake cohort should be placed in quarantine for 14 days.
 - f) Removal on transfer separation status requires review by the IPN or designee in prisons or the WR Medical Consultant.

- g) Refer to Quarantine section regarding the proper handling of laundry, meals, medications, phone calls, etc.
- 8) **Testing** for patients placed on transfer separation:
 - a) Within 24 hours of arrival, patients in transfer separation will be tested for COVID-19
 - b) All patients will be tested for COVID-19 by PCR if they have never had known COVID-19 before, unless the patient refuses.
 - i) If negative, COVID-19 nasal PCR testing will be repeated on day #7.
 - ii) If the second test is negative, the patient can be released to the general population on day 10 post-transfer.
 - c) If the patient previously had COVID-19 91-180 days ago, testing for COVID-19 will be by rapid antigen testing.
 - d) If it is greater than 180 days since the patient had a known positive COVID-19 test, then standard COVID-19 PCR testing will be done as above.
 - e) In the event that the patient is unable to be tested (for example if testing is declined), the patient should be on transfer separation for up to 14 days.
 - f) Patients becoming symptomatic or testing positive at either point will be transferred to medical isolation and managed according to protocol.
 - i) If a patient in transfer separation is put into medical isolation and is released from medical isolation after testing negative, they will return to transfer separation status until 10-14 days have passed since arrival at the facility depending on test dates.
- 9) Proper PPE as per [PPE Matrix](#) for transfer separation.

Protective Separation for Prisons

- 1) Housing units with a high concentration of individuals at high risk for severe COVID-19 may be placed on protective separation status in order to reduce the risk of introduction and transmission of virus.
 - a) At the current time, the following units are on protective separation status:
 - i) CRCC-Sage East
 - ii) All DOC facility inpatient units
 - iii) Other facilities or units if designated by EOC
- 2) Special direction to staff working on protective separation units:
 - a) Only necessary and assigned staff should have access to this unit
 - b) Staff must wash hands before entering and exiting the unit
 - c) Staff will remove and dispose of their routine face mask and don a new surgical mask upon entering the unit.
 - d) No staff interacting with quarantined and isolated individuals should be entering these units during their assigned shift
 - e) Staff and porters will wear a face shield over their surgical mask in protective separation units when in contact with patients.
 - i) Fully vaccinated staff and porters working in Sage do not have to wear a face shield unless interacting with a patient in quarantine/isolation or if there are other indications for the face shield per the [PPE Matrix](#), but all staff working in an IPU should continue to wear a face shield when in contact with patients.

- f) When not interacting with patients, staff will maintain 6 feet of distance from other staff and continue to wear a surgical mask at all times
- 3) Special direction to incarcerated individuals living on protection separation units:
 - a) Individuals are restricted to interacting with others only from within their living unit
 - b) Patients are provided a surgical mask for use at all times when outside their cell/room
 - c) Patients are restricted from eating in main chow halls and meals are delivered to the living unit
 - d) Individuals shall be given pill line at their cells
 - e) Individuals should be allowed to self-quarantine if they choose
 - f) Individuals should be allowed to go outside with just their living unit
 - g) Porters should be from the unit in protective isolation when possible and may not be from a unit with known active cases. If porters are not from the protective living unit they are working in, they will undergo serial COVID-19 PCR testing once or twice a week similar to staff in the respective units.
 - 4) Patients transferring into protective separation units will be offered the COVID-19 vaccine based on vaccine availability prior to transfer, if possible, or upon arrival in the unit, if the vaccine series was not already completed
 - 5) Testing of incarcerated individuals transferring into protective separation units:
 - a) For living units, like Sage East, prior to transfer into the unit, patients will have:
 - i) Two negative COVID-19 test results and a negative viral respiratory panel (no rapid influenza test is necessary). The second COVID test should be collected with the viral respiratory panel 7 days after the first COVID test.
 - ii) The transfer should occur as soon as possible after the second test results are received and with 1 week of testing.
 - iii) Incarcerated individuals should be screened the day of transfer utilizing the screening questions and temperature checks per protocol for intrasystem transfers.
 - b) Patients transferring into facility inpatient units (IPUs):
 - i) Do not require testing PRIOR to transfer to the IPU
 - ii) Patients should be screened the day of transfer utilizing the screening questions and temperature checks per protocol for intrasystem transfers
 - iii) Upon arrival in the IPU, place transferring inpatients into single rooms, whenever possible
 - iv) After arrival, test patients for COVID-19 twice, one week apart with a viral respiratory panel with the second test.
 - v) Patients should not intermix, have access to inpatient unit day rooms, or be roomed together until they have had two negative COVID test results and a negative viral respiratory panel
 - vi) Patients on isolation or quarantine for COVID-19 should be placed in a negative pressure room when housed in an IPU. If no negative pressure room is available, consult with the CMO, deputy CMO, or COVID-19 provider on duty.
 - vii) Patients returning to the IPU from a community hospital after at least an overnight stay, will be placed into intake separation upon return. Intake separation is not necessary if they return directly to general population or if it is an emergency room visit that does not include an overnight stay.

PPE Requirements for Prisons and Work Release Staff:

1. **Tyvek suites** are not considered appropriate PPE for the purpose of this guideline and should not be used when contacting patients with suspected or confirmed COVID-19 or those on quarantine within DOC.
2. Contact with asymptomatic individuals who are not on medical isolation or quarantine:

- a) **Gloves**
 - i) Follow standard universal precautions
- b) **Routine face covering**
 - i) Follow the most current agency directives on what constitutes an appropriate every day face covering and when it needs to be worn
- 3. Wear PPE when in contact with individuals on medical isolation, quarantine, intake separation and transfer separation as per the [PPE Matrix](#)
- 4. A PAPR can be substituted for an N95 mask and eye protection according to the PAPR protocol and PAPR Training powerpoint.
 - i) Refer to the PAPR Spotter Guide on how to properly don & doff
 - ii) PAPR use is not amenable to dental procedures
- 5. During active screening, the screener should stand behind the protective barrier. Temperature should be taken by reaching around the barrier. The screener should ensure they are positioned so that the barrier blocks any potential respiratory droplets from the screened individual. If no contact was made between the screener and the screened individual, gloves do not need to be changed between screenings, unless they are visibly soiled or torn. Gloves should be removed and hands sanitized when not actively screening (i.e. there is no one waiting in line to be screened).
- 6. If a breathalyzer screening is necessary on a person without COVID-19 symptoms, in addition to a protective barrier, don proper PPE per the [PPE matrix](#), and have the person face away from any staff when performing the test. Disinfect the breathalyzer machine after use.
- 7. All staff working in DOC locations must wear an approved surgical mask while on duty as per the [PPE matrix](#).
- 8. Staff in protective separation units will wear a face shield over their surgical mask when in contact with patients and will maintain 6 feet of distancing in all areas, including from other staff. Vaccinated staff in Sage do not need to routinely wear a face shield when interacting with patients.
- 9. Recommended personal protective equipment for all DOC staff is summarized in the linked [PPE matrix](#).

Environmental Cleaning

- 1) Enhanced frequency of cleaning and disinfection procedures of high touch surfaces is recommended during the COVID-19 pandemic in prisons and work releases.
- 2) Disinfectant must be [EPA approved for COVID-19](#).
 - a) [All DOC approved disinfectants are adequate for COVID-19](#).
 - b) Follow manufacturer instructions regarding contact time necessary for the disinfectant to work. Most quaternary ammonium compounds require 10 minutes of contact time, including the Pink Correct Pac solution.
- 3) Management of laundry:
 - a) Laundry from medical isolation or quarantine patients and cells will be placed in rice bags and transported in yellow bags.
 - b) In work release, the resident will notify staff by phone when they place their laundry outside their door. Staff will do the laundry for residents on medical isolation or quarantine at least weekly.
 - c) Proper PPE for handling of laundry for individuals on isolation or quarantine is on the [PPE Matrix](#)
 - d) Contents should be treated as infectious laundry and placed into the washing machine set on hot water in the rice bag. Once out of the washing machine, it is no longer considered an infectious risk.
 - e) Laundry from patients on isolation and quarantine does not have to be washed separately from others.
- 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. If picking up the food trays requires entering a quarantine or medical isolation area, follow the [PPE Matrix](#).
 - b) In work release, the meal should be left on a chair or table outside each resident's room and the resident should be notified that it is there.
- 5) Disinfection of bathrooms in a living unit or work release, if the entire area is on quarantine
- a) The number of people allowed to use the bathroom at any time should be limited based on space and cohorting
 - b) Prior to using the bathroom, the individual should wipe down any areas that remain wet with disinfectant from the prior user with a clean paper towel.
 - c) After using the toilet, the lid of the toilet should be closed prior to flushing if possible
 - d) The person should then wash their hands thoroughly
 - e) After hand washing, the person should take the spray bottle of disinfectant kept in the bathroom and starting at the back of the bathroom, spray any area that was touched, making sure to include the flush handle, toilet seat, and sink faucets while backing out of the bathroom.
 - f) The spray bottle should be returned to its original location prior to leaving the bathroom
- 6) Medical waste from medical isolation and quarantined cells can be discarded using the regular waste disposal process.
- 7) Any individuals involved in cleaning rooms occupied by isolated suspected or confirmed COVID-19 cases, including DOC staff and employed incarcerated individuals, should wear PPE as per the [PPE Matrix](#). Cleaning of a room after someone with COVID-19 has been removed should be delayed for as long as possible.
- 8) Rooms occupied by quarantined patients, who are moved prior to the completion of the 14-day period, should be similarly cleaned only by individuals wearing PPE as per the [PPE matrix](#).
- 9) Whenever possible, porters should be from the unit being cleaned.
- 10) Areas with potential COVID-19 exposure should not be scrubbed, deep cleaned, or power washed due to concern that these methods could cause virus to be aerosolized.
- 11) Medical isolation and quarantined areas with potential COVID-19 should not be vacuumed due to the potential for vacuuming to aerosolize virus. Regular vacuuming can restart once the area has been off medical isolation/quarantine for 7 days.
- 12) Disinfection of on-site hemodialysis unit at Monroe Correctional Complex before and after each group dialysis session
- a) Cleaning and disinfecting should be performed with no patients present in the unit.
 - b) After each dialysis session no staff or porters should enter the unit for 1 hour, at which time the unit can be entered for disinfecting.
 - c) Staff and porters entering the unit for cleaning should wear the following PPE: Gown, gloves, eye protection, and surgical mask.
 - d) The dialysis unit should be cleaned and disinfected on the day of the dialysis session. If there are multiple sessions per day the unit should be cleaned and disinfected prior to each session that day.
 - e) All surfaces, equipment, and supplies within 6 feet of the patient should be disinfected or discarded
 - i) This includes walls, floor, cabinets, desks, countertops, and any other items within 6 feet of the dialysis station
 - ii) Licensed dialysis unit staff are responsible for cleaning and disinfecting the dialysis station
 - iii) Dialysis unit porters are responsible for cleaning and disinfecting the environment around the dialysis station as described in i) above
 - iv) Disposable medical supplies near the hemodialysis station should be discarded.

- f) All staff and porters should be educated, trained, and have competency assessed for these cleaning and disinfecting procedures

Outbreak and Cluster Testing and Management

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

- 1) Cluster definition: A group of confirmed cases of COVID-19 that only involves staff and/or volunteers.
 - a. **Limited Area Cluster**
 - i. Two or more confirmed cases of COVID-19 in staff and/or volunteers occurring within 14 days who work in the same living unit or work area without known community exposure to explain their infection.
 - b. **Facility Wide Cluster**
 - i. 20 or more confirmed cases of COVID-19 in a main facility, 6 or more confirmed cases of COVID-19 in a camp (free-standing or co-located minimum security unit), or 2 or more confirmed cases of COVID-19 in a work release within 14 days among staff and/or volunteers across a facility regardless of their position or post OR
 - ii. 12 or more confirmed cases of COVID-19 in a main facility or 4 or more confirmed cases of COVID-19 in a camp (free-standing or co-located minimum security unit) within 14 days among staff and/or volunteers within a facility that have direct contact with the incarcerated population.
 - c. EOC will determine when a facility meets the definition of a cluster
- 2) Outbreak definition: A group of confirmed cases of COVID-19 that includes at least one incarcerated individual.
 - a. **Limited Area Outbreak**
 - i. Two or more confirmed cases of COVID-19 in incarcerated individuals occurring within 14 days who reside in the same living area or work release OR
 - ii. One or more confirmed cases of COVID in an incarcerated individual AND one or more confirmed cases of COVID in staff or volunteers working in proximity to the incarcerated individual case/cases occurring within 14 days.
 - b. **Facility Wide Outbreak**
 - i. Two or more Limited Area Outbreaks that are connected, occurring simultaneously in the same facility.
 - c. Incarcerated individual COVID cases occurring in intake separation areas are not included in (a) above. Management of multiple cases in intake separation areas will be discussed with EOC - Health Services on a case by case basis.
 - d. Discussion with EOC – Health Services may be necessary to determine if cases on transfer separation will be attributed to the sending or receiving facility.
 - e. If an outbreak occurs in a prison or work release, the respective prison and work release outbreak checklists should be followed.
- 3) If two or more symptomatic patients test positive for influenza please refer to the Seasonal Influenza Protocol for ongoing management.
 - a. If overlapping COVID-19 and influenza outbreaks occur in the same living area contact COVID medical duty officer or Infectious Diseases Consultant.
- 4) **Contact tracing, mapping, quarantine:**
 - a. Notify the Occupational Health Medical Director or designee if two or more staff and/or volunteers in a facility tested positive from the same work area or living unit within 14 days of each other.

- b. Once a cluster or outbreak of COVID-19 has been identified, contact tracing of suspected and confirmed COVID cases will be conducted in order to identify (“map”) close contacts and determine a recommendation for quarantining of individuals and living areas.
 - i. In a prison, mapping and tracing is done by the Infection Prevention Nurse (IPN), in cooperation with the Occupational Nurse Consultant (ONC) and the facility mapping team, if staff cases are involved.
 - ii. In a work release, on site mapping and tracing is done by the Work Release Medical Consultant or COVID Medical Duty Officer, in cooperation with the WR COVID Officer. Local Public Health maps staff and resident contacts in the community.
- c. Who to quarantine will be determined on a case-by-case basis considering environmental, clinical, and operational aspects of the scenario in coordination with the Infection Prevention Nurse, WR Medical Consultant and/or Occupational Health Medical Director.
- d. When contact tracing is complete the identified individuals and living areas will be placed on quarantine as indicated. This may occur at the unit level, multi-unit level or facility level, based on details of the contact tracing and potential for wider exposures throughout the facility.
- e. Patients testing positive for COVID will be moved to medical isolation or a Regional Care Facility (RCF) based on level of medical care needed. Patients in work release may also move to medical isolation in the community at a facility run by DOH or, as necessary, the local health jurisdiction based on recommendations of the WR Medical Consultant.
- f. Testing of affected DOC staff should occur simultaneously with incarcerated individual testing in a cluster or outbreak setting to limit risk for re-introduction of COVID in populations that have tested negative. Staff who had COVID-19 within the last 90 days do not need to be tested.
- g. Testing of the population for COVID-19 during an outbreak will be done in the room/cell of each individual.
- h. Staff working in cluster or outbreak areas will wear surgical mask and face shield at all times, unless the situation requires additional PPE as directed elsewhere in this protocol or the [PPE Matrix](#).
- i. Patients in quarantined living areas will have symptom screening, temperature and oxygen saturation checks two times daily, and will be moved to medical isolation areas if they screen positive or become symptomatic.
- j. When symptomatic or COVID positive patients are moved to medical isolation from a quarantined unit, the remaining cohort who were potentially exposed to the individual will have its quarantine period reset to day 1.

5) Unit operation and cohorting:

- a. After a cluster is identified, movement of the population will not be affected unless one or more incarcerated individuals from the affected area (limited area cluster) or facility (facility wide cluster) are confirmed to have COVID-19 at which time the facility is on limited area or facility wide outbreak.
- b. Incarcerated individuals in living areas on quarantine during an outbreak situation should be placed into distinct contact cohorts at the beginning of the quarantine period:
 - i. The purpose of cohorting is to minimize the spread of COVID between cohorts and limit the number of individuals who acquire COVID, but it does not necessarily eliminate the need for multiple cohorts or entire units to quarantine.
 - ii. Cohorts will be comprised of the smallest number of individuals as is operationally feasible as determined by the facility Cohort Specialist in coordination with the IPN.
 - iii. Patients should not change cohorts through the duration of the quarantine period.
 - iv. Unit operations should be managed so that cohorts do not have contact with other cohorts in the quarantined unit or with any incarcerated individuals outside of the quarantined unit.

- v. Once a case of COVID is diagnosed within a cohort, it may be necessary to further separate the individuals remaining in quarantine in that cohort to minimize transmission within that cohort and avoid further impacts on other cohorts in the living unit.
 - c. If essential workers, such as porters, kitchen workers, or laundry workers from the quarantined unit/facility are needed to maintain prison operations, the Incident Command Post (ICP) will discuss the situation with the IPN or EOC at the start of the quarantine to explore solutions for providing unit services while mitigating risk of transmission.
 - d. Continuation of court-ordered programming, religious services, visitation and other prison movements outside of the quarantined area should be discussed with EOC.
 - e. No transfers should occur in or out of areas on quarantine during an outbreak.
- 6) Population testing and Cluster/Outbreak resolution:**
- a. During a COVID-19 cluster, the incarcerated individuals in the affected area or entire facility will undergo initial testing.
 - i. In areas where all of the tests are negative, the need for additional testing and resolution of the COVID-19 cluster will be determined by the Occupational Health Medical Director in collaboration with the COVID Medical Duty Officer.
 - ii. Areas that have someone with a positive test will transition to outbreak status and will be placed on quarantine.
 - b. In quarantined areas where incarcerated individuals testing positive for COVID-19 positive are identified, those testing negative initially will be re-tested as soon as initial test results are available, ideally within 48 hours.
 - c. Subsequent serial testing will be repeated every seven days until all incarcerated individuals in the quarantined area have two consecutive negative weekly results
 - d. Once serial testing results show that all incarcerated individuals in the living area or work release have two negative tests on days 5-7 and 10-14 of a 14 day period. AND they have been on quarantine status at least 14 days from their last contact with COVID positive or symptomatic patients, the living area or work release can be removed from quarantine.
 - e. Prior to moving patients back into a quarantined living area in a prison during an outbreak situation, discuss with IPN and/or EOC. In a WR, the situation will be discussed with the WR Medical Consultant.

Release of Patients into the Community

- 1) Facilities will use the release protocols to guide safe release of patients back to the community in relation to COVID-19:
 - a) *Protocol for Transition and Release – Violators*
 - b) *Protocol for Transition to the Community from Prisons*
 - c) *Protocol for Transition to the Community from Prisons – Immediate Release*
 - d) *Protocol for Transition to the Community from Work Release*
- 2) Every facility will identify a team to assist with release planning for individuals releasing on COVID-19 medical isolation or quarantine. They will also assist with release planning when the facility is on outbreak status.
 - i) For prisons, the release team should, at a minimum, include health services, classification, and if relevant, community custody
 - ii) For work release, the release team should at a minimum, include the WR COVID Officer, WR Medical Consultant or designee, and if relevant, the Community Corrections Officer
- 3) Patients in medical isolation:

- a) For any patient who had a positive COVID-19 test in medical isolation who is releasing from a DOC facility will release in medical isolation if it is 10 days or less from symptom onset or COVID-19 test date. The facility release team will follow the COVID-19 release protocol when available to ensure proper transportation, housing, and community notifications are made prior to release of the individual.
 - b) If the patient had a positive COVID-19 test and remains in medical isolation at the facility, but more than 10 days have passed from symptom onset or test date, they can be off isolation once outside the facility perimeter and do not require special arrangements in the community
 - c) If the patient has suspected COVID-19 and their first COVID-19 PCR test has come back negative, but the second test is pending or has not yet been done, they can be off isolation once outside the facility perimeter and do not require special arrangements in the community. If there is a pending PCR test, it will be cancelled.
 - d) If the patient has suspected COVID-19 and two COVID-19 PCR tests have come back negative, but the patient remains in medical isolation, they can be off isolation once outside the facility perimeter and do not require special arrangements in the community.
 - e) If the patient has suspected COVID-19, but no COVID-19 test results are back yet. The patient will have a COVID-19 rapid antigen test within 24 hours of release and any pending PCR tests will be cancelled.
 - i) If the COVID-19 rapid antigen test is negative, the patient should remain on isolation in the facility, but can be off isolation once outside the facility perimeter and do not require special arrangements in the community.
 - ii) If the COVID-19 rapid antigen test is positive, the patient will be considered a preliminary positive and will release in medical isolation. The facility release team will follow the release protocol to ensure proper transportation, housing and community notifications are made prior to release of the individual.
 - f) An instructional brochure will be given to every patient releasing from medical isolation in [English](#) or [Spanish](#).
- 4) Patients in quarantine due to close contact or facility outbreak status:
- a) For any patient in quarantine for COVID-19 who is releasing from a DOC facility, the facility release team will follow the COVID-19 release protocol when available to ensure proper transportation, housing, and community notifications are made prior to release of the individual.
 - b) Prior to release of a patient in quarantine, they will have a COVID-19 rapid antigen test within 24 hours of release and any pending PCR tests will be cancelled.
 - i) If the COVID-19 rapid antigen test is negative, they will release in quarantine status as planned
 - (1) If the facility is NOT on outbreak status and the patient is on quarantine due to a close contact, they should complete a total of 14 days of quarantine (e.g. if they have already been in quarantine for 5 days in the facility by the time of release, they only need to be in quarantine an additional 9 days in the community).
 - (2) If the facility IS on outbreak status, any patient releasing from that facility will need to be in quarantine for a full 14 days in the community from the day of release.
 - ii) If the COVID-19 rapid antigen test is positive, they will release in medical isolation as above and will be considered a preliminary positive and the plan for transportation, housing, and community notification will be updated as necessary.
 - c) An instructional brochure will be given to every patient releasing from medical isolation in [English](#) or [Spanish](#).
- 5) For ALL unvaccinated patients releasing who are not on isolation or quarantine and are not at a facility on Limited Area or Facility wide outbreak or cluster status:
- a) A COVID-19 rapid antigen test will be done within 24 hours of release.
 - i) If the COVID-19 rapid antigen test is negative, no special arrangements are necessary and the release can proceed as planned.

- ii) If the COVID-19 rapid antigen test is positive, they will be immediately placed in medical isolation until release and will be considered a preliminary positive and the plan for transportation, housing, and community notification will be updated.
 - (1) An instructional brochure will be given to every patient releasing from medical isolation in [English](#) or [Spanish](#).

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 those with community custody violations, 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 Facility Medical Director in consultation with the COVID-19 Medical Duty Officer.
- 3) When a unit or facility experiences an outbreak, transfers in and out of that unit will be suspended and the situation discussed with the COVID-19 EOC.
- 4) For any patients with confirmed or suspected COVID-19 disease by a licensed medical provider being transported into or between facilities, custody officers, community custody officers, or other DOC staff in close contact with the patient will don PPE per the [PPE Matrix](#) which includes disposable examination gloves, disposable gown, fit-tested, N-95, and eye protection.
- 5) For transport for all other individuals, staff will don PPE per the [PPE Matrix](#) which includes gloves, gown, surgical mask, and eye protection.
- 6) 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.
- 7) During transport the air-conditioner will be set on non-recycle per the transportation protocol
- 8) When temperature allows, front and back windows will be cracked open to allow for air flow through the vehicle
- 9) Transport of more than one patient at a time from medical isolation or quarantine will be reviewed with the Infection Prevention Nurse at the facility, WR Medical Consultant, or COVID-19 EOC.
- 10) A symptomatic patient will not be transported with anyone else without discussion with the DOC Nurse Desk, COVID Medical Duty Officer, WR Medical Consultant, or the facility Infection Prevention Nurse depending on the scenario and location of the transport.
- 11) Transportation staff should adhere to the following procedure when doffing PPE after transport of a patient with suspected or confirmed COVID-19:
 - a) Transfer patient to custody of facility staff
 - b) Doff PPE (gown/gloves/eye protection) per protocol into nearest garbage can, but keep on mask and sanitize hands
 - c) Return to vehicle and don clean gloves
 - d) Sanitize vehicle
 - e) Doff rest of PPE and sanitize hands
 - f) Don routine surgical face mask
- 12) The transport vehicle will be cleaned and disinfected after each use.

Contact Tracing

- 1) Cases of suspected and confirmed COVID-19 in Prison will be thoroughly investigated by the IPN with assistance as needed from the facility mapping team to identify additional contacts within the facility for the IPN to further investigate:
 - a) Review the patient's cell and living unit location, job, classes, etc. to determine who could have been exposed and needs to be quarantined.
 - b) If in the course of the contact tracing it is apparent that DOC staff may have had close contact with the confirmed or suspected COVID-19 case, the IPN will send an email with case details to the following Occupational Health email address: DOCoccupationalhealthandwellness@DOC1.WA.GOV and the Facility Incident Command Post.
- 2) Cases of suspected and confirmed COVID-19 among residents in WR will be thoroughly investigated within the facility by the WR Medical Consultant with assistance as needed from the WR COVID Officer.
 - a) If in the course of the contact tracing it is apparent that DOC staff may have had close contact with the confirmed or suspected COVID-19 case, the WR Medical Consultant will send an email with case details to the following Occupational Health email address: DOCoccupationalhealthandwellness@DOC1.WA.GOV and the WR Administrative Assistant.
 - b) The Local Health Jurisdiction will conduct the mapping and tracing of community close contacts of both staff and residents.
 - c) The ONC will determine the return to work date of staff who were mapped out of work release due to a close contact.
 - d) The secondary screeners will determine the return to work date for staff who have screened out of work release through the active screening process.
- 3) The decision to classify a contact as close or high risk and requiring quarantine will be a clinical decision by the IPN or WR Medical Consultant taking into consideration the guidance described here. Consultation with the COVID-19 Duty Officer, a DOC Infectious Disease physician, or designee should be considered if any uncertainty exists regarding how to classify a contact with a suspected or confirmed COVID-19 case.
- 4) A close, or high-risk, contact with potential COVID-19 cases will be defined as follows for the purpose of this guideline:
 - a) Close contact is defined as being within 6 feet of someone with suspected or confirmed COVID-19 for a cumulative total of ten minutes within a twenty-four hour period, starting 2 days prior to symptom onset or test date (if asymptomatic).
 - b) Having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).
 - c) Contact not considered close or high risk include briefly entering the patient room without having direct contact with the patient or their secretions/excretions, or a brief conversation with a patient who was wearing a facemask.
 - d) 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 generating respiratory aerosols through actively coughing, singing or shouting during the contact, and less likely if they are wearing a facemask. Other factors to consider include: presence of any symptoms, proximity, duration of exposure, environmental factors (indoor/outdoor, ventilation in the area).
 - e) Internal reporting of medical isolation and quarantine of individuals after mapping and tracing
 - i) For WR, the WR Medical Consultant or designee will report the need to isolate a patient and the need to quarantine other patient/s as indicated to doccovid19cases@doc1.wa.gov, the EOC Infectious Disease

Specialist, the WR COVID Officer, and the COVID Liaison for WR. Staff mapping results will be reported by the ONC to doccovid19cases@doc1.wa.gov, DOCDLWRSL2S@DOC1.WA.GOV, the WR COVID Officer, and the WR HQ Administrative Assistant.

- ii) For prisons, the IPN or designee will report the need to isolate a patient and the need to quarantine other patient/s as indicated to the facility COVID-19 Data Manager, facility ICP as needed, Facility Medical Director, and COVID-19 EOC.
- f) The IPN or WR Medical Consultant will update the contact investigation and review medical isolation/quarantine status of the tested and exposed patients after receipt of test results.
- g) Occupational Nurse Consultants will, in communication with the IPN, review the case for potential close contacts among DOC prison staff.

Serial Testing in Work Release

- 1) Residents who have not completed their COVID-19 vaccination arriving in work release will begin weekly serial testing for COVID-19 after the completion of transfer testing or separation.
- 2) Serial testing refers to the screening of asymptomatic patients with a COVID-19 test. It does not refer to the testing done when patients are placed on isolation or quarantine.
- 3) Serial testing of unvaccinated work release residents will be done using a COVID-19 rapid antigen test twice weekly with at least 3 days between test days.
- 4) Serial testing should be done on the same days every week if possible. If the patient is out of the facility or unavailable on their usual assigned day, they will be tested the next time the patient is available to be tested.
- 5) COVID-19 rapid antigen test results will be reported as per DOH guidelines. See section Testing Procedures below.
- 6) At the time of testing, the identity of the resident will be confirmed by two methods of identification, such as full name and DOC number or full name and date of birth.
- 7) Serial testing can be done at the duty station or other area with the staff behind a barrier. If there is a line, residents should stand 6-feet apart and ideally there should be markers on the floor to ensure adequate distancing.
- 8) Residents will be handed a swab and instructed to self-collect an anterior nares specimen.
- 9) The WR COVID Officer will be immediately notified of any positive results. The WR COVID Officer will then notify the Reentry COVID Liaison and Work Release Medical Consultant.

Testing Procedures

- 1) For influenza rapid point of care testing, follow test manufacturer testing instructions
- 2) For viral respiratory panel, follow Interpath lab testing instructions for test number 2910.
- 3) Polymerase chain reaction (PCR) testing for COVID-19:**
 - a) PCR is a molecular test that detects virus genetic material and is used in all cases that testing is required by this protocol, unless other testing methods are specifically mentioned.
 - b) Upper respiratory samples appropriate for COVID-19 PCR testing can include any of the following. Patient collected nasal anterior and mid-turbinate samples are preferred. All sampling techniques require synthetic tipped swabs, such as dacron, nylon, or polyester, without wooden handles:
 - i) Nasopharyngeal (NP) swab:

- (1) NP swab sample collection is considered an aerosol generating procedure that requires the clinician to wear full PPE including an N95 mask.
- (2) Perform NP swab on both sides of the nasopharynx, with either one swab or two depending on composition of testing kit and swab availability
- (3) Please review the following nasopharyngeal swab sample collection guidance:
 - (a) NP swab is clinician collected only
 - (b) [NP swab guidance document](#)
 - (c) [NP swab demonstration video](#)
- ii) Nasal mid-turbinate swab:
 - (1) Nasal mid-turbinate swab can be clinician or patient collected.
 - (2) Use a flocked tapered swab. Tilt patient's head back 70 degrees. While gently rotating the swab, insert swab less than one inch (about 2 cm) into nostril (until resistance is met at turbinates). Rotate the swab several times against nasal wall and repeat in other nostril using the same swab.
- iii) Anterior nares specimen swab:
 - (1) Anterior nares specimen swab can be clinician or patient collected.
 - (2) Using a flocked or spun polyester swab, insert the swab at least 1 cm (0.5 inch) inside the nares and firmly sample the nasal membrane by rotating the swab and leaving in place for 10 to 15 seconds. Sample both nares with same swab.
- c) There are currently two laboratory options for COVID-19 testing:
 - i) **Interpath Laboratory:**
 - (1) Testing through Interpath does not require specialized supplies for packaging and shipping as samples are picked up through the established Interpath lab courier.
 - (2) Collect COVID-19 specimen per Interpath Laboratories [test collection guidance](#).
 - ii) **Northwest Pathology or Atlas Genomics Lab:**
 - (1) Enter the Northwest Pathology/Atlas Genomics online portal, [TestDirectly](#), to enter a testing order.
 - (a) Health Services staff must have pre-authorization to access this site. Contact Docdlcovid19testing@doc1.wa.gov to request site access.
 - (b) Create or locate the patient profile, create an electronic order, and print the requisition and/or barcode label from the portal.
 - (2) Collect COVID-19 specimen per Northwest Pathology [test collection guidance](#).
 - (3) Northwest Pathology specimens are validated for 7 days at room temperature, Atlas Genomics specimens are validated for 5 days at room temperature.
 - (4) Ship test sample via FedEx. Pre-paid labels and shipping containers can be ordered in advance from the [Washington Department of Health](#). COVID-19 viral test kits should be ordered through the facility Logistics Section Chief.
 - (5) Test results are available through the [TestDirectly](#) portal.
- 4) **Rapid antigen testing for COVID-19:**
 - a) Watch [Module 1-4 instructional videos](#) on the webpage prior to performing the BinaxNOW COVID-19 Ag Card test on this webpage (Press yes when prompted to proceed. Scroll down to the videos below; Module 5 does not need to be viewed)
 - i) Module 1: Getting Started
 - ii) Module 2: Quality Control
 - iii) Module 3: Specimen Collection & Handling

- iv) Module 4: Patient Test
- b) Prior to using a swab from a new box on a patient, perform a negative and positive control test as per instructions in the box or the Module 2 video above
- c) Conduct the antigen test on the patient according to the package insert
 - i) Obtaining the specimen
 - (1) Carefully insert the swab into the nostril
 - (2) Using gentle rotation, push the swab until resistance is met, less than one inch into the nostril
 - ii) Rotate the swab 5 times or more against the nasal wall then slowly remove from the nostril
 - iii) Using the same swab, repeat sample collection in the other nostril
 - iv) Test direct nasal swab as soon as possible after collection
- d) Using the test card
 - i) Remove card from its pouch just before use and lay flat (opened)
 - ii) Hovering ½ inch above the top hole, slowly add 6 drops of reagent to the top hole of the swab well (Do not touch the card with the dropper tip while dispensing)
 - iii) Insert sample swab into bottom hole
 - iv) Firmly push upward so that the swab tip is visible in the top hole
 - v) Rotate swab shaft 3 times clockwise (Do NOT remove swab)
 - vi) Peel off adhesive liner from right edge of the test card and close and securely seal the card
 - vii) Set timer for 15 minutes
 - viii) Read the result in the window 15 minutes after closing the card (It is important to read the result promptly at 15 minutes and NOT before)
- e) Interpret the results at 15 minutes
 - i) Negative: One pink line at the level of the control
 - ii) Positive: Two pink lines at the level of the control and the sample
 - iii) Invalid:
 - (1) One line at the level of the sample, but the control line is missing
 - (2) No lines at all
 - (3) A blue line at the level of the control
- f) Dispose of used test kit after reading the result in a biohazard red bag
- g) Any invalid tests should be immediately repeated using another test kit
- h) Document test result on [DOC 13-415 In-House Lab Results](#)
- i) See specific sections of this protocol to determine clinical action to take in response to the COVID-19 rapid antigen test result. In general, patients with just a positive COVID-19 rapid Ag test result:
 - i) Are considered preliminary positives until the result is confirmed with a standard PCR test
 - ii) Will be single celled and will NOT be housed with other COVID-19 positive patients in a cell or RCF
- j) Clinical scenarios in which rapid antigen testing is indicated per protocol include pre-procedure, pre-release to the community, patients who require testing who have had COVID 90-180 days ago, and in patients who use aerosolizing machines such as CPAP, BIPAP or a nebulizer prior to taking off medical isolation. Other indications require approval of the CMO, deputy CMO or infectious disease specialist.
- k) Reporting positive test results to DOH can occur in one of two ways:
 - i) Fax each individual [COVID-19 POC DOH Reporting Form](#) completely filled out to DOH at 206-512-2126
 - (1) Test Name: Abbott BinaxNOW COVID-19 Ag CARD

OR

- ii) The facility will completely fill out the [DOH POC Reporting Spreadsheet](#) for ALL results of rapid antigen testing, positives and negative results in two separate files, and at the end of each day email

the spreadsheets of positives via secure email (by putting the following in the subject line: [SECURE] DOC POC COVID-19 testing with date) to Phocis-fax@doh.wa.gov

- l) Once DOH has an online reporting system, all COVID-19 rapid antigen test results will be entered per DOH request.

Reuse of N95 Respirators:

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

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

Given the current adequate supply of N95 respirators, they should only be reused if the staff member is limited to a specific size or brand of N95 respirator that is in short supply.

Reuse of N95 respirators:

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

Do NOT reuse and DISCARD N95 respirators if:

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

Donning and Doffing of N95 respirator:

Donning a NEW N95 respirator:

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

Donning a USED N95 respirator:

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

Doffing an N95 respirator:

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

Guideline Update Log

03/06/2020

- Under Health Services Evaluation, section 3.iii, added subsection 3 to include criteria for isolating patients who are suspected COVID-19 who cannot be tested.

- Under Infection control and Prevention section C.5, d. “COVID-19 patients will not be isolated in an IPU, unless they require IPU level of medical care.” was deleted.
- Under Infection control and Prevention section C.9 added.
- Section Transportation of patients with suspected or confirmed COVID-19 disease added.

03/09/2020

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

03/11/2020

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

03/12/2020

- Section Health Services Evaluation part 5 Testing Procedure updated

03/13/2020

- Section Testing Procedure information regarding testing through Interpath labs

03/17/2020

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

03/18/2020

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

03/19/2020

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

03/20/2020

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

03/25/2020

- Section Patients at High Risk for Severe COVID-19 added
- Section Infection Control and Prevention added statement regarding release from quarantine requirements

- Section Health Services Evaluation added pharyngitis to screening questions
- Section Infection Control and Prevention, added PPE Requirements for Prisons and Work Release Staff

03/27/2020

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

04/03/2020

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

04/07/2020

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

04/15/2020

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

04/21/2020

- Section Infection Control and Prevention added statement that Tyvek suites are not appropriate PPE for this purpose and should not be used.
- Section Infection Control and Prevention added statement that quarantined patients must don a surgical mask anytime they leave their cells.
- Section Infection Control and Prevention added statement regarding all staff wearing approved face coverings while on duty.
- Section Patients at High Risk for Severe Covid-19 changed interventions for high risk and very high risk patients

- Section Contact Tracing and Case Reporting changed positive COVID test result reporting to include COVID medical duty officer and COVID cases email box.
- Section Health Services Evaluation added diarrhea and loss of taste/smell to screening questions.
- Section Infection Control and Prevention added statement regarding droplet precaution signs in quarantine units
- Section Infection Control and Prevention added subsections h. and i. regarding phone use in medical isolation

04/24/2020

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

05/06/2020

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

05/15/2020

- Section Infection Control and Prevention added information for each care situation regarding when to change PPE
- Section Infection Control and Prevention added subsection Protective Separation
- Section Reuse of N95 Respirators added
- Section Health Services Evaluation changed testing criteria for viral respiratory panel

- Section Infection Control and Prevention subsections Routine Intake Separation and Separation Prior to Work Release Transfer were combined into Intersystem Transfer Separation and the period of pre-work release separation was changed to 14 days

06/29/2020

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

07/20/2020

- Section Infection Control and Prevention Categories, Quarantine, Clinical Management of Patients on Quarantine Status, changed #2 to ‘Patients placed into quarantine status who are close contacts of confirmed (by a positive COVID test) cases will be tested for COVID-19 with a viral PCR test within 24 hours.’
- Section Infection Control and Prevention Categories, Medical Isolation- Clinical Management of Medical Isolation Patients- added #3b: Any patient with significant immunocompromise by diagnosis or medication as determined by a medical practitioner will be discussed with the COVID medical group prior to release from medical isolation
- Section Transportation of Patients with Suspected or Confirmed COVID-19 Disease #4 added describing procedure for donning and doffing PPE before and after disinfection of the transport vehicle.
- Section Infection Control and Prevention- Environmental Cleaning- added #10 ‘Areas with potential COVID-19 exposure should not be vacuumed due to the potential for vacuuming to aerosolize virus.’
- Section Infection Control and Prevention Categories- Medical Isolation- added #7 requiring patients on medical isolation who use CPAP or nebulizer treatments to be housed in negative pressure isolation rooms.
- Section Infection Control and Prevention Categories- Medical Isolation- Clinical Management of Medical Isolation Patients- added #3a regarding patients with confirmed COVID-19 using CPAP or nebulizers requiring 2 negative COVID-19 tests 48 hours apart prior to release from medical isolation.
- Section Infection Control and Prevention Categories- Intake Separation added COVID-19 testing process for intersystem intakes (added to version 19)
- Section Infection Control and Prevention Categories- Post Isolation Convalescent Housing was deleted
- Section Infection Control and Prevention Categories- Quarantine- Intake Separation- changed #3 to ‘Patients in these categories should be separated from the general population at the receiving facility for 14 days after arrival if COVID-19 testing is not available or is not feasible due to the patient’s length of stay’

- Section Infection Control and Prevention Categories, Separation Prior to Work Release Transfers was deleted
- Section Transportation of Patients with Suspected or Confirmed COVID-19 Disease- added #3 'When two or more cases of confirmed COVID-19 are present within a 30 day time period in a facility's housing unit transfers in and out of that unit will be suspended and the situation discussed with Prisons/Health Services Unified Command.'

09/08/2020

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

10/06/2020

- Section Health Services Evaluation- added #1. e.
- Section Health Services Evaluation- #3. a. added 'muscle aches that cannot be attributed to another cause.'
- Section Health Services Evaluation- #4. a. added 'or other influenza-like illness'.
- Section Health Services Evaluation- added #4. d.
- Section Health Services Evaluation- #4 e. i. and ii. SIGNIFICANT CHANGES PLEASE REVIEW CAREFULLY
- Section Health Services Evaluation- added #5.
- Section Testing Procedure- added #1 and #2
- Section Testing Procedure- #3. a. added 'Patient collected anterior nares and mid-turbinate samples are preferred'.
- Section Infection Control and Prevention/Infection Control and Prevention Principles- added #2.
- Section Infection Control and Prevention/Infection Control and Prevention Principles- added #4. h. 2. Regarding showers in quarantine.
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation/Clinical Management of Patients in Medical Isolation- #1 and #2 contain extensive revisions please review section. #5 added 'oxygen saturation'. #6 added b.

- Section Infection Control and Prevention/Infection Control and Prevention Categories/Quarantine/Clinical Management of Patients in Quarantine/ #2 changed 'within 24 hours' to 'within one business day'. Added #6.
 - Section Infection Control and Prevention/Infection Control and Prevention Categories/Protective Separation- #4 added viral respiratory panel testing to intake separation testing procedure.
 - Section Outbreak Testing and Management- added #2 regarding influenza outbreaks and #3 added 'facility mapping team'.
 - Section Reuse of N95 Respirators- added #1. c.
 - Section Transportation of Patients with Suspected or Confirmed COVID-19 Disease- added #7. d. adding eye protection to PPE for transportation staff
- Section Contract Tracing and Case Reporting 1. d. i. updated definition of close contact, and 1. g. added notification for new isolation and quarantine patients to facility ICP.

12/2/2020

- The entire document was updated to better reflect the needs in work release facilities
- Section Initial Evaluation - #7. b. i. and ii added that influenza and respiratory viral testing only needed in patient with respiratory symptoms
- Section Infection Control and Prevention/Infection Control and Prevention Principles/Facility Management of Isolated/Quarantined Patients– g. eliminated category Phone Use in Medical Isolation for Areas WITHOUT In-Cell Phone Use
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation/ PPE for Medical Isolation – updated to match PPE Matrix v12
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation/ Clinical Management of Medical Isolation Patients - #4 changed criteria for release from isolation status
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation/ Clinical Management of Medical Isolation Patients – added #5
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Quarantine/PPE for Staff Interacting with Quarantined Patients – updated to match PPE Matrix v12
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Quarantine/Clinical Management of Patients on Quarantine Status – added #7
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Intersystem Transfer Separation/Intake Separation for Prisons – added #3. a. iv and #6
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Intersystem Transfer Separation/Protective Separation for Prisons – deleted AHCC K Unit from #1. a.
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Intersystem Transfer Separation/Protective Separation for Prisons – added #2 f. and #3 f.
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Intersystem Transfer Separation/Protective Separation for Prisons – clarified #4 a.
- Infection Control and Prevention/PPE Requirements for Prisons and Work Release Staff – Updated to match PPE Matrix v12
- Infection Control and Prevention/Environmental Cleaning – clarified approved disinfectants in #2 and added #5
- Release of Patients into The Community – added #1. c., #2. b. and #2. c.
- Transportation of Patients with Suspected or Confirmed COVID Disease – added #4 through #9

- Contact Tracing – clarified #4. d.

01/25/2021

- Section Screening - #7 undated to take into account DOH influenza surveillance data and added additional laboratory testing to consider
- Section Screening - #8 added link to the DOC Use of Remdesivir Protocol
- Section Infection Control and Prevention/Infection Control and Prevention Principles - #4d added alternative living units
- Section Infection Control and Prevention/Infection Control and Prevention Principles - #ha)1) showers can be per normal unit procedures if a unit is only housing confirmed COVID cases
- Section Infection Control and Prevention/Infection Control and Prevention Principles - #4d section to protocol for the hemodialysis unit at MCC
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation - #1 and #5 edited to include guidance for patients who previously have had COVID-19 infection
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation/Facility Management of Patients on Medical Isolation Status - #2 clarified management based on type of COVID-19 testing
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation/Clinical Management of Patients in Medical Isolation - #4 Updated when patients can come off medical isolation
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Medical Isolation/Clinical Management of Patients in Medical Isolation -#4b Updated when patients using aerosolizing machines can come off medical isolation
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Quarantine/Clinical Management of Patients on Quarantine Status - #2 Added that patient with COVID-19 within the past 90 days do not need to quarantine
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Quarantine/Clinical Management of Patients on Quarantine Status - #3c Added that testing patients on quarantine is not needed if they have had COVID-19 in the past 180 days
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Routine Pre-Procedure COVID-19 Testing – Updated section to incorporate COVID-19 rapid antigen testing
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Intersystem and Intrasytem Transfer Separation/Intake Separation for Prisons - #4 updated proper PPE to match the PPE matrix
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Intersystem and Intrasytem Transfer Separation – Added section on transfer separation for prisons and work releases
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Protective Separation - #2 and #3 Clarified information regarding porters in these units
- Section Infection Control and Prevention/Infection Control and Prevention Categories/Protective Separation - #4 Clarified information about protective separation in IPU's
- Section infection Control and Prevention/PPE Requirements for Prisons and Work Release Staff – Updated to allow for PAPRs in place of N95 and eye protection consistent with new PAPER protocol
- Section infection Control and Prevention/Environmental Cleaning – #11 Added bullet about disinfection of the hemodialysis unit

- Section Release of Patients Into The Community – section updated to be consistent with and refer to the new release protocol
- Section Testing Procedure - #4 Added section on COVID-19 rapid antigen testing procedures and reporting

03/22/2021

- Modified language throughout document to reflect 3/3/2021 memo directive to issue entire population surgical masks
- Changed COVID-19 primary point of contact in work release from the Community Corrections Supervisor to the Work Release COVID Officer.
- Changed headquarters work release contact from CCD/Work Release Unified Incident Command to the Work Release COVID Liaison.
- Sections Screening #6a & Contact Tracing #4e i) - Changed the mapping of staff in WR from the WR Medical Consultant to an Occupational Nurse Consultant.
- Updated PPE recommendations throughout document to reflect changes in v16 of the PPE Matrix
- Updated document to reflect the availability of both serial testing and COVID-19 rapid antigen testing at all work release facilities.
- Section Initial Evaluation #3a - Clarified that patients with muscle aches due to COVID-19 vaccination do not need to be isolated.
- Section Initial Evaluation #4 - Updated sections referring to aerosol generating equipment.
- Updated sections referring to on-site aerosolizing procedures to include pulmonary function testing (PFTs) and outpatient nebulizer treatments.
- Section Case Reporting #6 - Added reference to the Prison Facility Data Manager
- Section Infection Control and Prevention/Infection control and prevention principles #1c & Outbreak Testing and Management: Clarified purpose of cohorting.
- Section Infection Control and Prevention/Infection control and prevention principles #4d - Added that patients in isolation and quarantine should have access to personal property
- Section Infection Control and Prevention/Infection Prevention and Control Strategies & Infection Control and Prevention/Infection Prevention and Control Strategies/Quarantine/Clinical Management of Patients on Quarantine Status #5b i) - Highlighted that oxygen saturation monitors need to be disinfected between patients.
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Quarantine/Facility Management of Patients on Quarantine Status #11 - Added that patients in quarantine in work release should also be given a cell phone.
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Quarantine/Clinical Management of Patients on Quarantine Status #2 - Clarified that patients still need to be quarantined after COVID-19 vaccination.
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Quarantine/Clinical Management of Patients on Quarantine Status #3a - Added flexibility on the timing of second test for COVID-19 in quarantine
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Quarantine/Clinical Management of Patients on Quarantine Status #3c-e - Added clarification on how to handle testing for patients who previously had COVID or refuse testing.

- Infection Control and Prevention/Infection Prevention and Control Strategies/Quarantine/Clinical Management of Patients on Quarantine Status #7: Clarified who to notify if a negative pressure room is not available for a patient using aerosol generating equipment.
- -Infection Control and Prevention/Infection Prevention and Control Strategies/Routine Pre-procedure COVID-19 Testing #1f: Added guidance regarding on-site pulmonary function testing and nebulizer treatments.
- Section -Infection Control and Prevention/Infection Prevention and Control Strategies/Routine Pre-procedure COVID-19 Testing #3 - Added option to do pre-procedure testing by PCR
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasystem Transfer Separation/Intake Separation for Prisons #1d - Added Clarification on when intake separation was necessary when returning from court or the hospital
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasystem Transfer Separation/Intake Separation for Prisons #3b-d - Added clarification on how to handle testing for patients who previously had COVID or refuse testing.
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasystem Transfer Separation/Transfer Separation for Prisons and Work Release #2 - Added that transfer separation can be done prior to transfer depending on scenario
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasystem Transfer Separation/Transfer Separation for Prisons and Work Release #3b-d - Added clarification on how to handle testing for patients who previously had COVID or refuse testing.
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasystem Transfer Separation/Protective Separation for Prisons #3g - Added that porters assigned to units in protective separation should undergo weekly serial testing similar to staff
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasystem Transfer Separation/Protective Separation for Prisons #4 - Added recommendation to offer COVID-19 vaccination as available to individuals in protective separation
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasystem Transfer Separation/Protective Separation for Prisons #5b vii) - Clarified when intake separation was necessary when patients are returning from a community hospital offsite trip.
- Section Infection Control and Prevention/PPE Requirements for Prisons and Work Release Staff #3a iii) - Added information about using a PAPR in place of an N95 respirator.
- Section Outbreak Testing and Management #1d - Added need for discussion about where to attribute cases in transfer separation.
- Section Outbreak Testing and Management #4b - Added the role of the facility Cohort Specialist
- Section Outbreak Testing and Management #5 b&c - Clarified when a unit on outbreak status can come off quarantine.
- Section Release of Patients into the Community #3b i): Clarified the length of quarantine after release
- Section Release of Patients into the Community #4 - Added COVID-19 rapid antigen testing of ALL patients prior to release
- Section Contact Tracing #2a - Contact tracing of staff in work release will now be done by Occupational Health.
- Section Contact Tracing #4e ii) - Added the facility COVID-19 Data Manager
- Section Serial Testing in Work Release - Added section on serial testing of residents in work release
- Section Reuse of N95 Respirators - Since N95 respirators are no longer in short supply, re-use is discouraged.

06/25/2021

- Section Initial Evaluation - #3 recommended that PPE including an N95 or PAPR should be donned when responding to a medical emergency until the COVID-19 status of the patient is clarified.
- Section Initial Evaluation - #7 added link to the DOC Use of Casirivimab + Imdevimab use for COVID-19 protocol
- Section Infection Control and Prevention/Infection Control and Prevention Principles - #1c Highlighted that individuals within a cohort still need to socially distance.
- Section Infection Control and Prevention/Infection Control and Prevention Principles – f, g, h adding signage at choke points, barriers, and maximizing air flow and air filtration as COVID-19 mitigation measures.
- Section Infection Control and Prevention/Infection Control and Prevention Principles – 4i b)3 clarified that if cell phones are shared between residents then STAFF should properly disinfect before the exchange.
- Section Infection Control and Prevention/Infection Control and Prevention Principles – 4j a)7 clarified that porters should wait 15 minutes before cleaning a shower after it is used by individuals in isolation or quarantine.
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasytem Separation/Transfer Separation for Prisons and Work Release - #4 added to exclude fully vaccinated individuals from the need to undergo transfer separation.
- Throughout document eliminated references to proper PPE and refer to the PPE Matrix as guidance.
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Protective Separation for Prisons – #3g Porters working in protective units who live outside the unit should serial test as often as the staff working in that unit.
- Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasytem Separation/Protective Separation for Prisons - #2 e) i) Fully vaccinated staff at Sage no longer need to routinely wear eye protection when interacting with patients.
- Section Infection Control and Prevention/Environmental Cleaning – #3e & #3f Clarified that laundry from patients on isolation and quarantine does not have to be washed separately from others. Also, cleaning of rooms after an isolated patient has been removed should be delayed as long as possible.
- Section Outbreak and Cluster Testing and Management – The definition and response to a COVID-19 limited area and facility wide cluster was added. The definition of an outbreak was divided into limited area and facility wide outbreak.
- Section Release of Patients into the Community – Added the link to the release protocol and #5 Eliminated the need for rapid antigen testing prior to release for vaccinated patients who are not on isolation or quarantine and are not at a facility on outbreak.
- Section Serial Testing in Work Release – Eliminated need for vaccinated individuals to serial test. Changed serial testing for unvaccinated individuals from a weekly PCR to a twice weekly COVID-19 rapid antigen test.
- Section Testing Procedures – Updated procedures for submitting swabs to Northwest and Atlas Genomics labs and noted that DOH will soon have an online portal to upload all COVID-19 rapid antigen test results.

07/13/2021

- *Section Infection Control and Prevention/Infection Prevention and Control Strategies/Intersystem and Intrasytem Separation/Transfer Separation for Prisons and Work Release – Updated section to address what to do if testing prior to transfer fall on a weekend or holiday and how to transport patients. Also, clarified when transfer separation is still necessary.*
- *Section Release of Patients into the Community- #1 Link to the release protocol was inserted*