

POLICY B-02 INFECTIOUS DISEASE PREVENTION AND CONTROL

<p align="center">POLICY OF STATE OF DELAWARE DEPARTMENT OF CORRECTION</p>	<p align="center">POLICY NUMBER B-02</p>	<p align="center">TOTAL PAGES 13 plus one attachment</p>
<p>CHAPTER: 11 BUREAU OF HEALTHCARE, SUBSTANCE ABUSE, AND MENTAL HEALTH SERVICES</p>	<p>RELATED NCCHC / ACA STANDARDS: NCCHC: P-B-02 (essential), J-B-02 (essential), MH-B-01(essential), O-B-01 ACA: 5-ACI-6A-12 (Mandatory), 5-ACI-6A-14 (Mandatory), 5-ACI-6A-16 (Mandatory), 5-ACI-6A-17 (Mandatory), 4-ALDF-4C-14 (Mandatory), 4-ALDF-4C-15, 4-ALDF-4C-16 (Mandatory), 4-ALDF-4C-17 (Mandatory), 4-ALDF-4C-18 (Mandatory), 4-ACRS-4C-09, 4-ACRS-4C-10</p>	
<p>APPROVED BY THE BUREAU CHIEF:</p>		<p align="right">Bureau Chief, Michael Records (signature on file with BHSAMH)</p>
<p>APPROVED BY THE COMMISSIONER AND</p>		<p align="right">EFFECTIVE THIS DATE Acting Commissioner Terra Taylor, August 3, 2023 (signature on file with BHSAMH)</p>
<p align="center">APPROVED FOR PUBLIC RELEASE</p>		

- I. **AUTHORITY:** 11 *Del. C.* §6536 Medical Care
- II. **PURPOSE:** To ensure that there is a comprehensive Infection/Exposure Control Program that strives to minimize the incidence of communicable diseases among offenders and staff by ensuring that each Delaware Department of Correction (DDOC) facility has a comprehensive protocol that includes education, surveillance, prevention, treatment, follow-up, and other measures to control communicable diseases including but not limited to Influenza (Flu) Tuberculosis (TB), Hepatitis A, B, and C, Human Immunodeficiency Virus (HIV), vaccine preventable diseases (including COVID-19) and antibiotic resistant bacterial infections.
- III. **APPLICABILITY:** All Delaware Department of Correction (DDOC) employees and Contract Provider staff, offenders, visitors, volunteers, and any outside healthcare provider servicing DDOC offenders.
- IV. **DEFINITIONS:** See Glossary
- V. **SUMMARY OF CHANGES:** This policy was updated significantly and should be read in its entirety. Some changes include the requirement for a primary care provider to be trained in HCV treatment in order to treat patients with HCV. The policy was also updated to remove the requirement for a patient at liver stage F3 or F4 to be treated by infectious disease/gastroenterologist specialist. Instead, it allows for treatment for most patients by primary care provider with only those with advanced or decompensated liver disease

requiring referral to infectious disease/gastroenterology for treatment. The section on Tuberculosis testing and treatment was updated significantly as well. Additionally, there were numerous other minor changes that are too numerous to list.

VI. POLICY:

A. It is the policy of the DDOC that:

1. There is an ongoing surveillance program in place to detect offenders with infectious/communicable diseases in a timely manner.
2. Under this program, offenders will be screened for infectious diseases, offered treatment as appropriate and be enrolled in the appropriate Chronic Care Clinic as necessary for those conditions which require ongoing management and monitoring, including but not limited to HIV, Hepatitis C (HCV), TB.
3. Each facility shall have a written, facility-specific infection/exposure control plan that is approved by the Facility Medical Director and/or the Medical Contractor's Chief Medical Officer and the Bureau of Healthcare, Substance Abuse and Mental Health Services (BHSAMH) Medical Director. This plan is reviewed and updated annually.
4. The responsibility for ensuring compliance with the infection/exposure control plan rests with the Facility Medical Director (who may designate the day-to-day monitoring and enforcement to the facility Infection Control Nurse (ICN).

B. THE INFECTION/EXPOSURE CONTROL PLAN - MINIMUM REQUIREMENTS

1. The infection/exposure control plan will follow the guidelines and recommendations of the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA) and other pertinent guidelines relative to infection/exposure control such as those from the Federal Bureau of Prison (FBOP).
2. The facility-specific infection/exposure control plan must be reviewed annually, updated as needed by the facility ICN and the statewide ICN, and signed off on by the Facility Medical Director.
3. Updated infection/exposure control plan for each facility must be forwarded to BHSAMH Medical Director for review by December 31st of each year.
4. The facility-specific infection/exposure control plan must specifically address the following situations/conditions at a minimum:
 - a. Appropriate cleaning, decontamination, and sterilization of medical, dental, and laboratory equipment and instruments pursuant to applicable standards.
 - b. The proper disposal of sharps and biohazardous waste.
 - c. Effective screening and surveillance processes to detect offenders with infectious and communicable diseases.
 - d. Standard precautions to be used by health staff to minimize the risk of exposure to blood and body fluids. Standard precautions combine the major features of universal precautions and body substance isolation and apply them to all patients receiving care, regardless of their diagnosis or presumed infection status. Standard precautions include:
 - i. Hand Hygiene.
 - ii. Personal protective equipment (PPE).
 - iii. Sharps safety and safe injection practice.

- iv. Sterilization of instruments and devices.
- v. Environmental cleaning.
- e. Hand hygiene and nail care:
 - i. Hand hygiene program should include at the minimum:
 - a) Availability of and appropriate placement of alcohol-based hand sanitizers at strategic locations within the patient care environment.
 - b) Availability of sinks, soap, and water at strategic locations within the patient care environment.
 - c) Posted Guidance and training of staff on frequency and timing of hand hygiene including the “5 moments of hand hygiene” (See link [here](#)).
 - d) Posted guidance and training of staff on when soap and water should preferentially be used over hand sanitizers.
 - e) Monitoring system for ensuring staff compliance.
 - ii. Proper nail care must be enforced with prohibition of nail treatments that increase risk of infection.
 - a) Acceptable fingernails:
 - 1. Nail tips ¼ inch or less.
 - 2. Nail polish is acceptable if it’s able to be removed with polish remover.
 - b) Unacceptable fingernails:
 - 1. No chipped nail polish.
 - 2. No artificial nails or nail enhancements (staff with direct contact with patients or patient belongings).
 - 3. Artificial nails include nail enhancements, acrylic nails. Nail polish strips (“Color Street”), press on nails, bonding, tips, sculpting products, powders, dips, nail wraps, extensions, crackles, vinyl, stencils, decals. Stickers, stamps, pates, silks, jewels, gels, and overlays.
- f. Airborne precautions: Specifying diseases that require this and outlining procedures, including that patients requiring airborne isolation are housed in a functional Airborne Infection Isolation Room (AIIR).
- g. Droplet precautions: Specifying diseases that require this and outlining procedures.
- h. Contact precautions: Specifying diseases that require this and outlining procedures.
- i. Flu prevention and Flu outbreak procedures.
- j. Procedures in the event of a (non-Flu) outbreak. Including, at the minimum:
 - i. Diarrheal/GI disease outbreak.
 - ii. Vaccine preventable disease outbreak (e.g., COVID, measles, mumps).
 - iii. TB outbreak.
 - iv. Ectoparasites outbreak.

- v. Antimicrobial resistant infection outbreak (e.g., Methicillin Resistant Staph Aureus (MRSA), Clostridium. Difficile (C-Diff) outbreak).
- vi. Outbreak of a new disease or syndrome that does not fall into categories listed above.
- k. Ectoparasites surveillance and control
 - i. Screening for ectoparasites typically occurs at intake and any time an outbreak occurs among the offender population where offenders share living and bathroom facilities.
 - ii. Effective ectoparasite control procedures are utilized to treat infected offenders and to disinfect bedding and clothing. This shall include, at a minimum, the following:
 - a) Offenders, bedding, and clothing infected with ectoparasites are disinfected.
 - 1. When disinfecting bedding, caution should be taken to ensure that aerosolized treatments don't adversely affect patients with chronic respiratory diseases.
 - b) Prescribed treatment considers all conditions (such as pregnancy, open sores, or rashes) and is ordered only by providers).
 - c) When delousing of offenders is indicated, it is done under the guidance of a provider.
- l. HIV, Sexually Transmitted Disease (STD) and Hepatitis screening including frequency at which screening will be offered and follow up actions for offenders who screen positive. HIV, and HCV testing should be conducted using an opt out approach and offered at a minimum during these events:
 - i. During intake provider visit.
 - ii. During annual/biennial preventative care visit.
 - iii. At least once in two years for persons enrolled in chronic care who do not have a test result dated within the prior 2 years.
 - iv. For offenders who request testing who do not have a current test result dated in the prior 1 year.
- m. Handling of special circumstances: Including protecting pregnant and immunocompromised staff and offenders from high-risk infectious diseases.
- n. Facility's capacity relative to isolation, and plan/procedures to guide action when such capacity is exceeded.
- o. Procedures in the event of needle-stick or other blood or body fluid exposure of staff or offenders, including as appropriate, post-exposure prophylaxis.
- p. Provision of medically indicated care for offenders who are infected.

C. MEDICAL ISOLATION – MINIMUM REQUIREMENTS

- 1. There are procedures for timely identification and, if indicated, the medical isolation of offenders with contagious diseases.

- a. Medical isolation means housing in a separate room with a separate toilet, hand-washing facility, soap, single use towels, and with appropriate accommodations for showering.
- b. Isolation practices shall include, at a minimum, the following:
 - i. Ensuring that there is handwashing for everyone entering and departing the offenders' room.
 - ii. Proper handling and disposal of infectious materials.
 - iii. Proper isolation methods as appropriate for the disease condition.
 - iv. Instructions for the offenders and staff entering the room.
 - v. Proper handling of food, utensils, and dishes.
 - vi. Proper handling of patient care equipment.
 - vii. Proper cleaning and disinfecting of isolation and general housing areas.
 - viii. Proper signage to advise healthcare workers of the need to practices enhanced transmission-based precautions. (Language on signage should be such that maintains privacy of patients protected health information)
- c. Offenders with active TB shall be housed in a designated AIIR until a medical provider determines that the offender no longer poses a risk to public health.
 - i. The public health risk is determined by estimating the patient's infectiousness based on factors that include but are not limited to the following: confirmation or exclusion of TB diagnosis, possibility of multidrug-resistant TB, sputum smear results, initiation of standard multidrug anti-TB treatment, and clinical response of the patient.
- d. AIIR must be properly checked as follows:
 - i. At least annually by a licensed mechanical services contractor.
 - ii. The Annual Inspection Certificate must be present outside the AIIR.
 - iii. The AIIR shall be inspected by facility ICN or designee nurse at least once per month and then daily when the room is being occupied by a respiratory isolation patient.
 - iv. A log must be maintained documenting all inspections. This log must include, at a minimum, the following:
 - a) Name of person conducting the check.
 - b) Date of the check.
 - c) Time of the check.
 - d) Results of the check.

D. ADMINISTRATIVE & ENGINEERING CONTROLS TO MINIMIZE EXPOSURE

1. The Facility Medical Director, who may designate this responsibility to the ICN for each facility must ensure that:
 - a. Medical, dental and laboratory equipment and instruments are appropriately cleaned, and sterilized per nationally accepted guidelines and applicable regulations.

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- b. Sharps and biohazardous waste are disposed of properly and in a manner that does not pose a threat to the health of staff or offenders.
 - c. Staff who administer injections or handle sharps are trained in and demonstrate competence in safe injection practices:
 - i. At new employee orientation (NEO) (Must be in-person hands-on training).
 - ii. Annually thereafter: This may be in person or via online training.
 - iii. Documentation of this training must be provided to the BHSAMH ICN on an annual basis.
 - d. All medical area workers (including contract provider staff, DDOC staff assigned to medical, and offenders) are familiar with plan for biohazardous waste, cleaning. (As appropriate to job description), decontamination of medical/dental equipment, and sharps control.
 - e. Footwear worn in the workplace must be sturdy, provide a firm base, be non-permeable, provide good support, as well as have slip-resistant soles. All footwear in clinical areas must be completely enclosed, covered back, no holes, no sling backs, and no excessively high platform shoes/heels. Socks must be worn at all times.
- 2.If the facility Medical Director designates the duties in #1 above to the facility ICN, they must ensure that the ICN is provided the resources, authority, and support needed to enforce items in #1 above.
- 3.The facility ICN should coordinate with security to ensure the following categories of offender workers obtain applicable infection/exposure control training:
- a. Laundry and barbershop workers: training on biohazard disposal, cleanup, decontamination of equipment, and how to protect themselves from exposure to blood and body fluids.
 - b. Food service workers: training on safe food handling practices to prevent outbreaks of gastrointestinal disease.
 - c. Offender workers in medical areas: training in appropriate methods for handling and disposing of biohazardous materials, and spills and for protecting themselves from exposure to blood, body fluids and communicable diseases.
- 4.Documentation of training of offender workers (medical, laundry, barbershop, food service) must be maintained by the facility ICN and shared with the BHSAMH ICN on a quarterly basis.
- 5.All workers (including contractual medical/behavioral health staff, DDOC security staff, & offender workers) who are expected to work in medical areas for ≥ 3 days in any given month, must have received training in infection/exposure control within the preceding year. This may be in-person training provided by the ICN or approved online training.
- a. The facility ICN or statewide ICN is responsible for ensuring that medical/behavioral health/pharmacy staff and offender workers receive training in this regard within one month of starting their job in medical areas. Records of this training are sent to BHSAMH ICN monthly.
 - b. The facility or statewide ICN is responsible for ensuring that medical/BH health/pharmacy staff and offender workers receive

refresher training on at least an annual basis and that records of this training are sent to BHSAMH on at least a yearly basis.

- c. The BHSAMH ICN is responsible for ensuring that all staff who will be assigned to work in facilities receive training in this regard during NEO.
 - d. The facility ICN or statewide ICN is responsible for ensuring that DDOC security staff who may be assigned to medical areas are provided with ample opportunity to receive refresher training in this regard. Proof that this training was made available must be provided to BHSAMH ICN on an annual basis and may include:
 - i. Sign in sheets for training classes provided.
 - ii. Email notification to facility security leadership announcing date and time of in person on-site infection control training for security staff.
 - iii. Email notification facility security leadership with links to approved online infection control training.
 - iv. The curriculum and content of the above must be agreed upon by both BHSAMH and the statewide ICNs.
6. An environmental inspection of infirmaries and other health services areas must be conducted on at least a monthly basis by the facility ICN (or other designated nurse who has received appropriate training) to verify that:
- a. Equipment is maintained and functioning. This includes but is not limited to sharps receptacles, autoclave equipment, sinks for hand washing and AIIR.
 - b. Health units are clean and sanitary.
 - c. The conditions of the health unit do not represent a threat to the health of offenders or staff.
 - d. Measures are taken to ensure the unit is occupationally and environmentally safe.
 - e. Sufficient materials and resources are available for staff to practice standard precautions. This includes but is not limited to handwashing stations (sinks and/or sanitizers), PPE, cleaning and disinfection supplies, sharps receptacles.
 - f. A monthly log is maintained of the results of autoclave spore testing (including dental autoclaves).
 - g. A monthly log is maintained of the sharps inventory control.
7. On a monthly basis, the facility ICN provides to BHSAMH ICN, the records of the monthly inspections completed and also presents this data at the facility Healthcare Advisory Committee (HAC) meeting.

E. PERSONAL PROTECTIVE EQUIPMENT

1. Personal protective equipment (PPE) must be provided in all medical areas in sufficient quantities to meet the needs of medical, behavioral contractual staff, DDOC staff and offender workers.
2. PPE to be stocked includes at the minimum: gloves, face/surgical masks, gowns, respirator masks (e.g., N95), and goggles (or other face/eye coverings). Latex-free options must be made available for the use of staff and other workers who may have latex allergies. Head and shoe covers should be stocked in small quantities for use as needed.

3. It is the responsibility of the facility ICN to ensure that stock PPE is unexpired and not damaged. Damaged or expired PPE should be discarded.
4. It is the responsibility of the facility ICN to ensure that fitting for respirator (N95 mask) occurs for all workers (including contractual medical/behavioral health staff, pharmacy vendor staff, DDOC security staff, offender workers) who are expected to work in medical areas for ≥ 3 days in any given month.
5. It is the responsibility of the BHSAMH ICN to work with the Bureau of Prisons (BOP) and Bureau of Community Correction (BOC) leadership at the state level to facilitate provision of respirator fit testing for DDOC staff outside of the facilities whose primary assignment includes medical transport of offenders.
6. Fit testing shall be made available to staff.
 - a. Annually.
 - b. Whenever there is a change in the brand of N95s ordered for use in facilities.
 - c. If a staff person has a significant change in their facial configuration (weight loss or facial hair).
7. The facility ICN maintains a log of staff/workers who have been fit tested, including the size and the brand of respirator (N95) mask and is able to provide this information to the staff /offender workers as needed.
8. The facility ICN provides BHSAMH with a quarterly report on fit testing completed.
9. In the event an offender is diagnosed with infectious TB (or other condition requiring airborne isolation), the facility ICN shall conduct Just-in-time N95 fit testing for workers who may be temporarily pulled to work in medical areas (and who were not previously fit tested).
10. A plan must be in place for staff who fail fit testing (e.g., due to unique/unusual face configuration) or who are unable to be fit tested (e.g., due to health condition). Examples of suitable plans may include reassignment of said staff in the event of a patient with disease that requires airborne isolation.

F. VACCINATIONS

1. The medical contractor will facilitate on-site provision of certain vaccinations to DDOC staff to protect them from infectious diseases that they may be exposed to in the correctional setting. Depending on vaccine availability and current organisms spreading in the community, these might include vaccinations against: COVID-19, Flu, Hepatitis A, & B, and Tetanus. The cost of the vaccines shall be borne by DDOC but the administration of the vaccines and reporting to the Delaware Vaccine registry (DeVax) shall be the responsibility of the medical contractor.
2. The medical contractor shall facilitate on-site provision of certain vaccinations to contractor medical and behavioral health staff to protect them from infectious diseases that they might be exposed to in the correctional setting. Depending on vaccine availability and current organisms spreading in the community, these might include vaccinations against: COVID-19, Flu, Hepatitis A & B, and Tetanus.
 - a. Cost of vaccinations provided to medical and behavioral health contractor staff shall be borne by medical and behavioral health contractors respectively but the administration and reporting to the

Delaware Vaccine registry shall be the responsibility of the medical contractor.

3. All offenders will be offered the age-appropriate vaccination upon admission to DDOC, during routine preventative visits and during routine chronic care clinics. They will also provide with information on how to access age-appropriate vaccines via sick call at a later date.
4. All offenders will be offered influenza vaccination during influenza season (September- April). This shall be done during intake physical, preventative visits, chronic care, sick call and via specialized “flu clinics.”
5. At the discretion of DDOC, if an offender is determined to pose a communicable disease threat to visitors, staff, or other inmates, that offender may be barred from holding certain or all Level 5 inmate jobs and from participating in contact visitation. The determination of the presence of a communicable disease threat will be made using a variety of information sources. This includes but is not limited to the medical record, results of laboratory testing, symptoms screenings, finding from medical examination and/or review of 's immunization records.
6. Offenders who refuse vaccination during outbreaks of infectious will be asked to sign a form documenting refusal and this form will be maintained in the Electronic Health Record (EHR).

G. TUBERCULOSIS (TB) SCREENING AND TREATMENT

1. TB testing must be completed by all staff that are required to complete Correctional Employee Initial Training (CEIT) or the Basic Officer Training Course (BOTC). This screening shall be part of their physical exam and completed prior to beginning employment.
2. For all other new staff, TB testing instructions will be provided by Delaware Department of Human Resources (DHR) or Human resources (HR) of the medical/behavioral/pharmacy or other contractor and completed prior to NEO.
3. Annual tuberculosis (TB) screening is mandatory for all offenders, DDOC staff, staff of other state agencies that routinely work in DDOC facilities, contract provider staff, and volunteers who regularly interact with offenders under the custody of DDOC.
4. The requirement for annual TB screening is fulfilled via one of three avenues:
 - a. Completion of TB screening questionnaire (for those for whom this is deemed appropriate based on guidance from BHSAMH ICN)- See appendix 1 for TB screening questionnaire and requirements.
 - b. Completion of an annual TB skin test.
 - c. Completion of an annual TB blood test (e.g., QuantiFERON or T-Spot).
5. Any DDOC staff that refuses to have the annual TB testing completed will be subject to disciplinary action determined by their Bureau policies.
6. Contract Provider staff that refuse to have the annual TB testing completed will have their security clearance suspended pending review by DDOC.
7. DDOC volunteers that refuse to have the annual TB testing completed will have their clearance to enter facilities suspended until the screening results are submitted.
8. It is the responsibility of the facility ICN to maintain a log of all contractor staff and offenders' TB screening results in a manner that is easily retrievable for surveillance purposes and yet does not violate HIPAA or other privacy laws.

9. It is the responsibility of the BHSAMH ICN to maintain a log of all DDOC staff's TB screening results in a manner that is easily retrievable for surveillance purposes and yet does not violate HIPAA or other privacy laws.
10. All offenders with a new positive TB screening (skin test, or questionnaire) must be placed in airborne isolation until they receive a CXR, and one of two things happens:
 - a. The CXR is read as negative for TB by a radiologist, *AND/OR*
 - b. Patient is evaluated by infectious disease physician or pulmonary physician and is deemed non-infectious for TB (e.g., following initiation of treatment and receipt of sufficient medication doses to render non-infectious).
11. Treatment for latent TB should be offered to offenders with positive TB screening and negative CXR. Offered treatment will be based on current CDC guidelines.
12. Offenders who are found to have evidence of active TB will be treated in accordance with current CDC treatment guidelines and must be seen by an infectious disease specialist at least once a month during treatment, and by the infection control nurse at least once every two weeks during treatment.
13. Offenders who have active TB and are deemed to be infectious (e.g., pulmonary TB or laryngeal TB) will remain in airborne isolation until deemed non-infectious by treating infectious disease or pulmonary medicine specialist.
14. Staff, volunteers, and contractors with a new positive TB screening (skin test, blood test or questionnaire) will be excluded from work until they have received a CXR.
 - a. The CXR must be completed within two business days. Once the CXR is completed one of the following happens:
 - i. The CXR is read as negative for TB by a radiologist and documentation provided to BHSAMH: BHSAMH will provide clearance for the staff member to return to work.
 - ii. The CXR is read as abnormal: the staff member is **REQUIRED** to be evaluated by one of the following and deemed non-infectious for TB prior to returning to work (this determination must be documented in writing and provided to BHSAMH):
 - a) Division of Public Health (DPH) Tuberculosis Clinic.
 - b) Community Infectious Disease Physician.
 - c) Community Pulmonary Medicine Physician.
15. A new positive TB screen for the purpose of this policy, refers to a positive TB blood test, skin test, or positive response on TB screening questionnaire that was not previously filed with BHSAMH or the medical contractor.
16. Staff, volunteers, and contractors with a **prior documented positive** who answers yes to any questions in Sections B, C, D on the questionnaire will require a CXR.
 - a. The CXR must be completed within two business days. Once the CXR is completed one of the following happens:
 - i. The CXR is read as negative for TB by a radiologist and documentation provided to BHSAMH: BHSAMH will provide clearance for the staff member to return to work.

- ii. The CXR is read as abnormal: the staff member is REQUIRED to be evaluated by one of the following and deemed non-infectious for TB prior to returning to work (this determination must be documented in writing and provided to BHSAMH):
 - a) Division of Public Health (DPH) Tuberculosis Clinic
 - b) Community Infectious Disease Physician
 - c) Community Pulmonary Medicine Physician

H. HIV & HEPATITIS C (HCV) SURVEILLANCE AND TREATMENT

In keeping with guidelines from the [Centers for Disease Control and Prevention](#) and the [United States Preventive Services Task Force \(USPSTF\)](#), all offenders shall be offered testing for HCV and HIV as part of their initial clinical evaluation which must be within 14 days of incarceration. Testing shall be offered using an “[opt-out approach](#)” in which the offender is informed that they will be tested for HIV and HCV along with other screening and diagnostic testing unless they opt-out/refuse.

Offenders who show evidence of active HCV disease must receive appropriate laboratory and physical evaluation for disease staging and treatment planning and must be started on treatment with direct acting antivirals with the aim of curing HCV.

1. Treatment with direct acting antivirals, must be in keeping with the guidelines of the [American Association for the Study of Liver Disease \(AASLD\)](#) and must be initiated within 3 months of diagnosis of HCV in all offenders (sentenced and unsentenced) who meet the following criteria:
 - a. Has evidence of advanced liver disease/ advanced fibrosis/cirrhosis as indicated by laboratory testing, physical exam findings and/or imaging studies.
 - b. Is willing to be treated.
 - c. There are no medical contraindications to treatment.
2. Treatment with direct acting antivirals must occur within six months of diagnosis of HCV in all offenders (sentenced or unsentenced) who meet the following criteria:
 - a. At time of diagnosis, does not have any laboratory, physical exam or imaging studies concerning for advanced liver disease/advanced fibrosis or cirrhosis (if they do, they are to be treated within three months of diagnosis).
 - b. Laboratory studies (HCV viral load/ quantitative PCR) done at least six months after initial diagnosis show persistence of HCV (i.e., has not spontaneously cleared infection).
 - c. Offender is willing to be treated.
 - d. There are no medical contraindications to treatment.
3. Treatment of HCV may be done by primary care providers who have received training in HCV treatment or by subspecialists (Infectious Disease (ID) or Gastroenterology (GI)). The following groups of offenders, however, ***must*** be treated by either an ID or a Hepatologist GI doctor. (Note that even for these offenders, the timeframes listed above for when treatment must start shall be adhered to):
 - a. Patients with advanced or decompensated liver disease.

- b. Patients who are co-infected with Hep B.
 - c. Patients who are co-infected with HIV (consult with ID not GI doctor).
 - d. Patients known to have failed prior treatment for HCV.
4. All patients whose laboratory testing shows evidence of HIV infection or who are known to be HIV infected must be managed as follows:
- a. HIV patients who at the time of incarceration were on HIV medication in the community- must be restarted on those HIV medications immediately upon incarceration and the patient must be seen by a medical provider trained and proficient in HIV management within one month of incarceration.
 - b. If there is any doubt about what medications and/or doses to place the patient on, the medical contractor's facility level providers MUST discuss with the medical contractor's HIV/Infectious disease doctor to obtain guidance on treatment recommendations. This provider-provider consultation must occur and be documented in the EHR within two business days of the HIV patient's admission to DDOC.
 - c. HIV patients not on medication- Must be evaluated for treatment by a medical provider trained and proficient in HIV management within 1 month of incarceration.
 - d. Frequency and timing of follow-up/subsequent visits of HIV patients with the HIV provider will be as determined by the HIV provider but must meet the following minimum requirements:
 - i. Like other chronic care clinics, HIV provider must document in each patient's EHR as to whether the control of their HIV disease is poor, fair, or good, and take disease status into account when determining frequency of return visits.
 - ii. Every HIV patient started on a new HIV medication must be seen in follow up by HIV provider within one month of starting the new medication.
 - iii. All patients with HIV must be seen by HIV provider at least once a year whether or not they are receiving HIV medications.

I. INFECTIOUS DISEASE REPORTING & REVIEW

1. Per Delaware law, the diagnosing provider at each facility must ensure that all reportable/notifiable diseases are reported to the DPH in a timely manner as appropriate to the disease.
2. It is the responsibility of the diagnosing provider to report the notifiable disease to the DPH. This responsibility may be designated to the facility ICN only if a system is in place to alert the ICN when a notifiable disease is diagnosed.
3. All reportable diseases need to also be reported to BHSAMH ICN along with DPH.
4. Note that there are different reporting timeframes for different reportable diseases. (See list of reportable diseases and reporting timelines at <https://dhss.delaware.gov/dph/dpc/rptdisease.html>)
5. Certain infectious diseases must be reported to BHSAMH on a monthly basis. For these diseases, the prevalence (total number of offenders with the condition) as well as the incidence (all new cases- including new intakes with pre-existing diagnosis & new diagnoses made in DDOC) must be reported by the 10th of each month for the prior month. They include:

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- a. TB (both active and latent).
 - b. Meningitis (all causes).
 - c. HIV.
 - d. Hepatitis A, B, C.
 - e. Sexually Transmitted Diseases: Chlamydia, Gonorrhea, Trichomonas, Syphilis.
 - f. Ectoparasites.
 - g. MRSA.
 - h. Other antibiotic resistant infections including e.g., *C. diff*, *Vancomycin resistant enterococcus (VRE)*.
 - i. Vaccine preventable disease including Flu, mumps, measles, COVID-19, etc.
 - j. During Flu season (Sept 15th to May 15th), cases of Influenza Like Illness (ILI) and confirmed Flu cases must be reported to BHSAMH and DPH on a weekly basis.
 - k. COVID-19.
 - l. The Flu roster will be sent to the BHSAMH ICN on an as needed basis as situations change.
6. Actions and activities relative to infection/exposure control shall be presented at HAC meetings in accordance with BHSAMH Policy A-04 Administrative Meetings and Reports.
7. Offenders with communicable or infectious diseases who are released from a DDOC facility are provided with community referrals as medically indicated. These referrals must be documented and saved in the EHR. This includes but is not limited to:
- a. HIV on treatment.
 - b. Hepatitis C on treatment.
 - c. TB (active or “latent”) on treatment.
 - d. Patients actively receiving intravenous antibiotics.
- J. The Contracted Medical Provider shall develop within 30 days of the effective date of this policy, a facility-specific procedure for each Level 4 and Level 5 facility implementing this policy and coordinating the procedure with the BHSAMH.

REFERENCES

Minnesota Department of Health explains infection control precautions:

<http://www.health.state.mn.us/divs/idepc/dtopics/infectioncontrol/pre/index.html>

National Institute for Occupational Safety and Health (NIOSH)

<https://www.cdc.gov/niosh/topics/hierarchy/default.html>

Centers for Disease Control (CDC) on respirators

https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/resresource3fittest.html

Delaware reportable diseases

<https://dhss.delaware.gov/dph/dpc/rptdisease.html>

CDC infection control basics

<https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>

CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html>

DDOC New Employee Tuberculosis Screening Form

Individuals with **NO** Known Prior Positive TB Skin Test or TB Blood Test

Healthcare Provider, please administer either PPD/TST skin test OR Quantiferon blood test if NO prior history of a positive skin test or Quantiferon. Please record results below:

PPD/TST skin test (To be filled out by clinician)

Test date	Lot#, EXP	Location (Check one)	Test placed by	Date read	Results (mm)	Read by
		<input type="checkbox"/> L forearm				
		<input type="checkbox"/> R forearm				

OR

Quantiferon blood test results: _____ (please include copy of lab report)

NOTE: Any results skin test result GREATER than 5mm or positive or indeterminate QuantiFERON must have a chest x-ray ordered and results must accompany this paperwork.

Individuals with known prior positive TB skin test or Blood test (Quantiferon):

Healthcare Provider, please complete this portion ONLY if the individual has a history of prior positive PPD or QFT:

- Date of prior TB screening test: _____
- Current TB symptoms (Please check all symptoms that are present):
 - Persistent cough lasting 3 weeks or more. Fever, chills, or night sweats
 - Hemoptysis (coughing up blood). Unintentional weight loss or unexplained fatigue.
 - Other _____ N/A- No TB symptoms are present.

If any current TB symptoms, please order chest x-ray and send results with this form.
- Individual completed treatment for active TB or latent TB: Yes/No (circle one)
 - If completed treatment, please provide details:
 - What medications did they get for active/latent TB? _____
 - Treatment duration _____
 - Date of completion of treatment: _____
 - If patient ***did not*** complete treatment for active or latent TB, they must have CXR that is current or dated within the past 6 months and report of x-ray must be provided with this form.
 - Date of chest x-ray _____

DATE _____ Patient name _____ Date of birth _____

MD/DO/NP/PA name (PRINT) _____ MD/DO/NP/PA signature _____

Clinic name _____ Clinic Phone number _____ fax or email _____

Clinic Address (St/City/State/Zip) _____

DOC use only: Human Resources please provide BHSAMH with a copy of this page and any chest x-ray or lab report by emailing to DOC_ICN@delaware.gov

**DOC SOP for Prevention and Control of
Viral Respiratory Infections (Including COVID & Influenza)**

12/01/23

Supersedes all previous DOC influenza & COVID SOP except where explicitly noted

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PURPOSE/SCOPE

This document provides guidance for the prevention and containment of endemic and/or seasonal viral respiratory infections including those caused by influenza (flu), coronavirus disease (COVID) and other viruses.

TARGET AUDIENCE

DDOC staff, contractors, volunteers, visitors, and other stakeholders

Updates for the 12/01/23 version

- Clarified who pays for vaccines for contractor vs DOC staff.
- Clarified that COVID vaccination will be made available on-site during times when CDC indicates increased COVID risk.
- Clarified that “EXPOSURE” as used in this SOP is determined by time spent, distance from infected person and use/non-use of PPE. Exposure is NOT defined by the category of person infected (inmate/staff/visitor/etc.).
- Removed requirement for doctors note as a return-to-work prerequisite following COVID hospitalization.
- Added language making it the responsibility of BHSAMH ICN to notify BOP/BCC/BHSAMH Chiefs when there is increased COVID or flu activity in a county.
- Added language that BHSAMH/BOP/BCC chiefs (with input from ICN and Medical Director) will determine when there is a need to restart testing of new intakes for COVID/flu and when to test transfers or halt transfers due to respiratory virus outbreaks.
- Removed requirement to notify DPH of negative COVID results as DPH no longer requires this information.

Previous document updates- running log

To view prior updates to this protocol, please double click on the icon below



DEFINITIONS

Isolation

Keeping a person who is already known to be sick/infected with a disease-causing germ separate from others to avoid spread of infection to uninfected persons.

Quarantine

Keeping a person who was exposed to germs/infection but is not yet sick away from others while monitoring for possible development of symptoms of the illness.

Exposure

“Exposure” for the purpose of this SOP is defined as being in contact with a person with test- confirmed viral infection within ≤ 6 ft for ≥ 15 minutes total during a 24 hour period in a situation where one or the other of the individuals was not wearing appropriate PPE. Note that regardless of the source of exposure (inmate/staff/visitor/other), an exposure is deemed to have occurred if the time, distance, and non-use of PPE criteria are met.

GENERAL GUIDANCE FOR PREVENTION AND CONTROL OF OUTBREAKS OF RESPIRATORY INFECTIONS

Vaccination

- Staff, contractors, and inmates shall be offered influenza vaccination. This will be made available on site at DOC facilities statewide during influenza season (October- May).
- During influenza season, all inmates shall be offered flu vaccine and the offer and outcome (accepted/refused), documented in the inmate’s electronic health record.
- COVID vaccines shall be available onsite at DOC facilities for staff, contractors, and inmates during those months when the CDC/DPH indicates increased circulation of COVID and recommends COVID vaccination for the general public.
- The cost of vaccines for DOC staff and inmates shall be borne by DOC. The cost of vaccines for contractor staff shall be borne by respective contractor organization.
- As part of intake process, inmates shall be provided written guidance on accessing vaccination against vaccine preventable diseases (including but not limited to COVID, flu, Hepatitis A & B, tetanus, and pneumonia vaccines).
- As part of their regular responsibilities, the facility infection control nurse AND chronic care nurse shall routinely review patient records to determine those who are not up-to-date on their vaccinations. (This includes vaccines against COVID, influenza and other vaccine preventable diseases listed above). Such vaccinations shall be offered to the patients and the offer and outcome (accept/reject) documented in the patient record.

Handwashing

Sufficient handwashing supplies and stations shall be provided throughout the facility including in the housing units, common areas, healthcare areas, dining areas, visiting areas and gatehouse areas. This includes provision of hand-sanitizers with at least 70% alcohol content, and sinks with soap and running water.

Cough etiquette

Inmates, staff, contractors, volunteers, and visitors should be educated on respiratory etiquette- i.e., sneezing or coughing into inner sleeve or tissue, rather than into hand, and avoiding touching eyes, nose, or mouth.

Education may be delivered by placing informational posters and flyers prominently in areas frequented by staff and inmates.

Education and Use of Appropriate PPE

- All staff who may come in contact or in close proximity with inmates with infectious diseases (including respiratory symptoms) must be educated on standard and transmission-based infection precautions.
- This education must be offered by infection control nurse at least once a year to the following:
 - Security staff.
 - Healthcare staff - Medical/Behavioral Health/Pharmacy.
 - Inmate workers working in infirmary or other medical areas.
- All staff must comply with infection prevention signage and proper PPE use for the areas they are working in.
- It is the responsibility of the medical vendor's facility infection control nurse to ensure that there is:
 - Designated PPE donning and doffing areas outside isolation areas.
 - Dedicated trash cans for contaminated PPE.
 - Signage on proper donning and doffing procedure at each isolation area.
 - Eye covering, gloves and gowns should be available as PPE for persons handling used laundry and food service items from quarantine/isolation areas.
- It is the joint responsibility of the medical vendor's facility infection control nurse; statewide infection control nurse and DDOC infection control nurse to ensure staff (inmate workers/medical/behavioral health/admin/security) who are expected to work in medical areas are offered education on standard precautions and transmission-based precautions.

Cleaning and disinfection

High-Touch Surfaces

Frequent cleaning of high-touch surfaces (i.e., doorknobs, handrails, telephones, keys, etc.) is crucial. Cleaning may be done using EPA-certified disinfecting wipes such as the "Red- capped PDI Sani Cloth Germicidal wipes" or equivalent as available.

Bleach solution (made from household bleach) is a good cleaning solution and a good alternative that is readily available. Follow manufacturer's instructions for application and proper ventilation.

Areas or Vehicles that Housed Persons with Respiratory Infections

Terminal cleaning should occur in areas that have housed persons with respiratory infections. Persons performing cleaning of areas that have housed potentially infectious patients must be provided with appropriate PPE as is needed to safely protect themselves while performing the cleaning.

Where available, rooms and vehicles that have housed persons with viral respiratory illness should have the air decontaminated with a hydrogen peroxide fogger (or similar space decontamination technology). Where foggers are not available, such rooms should be put out of use for at least 48 hours.

Isolation, Movement restrictions for Respiratory Infections

Avoid superinfection & spread of infection

Inmates with symptoms of respiratory infection should be separated from other inmates and isolated in designated isolation areas in their facility. Within the designated isolation areas, inmates should be housed in single cells to the extent possible. If there is a significant shortage of cell-space in the isolation areas, consideration may be given to one of these:

- Working with medical and security staff at another facility to transfer inmates to their isolation unit or area.
- Cohorting inmates with ***the same*** lab confirmed infection. (This should be done only as a last resort). E.g.- cohorting 2 patients who both have COVID only.
- At no time should patients with different (or unknown) respiratory infections be housed in the same cell. i.e., do not house a person with COVID + Flu with a person with COVID alone or flu alone. DO not house a person with symptoms but no laboratory diagnosis with another person with symptoms but no diagnosis or with a person with COVID or flu.
- Inmates with symptoms of respiratory illness should wear facemask/surgical mask when coming out of an isolation room.

Length of isolation & quarantine (inmate-patients)

Length of isolation is dependent on the incubation period and natural course of the known/suspected respiratory infection. Specifics are provided below for COVID and influenza.

- I. For patients with influenza ***only***: Isolation of an individual should continue until 24 hours after the resolution of fever (without the use of fever-reducing medications). No follow-up influenza testing is needed prior to return to general population.
- II. For patients with COVID only or COVID + Influenza: Isolation of the individual should continue until the following have occurred:
 - a. Patient has remained in isolation for at least 5 days.
 - b. Patient has been fever-free and free of symptoms for at least the last 24 hours of their isolation. *NOTE, exception is mild cough and loss of taste/smell which may linger but should be improving to consider patient for removal from isolation.*
 - c. No follow up COVID testing is required prior to return to general population.
- III. For patient with symptoms of COVID or flu with negative COVID and flu tests: Isolation of the individual should continue until the following have occurred:
 - a. They have had negative COVID PCR test, *AND*

- b. They have had a negative influenza PCR test, *AND*
 - c. They have been fever free and symptom free for at least 24 hrs.
- IV. Following COVID exposure: Quarantine exposed inmates for 5 days and test for COVID at day 3-5 following exposure. If positive COVID test, handle as for all positive COVID cases. If negative COVID test, inmate to complete 5-day quarantine.
- V. Following influenza exposure: Quarantine exposed inmates for 4 days from last exposure. Test only those who develop influenza symptoms.
- VI. Inmate COVID re-exposure following prior COVID diagnosis: Patients should not retest for COVID within 12 weeks of a prior COVID diagnosis. In the event they are re-exposed to COVID following a prior COVID diagnosis, the following guidance will apply:
- i. Re-exposure > 12 weeks after previous COVID diagnosis: Follow guidance for COVID exposure listed above including quarantine and repeat testing as appropriate.
 - ii. Re-exposure ≤ 12 weeks after a previous COVID diagnosis: DO NOT retest unless they develop symptoms of COVID. Ask patient to continue to self-monitor for symptoms

Active Surveillance/Screening for Symptoms on Affected/Quarantined Pods/Tiers

Once there is a laboratory confirmed case of influenza or COVID, daily temperature and symptom screening of those who are close contacts (who live or usually work in close quarters to the case e.g., cellmates, persons in adjacent rooms, persons on the same pod/tier) should begin.

- Following an influenza diagnosis screening should continue until 4 (four) days after the influenza case was placed in isolation.
- Following a COVID diagnosis, screening should continue until 5 days after the COVID case was placed in isolation.
- If a new case is identified and lab test returns positive for flu or COVID, the clock is reset and screening must continue for another 4 days (flu) or 5 days (COVID)

Exclusion of sick staff & return to work parameters

Based on staffing, operational and other needs the DOC commissioner reserves the right to adjust the exclusion and return to work parameters outlined below.

INFLUENZA Diagnosis in Staff: Exclusion & Return

- Persons diagnosed with influenza should be excluded from returning to work until they have been fever-free for at least 24 hours (without the use of fever reducing medications).
- No repeat testing or doctor's clearance is required for return to work following an influenza diagnosis.

COVID Diagnosis in staff: Exclusion and Return

Persons diagnosed with COVID should be excluded until they have been fever-free for 24 hours AND

- at least 5 days have passed since the onset of symptoms for those with symptoms (symptomatic) or

- 5 days have passed since they tested positive for COVID for those without symptoms (asymptomatic). **** NOTE: COVID test date is the day the sample was collected, not the date the results returned.**
- All staff returning to work after a COVID diagnosis must wear close fitting masks until it has been at least 10 days from their test date/onset of COVID symptoms.
- No repeat testing is required for return to work following a COVID diagnosis.
- Following a COVID diagnosis, do not repeat COVID testing until it has been at least 12 weeks from the prior COVID test, unless the individual has new symptoms. This is because COVID tests can stay positive for several weeks to months.

No doctor's clearance is required for return to work following a COVID diagnosis.

Exclusion of exposed staff

INFLUENZA Exposure: Exclusion and Return

Persons exposed to a case of lab-confirmed influenza should not be excluded unless they have symptoms themselves.

COVID Exposure: Staff

Staff do not need to quarantine and do not need to be excluded from work following exposure to a COVID case. Instead, staff should wear a mask covering mouth and nose while at work. Wearing of the mask should continue until at least 5 days from the time of exposure. Staff should be encouraged to get tested for COVID on day 5 following COVID exposure.

COVID Re-exposure following prior COVID diagnosis (staff)

As noted above, staff should not retest for COVID within 12 weeks of a prior COVID diagnosis. In the event a staff is re-exposed to COVID following a prior COVID diagnosis, the following guidance will apply:

- Re-exposure > 12 weeks after previous COVID diagnosis: Follow guidance for COVID exposure listed above.
- Re-exposure ≤ 12 weeks after a previous COVID diagnosis: DO NOT retest and do not exclude staff unless they develop symptoms of COVID.
- Staff to continue to self-monitor for symptoms.

TESTING, TREATING AND PROPHYLAXIS (Inmate)

Inmate testing

- All inmates presenting with symptoms of respiratory illness should be tested for ***both*** influenza and COVID at a minimum. Consideration should be given to send for a multiplex respiratory panel to test for other viruses if appropriate.
- Positive rapid tests (COVID and flu) should be considered to be true positives and the patient isolated and treated accordingly, until and unless a confirmatory lab-based PCR test results negative.
- Sending of sample for confirmatory lab-PCR testing following a positive rapid COVID test is at the discretion of the treating provider. This may be important in situations where a positive test cannot be explained based on exposure, patient movement and patient symptoms.

- ***All positive rapid flu*** tests must be sent for lab-PCR confirmation. The only exception is during an established outbreak. An outbreak is deemed as “established” when so determined by the BHSAMH infection control nurse in collaboration with DPH.
- Negative rapid tests in persons with concerning symptoms and/or recent exposure to flu/COVID should be confirmed with a lab-based PCR test (flu and COVID).
- PCR tests (rapid PCR or lab-PCR) must be reported to the Division of Public Health.

Antiviral Treatment

- Consideration for antiviral treatment with appropriate influenza antivirals is indicated as early as possible for any inmate with confirmed or suspected influenza. The decision to initiate antivirals, however, will be at the discretion of the treating provider.
- Consideration for antiviral treatment with appropriate COVID antivirals is indicated as early as possible for any inmate with risk factors for progression to severe COVID. The decision to initiate antivirals, however, will be at the discretion of the treating provider.
- Facility ICN should notify providers in a timely manner of all influenza or COVID positive patients so they can be evaluated for possible initiation of antivirals.
- It is the responsibility of the site medical director to review all cases of influenza or COVID to determine who would benefit from antiviral treatment. This responsibility may be delegated.

Prophylaxis (Medicines to Prevent Infection):

- Influenza antiviral prophylaxis should be considered for all contacts of laboratory confirmed influenza cases, at the discretion of provider.
- COVID antiviral prophylaxis should be considered for all contacts of laboratory confirmed COVID who are at high risk of developing severe COVID, at the discretion of the provider.
- It is the responsibility of the site medical director to review all cases of persons with established significant exposure to persons with influenza or COVID, and to determine who would benefit from antiviral prophylaxis. This responsibility may be delegated.

TRANSPORT & MOVEMENT

Offsite Medical Runs

- Officers transporting inmates with respiratory symptoms to medical appointments or to court, shall ensure that to the extent possible, adequate ventilation is maintained to reduce the risk of transmission of respiratory infections.
- Inmates with respiratory symptoms should be provided with a mask (preferably surgical mask) to cover mouth and nose.
- Masks should also be made available for use by officers transporting inmates with respiratory symptoms to medical appointments.
- C&T officers are responsible to provide constant supervision of inmates during transit. Anyone who develops medical distress should be attended to immediately.

- Officers transporting inmates to medical appointments and officers on hospital duty shall comply with the masking and other infection prevention requirements of the outside medical facility.

New Intakes, Transfers, Discharges and Work-release

New intakes

Symptom screening for symptoms of respiratory virus infection shall occur for all new intakes. This screening shall be done by intake nurse. Persons who have symptoms of respiratory virus infection shall be placed in medical isolation and tested for COVID and for influenza. Symptomatic patients whose COVID and flu tests return negative shall remain in medical isolation until at least 24 hours after their major symptoms AND fever have resolved.

During periods of increased respiratory virus activity within a county, COVID/Flu testing for all intakes to facilities in that county will prevent the introduction and spread of COVID/Flu. The BHSAMH infection control nurse (ICN) shall be responsible for advising the Medical Director, and the BHSAMH, BOP and BCC Chiefs when there are increased community/county levels of COVID/Flu. The ICN shall obtain this information from DPH or CDC sources. Once notified of heightened COVID/Flu activity, the decision to re-instate testing for new intakes shall be jointly made between the BHSAMH, BOP and BCC Chiefs with input from the Medical Director and ICN.

Transfers

Do not test transfers who are not symptomatic for COVID/flu. Persons presenting with COVID/Influenza symptoms or fever shall not be transferred to another facility until symptoms have resolved and COVID/influenza is ruled out by laboratory testing for COVID and Influenza. If results return positive, manage as per protocol for positive COVID or influenza. If results return negative, transfer should be delayed until at least 24 hours after fever and major symptoms have resolved.

During periods of increased respiratory virus activity within a county, COVID/Flu testing for all transfers from facilities in that county will prevent the introduction and spread of COVID/Flu in receiving facility. The BHSAMH infection control nurse (ICN) shall be responsible for advising the Medical Director, and the BHSAMH, BOP and BCC Chiefs when there are increased community/county levels of COVID/Flu. The ICN shall obtain this information from DPH or CDC sources. Once notified of heightened COVID/Flu activity, the decision to re-instate testing for transfers and/or to halt transfers shall be jointly made between the BHSAMH, BOP and BCC Chiefs with input from the Medical Director and ICN.

Discharge

Testing of persons being released from DOC custody shall occur at the request of a provider, receiving facility and/or patient. Testing shall also be offered if the person being discharged presents with COVID/influenza symptoms.

Work release

Routine or weekly testing of work-release inmates is not required/indicated. Testing should be done on a case-by-case basis when individuals report symptoms and/or when there has been a significant exposure.

REFERENCES

- CDC Healthcare facility COVID guidance September 2022 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>
- CDC Community COVID guidance August 2022 <https://www.cdc.gov/mmwr/volumes/71/wr/mm7133e1.htm>
- CDC quarantine guidance May 2022 <https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html>
- CDC COVID community level map <https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html>
- COVID antivirals <https://www.covid19treatmentguidelines.nih.gov/>
- CDC 12/23/2021 guidance on health workers <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
- CDC 12/27/21 Shortens quarantine and isolation period <https://www.cdc.gov/media/releases/2021/s1227-isolation-quarantine-guidance.html>
- CDC COVID guidelines for prisons <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>
- OSHA (Occupational Safety and Health Administration)
<https://www.osha.gov/SLTC/covid-19/emergency-response.html>
- Federal Bureau of Prisons
https://www.bop.gov/resources/pdfs/seasonal_influenza_guidance.pdf
- Centers for Disease Control and Prevention
<https://www.cdc.gov/flu/pdf/professionals/antivirals/antiviral-summary-clinicians.pdf>
<https://www.cdc.gov/flu/weekly/overview.htm>
- EMS transportation recs
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html>
- August 2020 PPE recs
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>
- Hemodialysis recs
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis.html>
- COVID & Prisons
https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#PPE_table
- CDC Isolation, quarantine recs (October 2020)
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>
- CDC testing recs (October 2020)
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html>
- CDC on critical staff shortages during COVID
https://www.cdc.gov/coronavirus/2019-ncov/community/critical-infrastructure-sectors.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcommunity%2Fcritical-workers%2Fimplementing-safety-practices.html
- CDC: Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States
<https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#authorized>