COVID-19 Pandemic Response Plan

Federal Bureau of Prisons

About This Document

This document contains an Index and Overview followed by 11 separate Modules and an Appendix. For details on what a particular module covers, see the short Table of Contents at the beginning of that module.

Printing: Most likely, you are viewing this document in PDF format. Note that each module starts on its own page 1. To print an individual topic without printing the entire document, use the page numbers listed below.

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RESPONSE PLAN OVERVIEW

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THE CHALLENGE OF COVID-19

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a novel coronavirus, is responsible for the clinical presentation of coronavirus disease 2019 (COVID-19). This is a respiratory illness—first described in Wuhan, China, in December 2019—that spread rapidly and is currently a global pandemic. The COVID-19 pandemic arrived at the Federal Bureau of Prisons' (BOP) institutions in mid-March 2020; as of August 2020, nearly every facility has identified confirmed cases.

A **PANDEMIC** refers to the international occurrence or spread of a particular disease, most commonly an infectious disease. More localized spread of disease is usually referred to as an **EPIDEMIC** or an **OUTBREAK**.

- Pandemics may occur for a variety of reasons, including **MUTATION** of existing pathogens (as is usually the case for the influenza virus) or development of **NEW PATHOGENS** like the severe acute respiratory syndrome coronavirus 2 (**SARS-CoV-2**), which is causing the current coronavirus disease 2019 (**COVID-19**) pandemic.
- An important characteristic of a pandemic caused by an infectious disease is the **ABILITY OF THE DISEASE TO BE TRANSMITTED** from one human to another. With Sars-CoV-2, human-to-human transmission first occurred in China in late 2019 and then spread globally in early 2020.
- Other important aspects that determine the disease's impact are its mode of **TRANSMISSION**, **INFECTIVITY**, and **VIRULENCE**.
  - **TRANSMISSION:** SARS-CoV-2 is spread primarily when an infected person coughs, sneezes, or speaks, thereby dispersing respiratory droplets that land on the mucous membranes of another person's nose, mouth, or eyes. The dispersal range for these droplets is about six feet. It may also be transmitted when a person touches a surface contaminated by infectious respiratory droplets and then touches their face, or when respiratory aerosols are generated during certain procedures.
  - **INFECTIVITY:** At first, it was thought that the virus was spread primarily by people who had developed symptoms of the disease—and that focusing efforts on these cases would be sufficient to contain the disease. It has since been determined that a significant number of people may be

transmitting the disease during asymptomatic, presymptomatic, or minimally symptomatic phases of the illness, which has contributed to the infectivity and communicability of the disease.

- **VIRULENCE AND SYMPTOMS:** Lastly, there is a wide range in **SEVERITY OF ILLNESS** (virulence), with current data indicating that the vast majority of cases are in the spectrum of asymptomatic to mild/moderate symptoms.
  - The **MOST COMMON SYMPTOMS** are cough and fever. Shortness of breath has been considered one of the three primary symptoms, but occurs less commonly than the other two.
  - Other **LESS COMMON SYMPTOMS** include body aches, headaches, sore throat, diarrhea, nausea, vomiting, abdominal pain, loss of smell or taste, and runny nose.
  - **Approximately 20 percent of cases will have severe or life-threatening illness and up to two to three percent of patients will die.** Some experts in the field estimate the mortality rate may be 10 times higher than that of seasonal influenza.

- **LONG TERM CONSEQUENCES OF COVID-19:** A patient's immune response appears to dictate long-term consequences to SARS-CoV-2. This immune response is dependent on multiple variables including viral virulence, exposure intensity and duration to the virus, and the host's comorbid medical conditions. Patients who recover from COVID-19 may not be contagious, but these patients may complain of persistent symptoms. Cellular damage from SARS-CoV-2 may cause long-term health consequences, including multiple organ injury.
  - Individuals who suffered mild or moderate illness presenting with persistent post-COVID-19 symptoms are called **LONG-HAULERS**. The most common persistent symptoms are fatigue, dyspnea/cough, headache, and joint aches.
  - As patients begin to recover from COVID-19, some individuals who suffered severe COVID illness may develop complications such as blood clotting, myocardial injury, liver injury, renal injury requiring long-term dialysis, and neurological injuries such as strokes, confusion, and anxiety. An estimated 20–50% of COVID-19 patients will continue to have health challenges post-hospitalization.
  - Recovered patients with complaint of persistent symptoms after acute COVID-19 should be monitored for long-term sequelae.

In addition to being highly contagious and potentially fatal, COVID-19 presents a number of other challenges including knowledge gaps about the disease, rapidly changing guidance, no effective prevention (vaccine) or treatments, limitations in testing capacity, difficulty preventing its spread in residential settings like correctional and detention facilities, and severe impacts on institutional and organizational operations created by staffing and supply shortages or large numbers of sick patients.

- **Knowledge about COVID-19 and public health guidance for responding to this pandemic is evolving quickly.** Practical tools, together with infection prevention and control plans for COVID-19, are being developed and edited frequently to correspond to current guidance from the Centers of Disease Control (CDC) and the World Health Organization (WHO).
- **COVID-19 presents unique challenges for management in the confined correctional environment.** Cases of COVID-19 have been documented in all 50 U.S. states. Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before infections are identified. Good hygiene practices, vigilant symptom screening, wearing of cloth face coverings, and social distancing are critical in preventing further transmission.

The COVID-19 pandemic is the most severe pandemic to affect this country in over 100 years, and must be approached with a sense of urgency. An effective response is possible, but requires rethinking of routine processes, procedures, policies, and priorities, in addition to the application of established infection prevention practices.

This document is designed to provide specific guidance on responding effectively to these challenges—and limiting the spread of COVID-19, its impact on people's lives, and the BOP's missional and operational effectiveness. Effective response to the challenge of COVID-19 requires that all disciplines in a correctional facility come together to develop, implement, and modify plans as information and conditions change.

Swift, decisive, yet evidenced-based planning is paramount.

RESPONSE PLAN MODULES

The **BOP COVID-19 Pandemic Response Plan** is divided into the following MODULES, each providing a detailed outline for correctional facilities. The modules will be updated as needed, based on guidance from key stakeholders including the CDC, WHO, and DOJ; recommendations may be revised as new information becomes available.

→ *It is important that the user check back periodically for updates to this plan.*

- MODULE 1. Infection Prevention and Control Measures
- MODULE 2. Personal Protective Equipment
- MODULE 3. Screening and Testing
- MODULE 4. Inmate Isolation and Quarantine
- MODULE 5. Surveillance
- MODULE 6. Inmate Movement
- MODULE 7. Non-COVID Routing Medical and Dental Services
- MODULE 8. Inmate Programming & Services
- MODULE 9. Inmate Visitation
- MODULE 10. Volunteer and Contract Staff Management
- MODULE 11. BOP Employee Management

DEFINITIONS

CLOSE CONTACT: In the context of COVID-19, an individual is considered a close contact if they have not been wearing appropriate PPE **and**:

- Been within 6 feet of a COVID-19 case for a prolonged period of time (15 minutes) **OR**
- Had direct contact with infectious secretions of a COVID-19 case.

Considerations when assessing close contacts include the duration of exposure and the clinical symptoms of the person with COVID-19 (i.e., coughing likely increases exposure risk as does an exposure to severely ill persons).

COHORTING: The practice of grouping patients infected or colonized with or potentially exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. In the BOP, this may refer to housing inmates of similar infection status together rather than in single cells.

CONTACT TRACING: Identifying people infected with COVID-19 (**CASES**) and the people with whom they came into contact (**CONTACTS**); and then working with them to interrupt disease spread. Contact tracing for COVID-19 typically involves:

- Interviewing people with COVID-19 (**CASE INVESTIGATION**) to identify everyone they had close contact with during the time they may have been infectious.
- Notifying contacts of their potential exposure.
- Referring contacts for testing and quarantine/isolation, as indicated
- Monitoring contacts for signs and symptoms of COVID-19

INCUBATION PERIOD: The stage of subclinical disease that extends from the time of exposure to the onset of disease symptoms.

MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive point of care (POC) or commercial laboratory test) COVID-19 infection, either to single rooms or by **COHORTING** them with other viral infection patients.

QUARANTINE: In the context of COVID-19, refers to separating (in an individual room or **COHORTING** in a unit) asymptomatic persons who may have been exposed to the virus to **(1)** observe them for symptoms and signs of the illness during the **INCUBATION PERIOD** and **(2)** keep them apart from other incarcerated individuals.

- The BOP utilizes **THREE CATEGORIES OF QUARANTINE:** Exposure, intake, and release/transfer.
- All BOP COVID-19 quarantine categories utilize a test in/test out strategy.

SYMPTOMATIC: People with confirmed COVID-19 have reported a wide range of symptoms that typically appear 2–14 days after exposure to the virus. People with confirmed or suspected COVID-19 infection presenting with any of the following symptoms are considered symptomatic:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

SOCIAL DISTANCING (a.k.a. PHYSICAL DISTANCING): Maintaining a distance of approximately six feet or more between each individual.

SURVEILLANCE: The ongoing systematic collection, analysis, and interpretation of **HEALTH-RELATED DATA**, closely integrated with the **TIMELY DISSEMINATION** of this data to those responsible for preventing and controlling disease and injury. Health data is defined and standardized by the Health Services Division and collected in a uniform and systematic manner. The authoritative and primary source of medical information is the electronic health record.

GENERAL PRINCIPLES OF A PANDEMIC RESPONSE

A. THREE PHASES OF RESPONSE: PREPARATION, RESPONSE, AND RECOVERY

The pandemic response is divided into three distinct, but overlapping, stages based on the time course of the pandemic: **PREPARATION**, **RESPONSE**, and **RECOVERY**. Individual institutions may be in different stages depending on whether they have had COVID-19 cases at their facility.

- **PREPARATION:** The importance for institutions to develop a response plan **PRIOR** to a local outbreak cannot be overstated. The plan should clearly define a systematic process for all of the elements outlined in the modules.
- **RESPONSE:** Upon identification of the first case, institution executive and medical staff should immediately:
  - Implement the local response plan.
  - Initiate and maintain communication with the regional medical director, health services administrator, and the QI/IP&C consultant.
- **RECOVERY:** This period will involve recovering from the effects of the pandemic emergency, evaluating the BOP response to it, and using this evaluation to prepare for subsequent waves of pandemic.

B. CONTAINMENT AND MITIGATION

Two major goals of a pandemic response are containment and mitigation:

- **CONTAINMENT:** To **LIMIT OR PREVENT SPREAD OF THE DISEASE**. For example, symptom screening, quarantine, and isolation are all containment efforts intended to limit the spread of disease.
- **MITIGATION:** To **LIMIT THE IMPACT OF THE DISEASE ON OPERATIONS** and to address operational challenges and disruptions created by the pandemic. Examples of such strategies include developing modified policies and procedures for routine operations, using alternative PPE strategies due to supply shortages, or setting up alternate care facilities to meet an increased demand for COVID-19-related health care.

CONTAINMENT STRATEGIES

There are a number of important containment strategies to be implemented.

- Environmental cleaning/disinfection/sanitation
- Health and hygiene practices:
  - Face covering (all inmates and staff in public places, with exceptions)
  - Covering the mouth and nose when coughing or sneezing
  - Hand hygiene – wash hands regularly with soap and water for at least 20 seconds or use hand sanitizer
  - Reporting illness early (staff and inmates) and staying home when sick (staff)

- Physical (social) distancing
- Screening for COVID-19 symptoms and signs (elevated temperature)
- Isolation, quarantine, PPE, and testing are essential aspects of limiting transmission and will be considered elsewhere in the document.

MITIGATION SCENARIOS AND STRATEGIES: CONVENTIONAL, CONTINGENCY, AND CRISIS

A framework for understanding mitigation strategies identifies three levels of operational disruption:

- **CONVENTIONAL** scenarios and strategies refer to minimal or no disruptions in normal operations.
- **CONTINGENCY** scenarios and strategies refer to mild to moderate disruption or impact on operations.
- **CRISIS** scenarios and strategies refer to severe disruption or impact on operations.

This framework recognizes that pandemics can make ordinary or well-established standards difficult or impossible to achieve and proposes reasonable alternative standards that provide an acceptable balance of risk and benefit, in light of the limitations created by the pandemic.

  - Examples include the CDC's Strategies to Optimize the Supply of PPE and Equipment during Shortages, the American Dental Association's recommendation to cancel non-urgent dental care, and the decision of many health systems to postpone routine or non-urgent health care interventions.

Mitigation strategies also need to address potential shortages in staffing, supplies, and the ability to provide certain services. Every aspect of the organization needs to have plans to address limitations and disruptions in in these areas, including alternative means of providing essential services.

C. COORDINATION

- It is critically important that correctional and health care leadership, and leadership from all divisions and departments meet regularly to review the current status of COVID-19, review updated guidance from the CDC, and flexibly respond to changes in current conditions.
- Regular meetings should be held, roles and responsibilities for various aspects of the local, regional, and central office response determined, and evidence-based plans developed and rapidly implemented. Consideration should be given to activating the **INCIDENT COMMAND SYSTEM** within the agency and each individual facility to coordinate response to the crisis.
- Responsibility should be assigned for tracking updates to national and local COVID-19 guidance.

Questions from institutions regarding any of the guidance in this Response Plan should be referred to your Regional Medical Director (RMD), Regional Health Care team, and Regional Director / Regional Emergency Operations Centers. The RMDs are aware of the most relevant and recommended approaches.

The medical management of COVID-19—including testing, housing, and treatment strategies—are clinical decisions and deference should be given to the RMD regarding these decisions within the clinical context of each situation and scenario that presents at the respective institution.

D. COMMUNICATION

- **The importance of regular communication with staff, incarcerated persons, and their families cannot be over-emphasized.** Specific methods of communication for all groups should be established. Staff should be assigned responsibility for crafting and disseminating regular updates.
  - ➔ *This CDC website offers printable educational posters at: https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html. At the site, type "COVID-19" into the search window.*
- Identify points of contact with local public health authorities, and initiate and maintain ongoing communication regarding changes to testing procedures, guidelines, and reporting.
- As part of plan preparation, communicate with community hospitals to discuss referral mechanisms for transferring severely ill patients to the hospital.

➔ *Questions or concerns from staff should be directed to the following email address: COVID-19Questions@bop.gov*

E. QUALITY IMPROVEMENT (QI)

Periodically throughout the outbreak and at the conclusion of it, review the implementation of your agency's or institution's COVID-19 Pandemic Response Plan to identify what has worked well (best practices),what has not, and deviations from established guidance (opportunities for improvement). Total numbers of cases and contacts treated/evaluated should also be reviewed. Engage the QI committee in evaluating the facility's pandemic response, and identify areas for improvement that should be reported to the leadership team.

F. EDUCATION AND TRAINING

STAFF EDUCATION AND TRAINING

Agency leadership must have clearly-defined mechanisms and well-developed strategies for communicating information and updates broadly and regularly to the field.

Throughout all BOP locations, post signage (available at the CDC site listed above under ***COMMUNICATION***) communicating the following:

- Symptoms of COVID-19 and hand hygiene instructions.
- Advice: Stay at home when sick; if COVID-19 symptoms develop while on duty, leave the facility as soon as possible and follow the CDC recommendations for *"What to Do If You are Sick"*.
- Elements of the facility's COVID-19 Response Plan for keeping employees safe, including social distancing.

➔ *To encourage social distancing and limit the chances of viral transmission, large staff meetings and recalls should be discouraged.*

INMATE EDUCATION AND TRAINING

Throughout the facility, post **SIGNAGE** (available at the CDC site listed above under ***COMMUNICATION***) communicating the following:

- Hand hygiene instructions and good health habits such as covering your cough and sneezes.
- Report symptoms of fever and/or cough or shortness of breath (and if another incarcerated person is coughing) to staff.

- Ensure that signage is understandable for non-English speaking persons and those with low literacy.
- Co-pays for respiratory illness symptoms or fever may be waived.
- Sharing drugs and drug preparation equipment can spread COVID-19.
- Plans to support communication with family members including visitation alternatives, if in-person visits are temporarily halted.
- What the institution is doing to keep incarcerated persons safe, including social distancing.

➔ *Weekly updates should be provided to the inmates via TRULINCS. To encourage social distancing and limit the chances of viral transmission, town halls should be discouraged.*

Module 1. Infection Prevention and Control Measures

WHAT'S NEW

- Additional guidance added for CONGREGATE ACTIVITIES. Congregate activities include all staff conferences and training and all applicable inmate programming.

MODULE 1 TABLE OF CONTENTS

A. HAND HYGIENE AND HEALTH HABITS

GOOD HEALTH HABITS—including those listed below—should be promoted to both employees and inmates, using a variety of means (e.g., educational programs, campaigns including posters, assessing adherence to hand hygiene practices, etc.):

- Avoid close contact with persons who are sick. (See SOCIAL DISTANCING below.)
- Avoid touching your eyes, nose, or mouth.
- Wash your hands often (after contact with high-touch surfaces, before eating, after using the restroom, after removing gloves, etc.) with soap and water for at least 20 seconds. If soap and water are not readily available, use an alcohol-based hand rub (ABHR).
  - ➔ ***The CDC has determined that either washing hands with soap and water (for 20 seconds) or using an alcohol-based hand rub (ABHR) (with at least 60% alcohol) will inactivate SARS-CoV-2,*** *the pathogen that causes COVID-19. Handwashing is also more effective than ABHR at removing certain other kinds of germs and chemicals. (See* ***HAND WASHING*** *and* ***HAND SANITIZER*** *below.)*
- Cover your sneeze or cough with a tissue, then throw the tissue in the trash. If a tissue is not available, cough or sneeze into your sleeve.
- Avoid non-essential physical contact. Avoid handshakes and "high-fives."

HANDWASHING

- Provisions should be made for all staff and visitors to wash their hands when they enter the facility.
- Supplies for handwashing (soap, running water, hand dryers or paper towels) should be readily available for all staff and inmates and continually restocked as needed.
- Provide a no-cost supply of soap to inmates, sufficient to allow frequent hand washing. To reduce the risk of cross-contamination, avoid bar soap and provide liquid or foam soap and a means to dry hands in shared inmate bathrooms where possible. If bar soap is distributed, ensure individuals are not sharing bars.

HAND SANITIZER

- Increase availability and access to alcohol based hand rub in monitored inmate common areas and staff common areas and housing units where a sink is not readily available.
- ABHR should be at least 60% alcohol.

Alcohol-based hand rub is flammable and must be used and stored correctly:

- STORAGE: Unopened containers must be stored in accordance with institution policy on the storage of hazardous products (secured, bin cards, etc.).
- IN-USE:

- **Wall-mounted dispensers in corridors and common areas** may contain up to 1.2 liters (0.32 gallons) of hand sanitizer for use by staff and inmates.
- **Wall-mounted dispensers in staff offices and work rooms** may contain up to 2.0 liters (0.53 gallons) of hand sanitizer for use by staff.
- **Wall-mounted dispensers must be installed away from ignition sources** (outlets, thermostats, appliances, etc.).
- **Individual bottles** of hand sanitizer may be issued to staff to keep on their person.
- **Inmates may NOT store alcohol-based hand sanitizer in their cells.**
- *Contact the Occupational Safety & Health Branch or consult NFC Life Safety Code (NFPA 101) for additional information on the placement of wall-mounted dispensers.*

B. SOCIAL DISTANCING (A.K.A. PHYSICAL DISTANCING)

Various administrative measures should be implemented to **MAXIMIZE SOCIAL DISTANCING** (reduce contact between people) and thereby reduce the chance of spreading viruses. See *Guidance on Congregate Activities* for additional information. Examples include:

- Minimize inmate movement by separating operations and programming by units (meals, recreation, medical, callouts, education, etc.), with disinfection between groups (e.g., after using phones, seating areas, computers, showers)
- Minimize inmate/staff movement:
  - Minimize transfer of inmates between units.
  - Have inmate housing units move together in restricted moves; avoid contact with other units.
  - Limit staff movement and assignments to single facilities and units, whenever possible
  - Stop or limit movement in/out of institution, as able.
  - Suspend work-release programs based on community and facility situation.
- Enforce increased space between individuals in holding cells, as well as in lines (consider marking the floors at six-foot intervals to help inmates visualize and maintain social distancing), in waiting areas such as intake (e.g., remove or tape-off every other chair in a waiting area), in dining halls (when main line resumes), in programming areas such as education, and during inmate movement / transfers.
- Entrance screening and key line:
  - Maintain social distance among all individuals in the area.
  - Consider marking the floors at six-foot intervals to help employees visualize and maintain social distancing.
- Gatherings of staff (meetings, recalls, lunch and learns, etc.)
  - Cancel such meetings when social distancing cannot be maintained by attendees.
  - WebEx Executive Conferencing Line: Each institution is being provided with lines to utilize for meeting where social distancing cannot be maintained.

GUIDANCE ON CONGREGATE ACTIVITIES

Congregate activities include all staff conferences and training and all applicable inmate programming.

- Virtual methods of congregation are preferred

- All individuals participating in congregate activities *should not* be in quarantine or isolation status due to COVID-19.
- All individuals participating in congregate activities *should not* be exhibiting any symptoms associated with COVID-19.
- The more people an individual interacts with and the longer that interaction lasts, the higher the potential risk of becoming infected with COVID-19. Guidance from the CDC on considerations for events and gathers can be found here: *https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/considerations-for-events-gatherings.html*
- **The following requirements need to be adopted when planning congregate activities:**
  - **ADMINISTRATIVE CONTROLS**
    - Encourage the use of outdoor seating areas and social distancing for any small-group activities
    - Perform enhanced cleaning of frequently touched surfaces between every gather.
    - Stagger start and break times
    - Remind participants to avoid any physical contact to include handshaking, hugs, and fist bumps.
  - **ENGINEERING CONTROLS**
    - Provide a meeting space that allows ≥60 sq. ft. per person (*e.g.* Divide the sq. ft. space by 60 which will provide the maximum occupancy allowed in that space)
      - Methods for calculating social distancing occupant loads can be found here: *https://www.usfa.fema.gov/coronavirus/planning_response/occupancy_social_distancing.html*
    - Modify the seating layout to allow 6 feet of separation between participants
    - Install shields/barriers between people where 6 feet is not able to be achieved while in compliance with fire and safety codes
      - CDC COVID-19 Employer Information for Office Buildings can be found here: *https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html*
    - Mark off or remove extra seats
    - Remove high-touch communal items (e.g. pens, coffee pots, etc)
    - Encourage people to bring their own pens, water bottles or other personal items to avoid cross contamination (e.g. there should be no communal writing utensils provided for sign-in to decrease contamination)
    - Increase fresh air flow through the area by:
      - Increase the percentage of outdoor air circulated by the HVAC system
      - Open windows when possible
      - Use HEPA filters where possible
  - **PROTECTIVE EQUIPMENT**
    - All participants must bring and appropriately wear institution-approved cloth face coverings as indicated in the BOP memo for *Mandatory Use of Face Coverings for BOP Staff* dated August 24, 2020.

C. ENVIRONMENTAL CLEANING AND DISINFECTION

TERMS

- **CLEANING** refers to the removal of dirt and impurities, including bacteria and viruses from surfaces. Cleaning alone does not kill germs, but helps to remove them and reduce the risk of spreading infection.
  - ➔ *Cleaning a surface, before disinfecting it, allows the disinfectant to "reach" the surface more effectively.*
- **DISINFECTING** works by using chemicals to kill bacteria and viruses on surfaces, including those that remain on a surface after cleaning, to reduce the risk of spreading infection.

PLANNING AND PREPARATION

- Develop a local daily cleaning schedule utilizing your housekeeping plan to clean and disinfect, when indicated, all areas of the institution.
  - ➔ *Refer to the **APPENDICES** for a Recommended Cleaning Schedule.*
- Identify inmates who are already trained to clean and disinfect all areas of the institution daily.
  - ➢ Consider cross-training multiple work crews that are housed separately for performing environmental cleaning.
  - ➢ Training should include basic cleaning and disinfection methods, cross-contamination prevention, cleaning product safety, PPE use, and hand washing.
  - ➢ Assign the same inmate(s) to the same locations to clean and disinfect daily.
  - ➢ Consider cross-training additional workers housed in separate areas to provide backup in the event one group becomes ill.
- Ensure adequate supplies to support intensified cleaning and disinfection, including PPE as indicated.
  - ➔ *See **MODULE 2** for information on PPE.*
- Initiate a plan to restock rapidly when needed.

HIGH-TOUCH SURFACES AND HIGH-TRAFFIC AREAS

- Institute a continuous cleaning/disinfection schedule for all high traffic/touch areas.
- Routine cleaning of "**HIGH-TOUCH**" (frequently touched) surfaces should be **increased to no less than several times per day**.
- High-touch surfaces include items such as light switches, doorknobs, door handles, desk tops, drawer handles, keys, shared pens, handrails, telephones, computer keyboards and mice, elevator buttons, cell bars, bathroom faucets, etc.

ROUTINE CLEANING AND DISINFECTION

➔ ***Neither the CDC nor the EPA support the use of thermal or electrostatic foggers for disinfection procedures.***

- If surfaces are dirty, they should be manually cleaned prior to disinfection.
- Once the cleaning process is complete, inmates equipped with PPE should spray disinfectant on all hard surface areas with chemical backpack sprayers, if available.
  - ➢ If backpack sprayers are not available, have additional inmates with hand-held spray bottles complete this task.

- Remember to adhere to the wetting time indicated by the disinfectant manufacturer.
- This process should be completed as scheduled and more often if needed.

- **Clean and disinfect according to label instructions,** including pre-cleaning steps, product dilution, contact time, and potable water rinse directions.
  - Follow manufacturer's directions including pre-cleaning steps, product dilution, contact time, and rinse directions. The contact time is the amount of time the surface needs to be treated for the product to work. Many product labels recommend keeping the surface wet for a specific amount of time.
  - Follow label instructions for safe and effective use of the product, including precautions that should be taken when applying the product, such as required **PPE** and making sure there is good ventilation during use, and around people.
  - Refer to the manufacturer's documentation for product hazards, as well as shelf life for the concentrated and diluted solutions.
    - *For example, in the case of Virex II/256, the concentrated form has a three-year shelf life, but once diluted it has only a one-year shelf life.*

- The CDC recommends using an EPA-registered, hospital-grade disinfectant from **LIST N** for disinfecting surfaces.
  - **LIST N,** the list of EPA-approved products for **COVID-19 disinfection,** is available at: *https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19*
  - Institutions should check with health services to find out if the product currently in use is included on **LIST N**. If the health services product is on **LIST N**, leadership can decide to expand its use for the facility or choose another product from the list.
- Instructions for the use of a bleach solution, Virex II, HDQC2, and HALT are available in the **APPENDICES**.

HARD SURFACES

- If surfaces are dirty, they should be cleaned using soap and water prior to disinfection.
- For disinfection after cleaning, use products approved by EPA for COVID-19 (**LIST N**, see *Useful Links* below).
- If an EPA N-list disinfectant is unavailable, diluted household bleach solutions or alcohol solutions with at least 70% alcohol should be effective.
  - Diluted, unexpired household bleach can be used under direct supervision if appropriate for the surface.
  - Gloves and eye protection should be worn when using bleach products.
    - *Never mix household bleach with ammonia or any other cleanser.*
  - Prepare bleach solution by mixing:
    - 5 tablespoons (1/3 cup) bleach per gallon of water **OR**
    - 4 teaspoons of bleach per quart of water.

SOFT (POROUS) SURFACES (CARPETED FLOORS, RUGS, DRAPES)

- Remove visible contamination, and clean with appropriate cleaners for these surfaces.

- If washable, launder in hottest water setting for the item and dry completely. Otherwise, use products approved by EPA for COVID-19 disinfection (**LIST N**, see *Useful Links* below).

ELECTRONICS

- For electronics such as tablets, touch screens, keyboards, and remote controls: Remove visible contamination if present.
- Follow the manufacturer's instructions for all cleaning and disinfection products.
- Consider use of wipeable covers for electronics.

USEFUL LINKS FOR ADDITIONAL DISINFECTION GUIDANCE

- EPA listing (**LIST N**) of approved disinfectants used to eradicate COVID-19: *https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2*
- EPA frequently asked questions regarding disinfectants and COVID-19: *https://www.epa.gov/coronavirus/frequent-questions-about-disinfectants-and-coronavirus-covid-19*
- CDC recommendations for cleaning and disinfection: *https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html*
- CDC IP&C recommendations for healthcare workers during the COVID-19 pandemic: *https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html*

D. FACE COVERINGS

➔ ***Cloth face coverings are worn to protect others, but are not considered to offer protection for the wearer and are not considered to be PPE.*** *"My mask protects you. Your mask protects me." Cloth face coverings are worn as a measure to prevent spread of respiratory droplets and mitigate against transmission. Cloth face coverings are not substitutes for surgical masks or N-95 respirators where PPE is indicated. Refer to* **MODULE 2** *for guidance on when PPE is recommended.*

- All individuals, staff and inmates, are to wear cloth face coverings to the extent practicable when social distancing cannot be maintained and within the common-area facilities and workspaces.
- It is important to reinforce correct wearing of face coverings by both staff and inmates.
  - Wash hands before putting on a face covering
  - Always use the same side for contact with nose and mouth
  - Avoid touching the side of the covering that touches the face, handle face coverings only by the ear loops or ties.
  - Place completely over nose and mouth and secure it under the chin while fitting it snugly against the side of the face
  - Do not pull the face covering down to talk
  - When removing the face covering:
    - Fold outside corners together to prevent contamination of the surface
    - Be careful not to touch eyes, nose and mouth when removing and wash hands immediately after removing.
- Individuals may remove a face covering when working in a private office, cubicle, or workspace where **at least six feet** of social distance can be maintained.

- A staff member may have an inmate remove their cloth face covering to perform safety and security checks. Once the check is complete, the inmate should place the covering back on their face.
  - To reduce the risk to staff, inmates should remove the face covering themselves.
  - If an inmate cannot remove a face covering, staff should put on gloves prior to removing the inmate's face covering. The staff should stand to the side or behind the inmate so they are not in direct line with the inmate's nose and mouth. The mask should be removed so that the inside of the covering stays on the inside.
  - If staff assist with placing the face covering back on the inmate, staff should place the face covering back on the inmate in the same orientation it was worn before taken off (inside of the covering stays on the inside).

TYPES OF FACE COVERINGS TO BE USED

- Two-layer cloth face coverings are recommended.
  - *Single-layer face coverings (including balaclava or neck gaiters) are NOT recommended.*
- Surgical masks and N-95 respirators are reserved for environments that the BOP has designated as requiring PPE.
- Face coverings with exhalation valves or vents are NOT recommended. While the vents make it easier to exhale, they allow the escape of respiratory droplets into the environment and potentially to another person.

LAUNDERING CLOTH FACE COVERINGS

- All cloth face coverings should be laundered before first use.
- Cloth face coverings may be washed with other clothing.
- It is recommended that staff wash their cloth face coverings at home after each shift.
  - Launder items using the warmest water setting and dry completely.
  - Clean and disinfect clothes hampers, or use a liner that can be washed or thrown away.
- Inmates should send cloth face coverings through the institution wash cycles with other clothing.

- *According to the BOP Facilities Operations Manual (P4200.12), the wash cycle temperature is to be a minimum of 160 degrees Fahrenheit.*
- *Guidance for staff and inmates on how to wear a cloth face covering may be found in the APPENDICES.*

E. SUPPLY MANAGEMENT

A sufficient stock of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) should be on hand and available, and a plan should be in place to restock as needed if COVID-19 transmission occurs within the facility.

It is recommended that facilities maintain a 90-DAY SUPPLY of the following items:

- Standard medical supplies for daily clinic needs
- Tissues
- Liquid or foam soap for hand washing, when possible, to avoid cross-contamination. If bar soap is distributed, each person should be given (cost-free) their own bar of soap, and bars should not be shared.
- Hand drying supplies

- Alcohol-based hand sanitizer containing at least 60% alcohol
- Cleaning supplies, including EPA-registered disinfectants from the EPA list N.
- Recommended PPE (surgical masks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls).

  → *See MODULE 2 for more detailed information on supply chain management, including recommendations for extending the life (optimization) of all PPE categories in the event of shortages, and when surgical masks are acceptable alternatives to N95s.*
- Sterile viral transport media and sterile swabs to collect specimens if COVID-19 testing is indicated. Institutions should work with locally established commercial laboratory contacts to ensure adequate supply chains for collection items. If adequate supply of collection items cannot be secured locally, notification should be provided to the Central Office HSD.

  → *See Module 7 for information regarding obtaining supplies for the collection of specimens if influenza testing is completed using the Abbott ID Now point-of-care machines.*

To ensure that appropriate 90-day supplies are on hand at all times throughout the deployment of this pandemic plan, the institution should ensure that the following PROCESS is in place:

1. **STAFFING:** A primary staff member or group of staff members should have delegated responsibility for all institution supplies, including PPE, cleaning and disinfection items, and other items listed above. Consider assigning several staff members to support the supplies mission.
2. **TRACKING:** One staff member should be assigned to enter the applicable data into the **SUPPLIES DASHBOARD**, to ensure accurate tracking of supplies and monitoring their use. This person should be either the primary staff member mentioned above, or one of the members of the supplies group.
3. **FORECASTING:** Submitting supply chain inventory according to Central Office direction is important to determine "**BURN RATES**" and to forecast usage needs across all institutions. Institutions may choose to calculate their own "burn rates" to assist with accurate forecasting of all required supplies.
4. **PROCUREMENT:** Institutions should track and keep historical information related to local attempts to procure all supplies. This information is helpful when pursuing national-level vendors, as those with supply sites close to institutions may expedite the delivery of required supplies.

→ *The Incident Command System (ICS) Logistics Branch actively seeks to find necessary PPE through government, commercial, and other sources to maintain PPE for staff during the pandemic. Institutions should continue local efforts to procure all levels of PPE that meet applicable standards, working with local vendors to establish supply chains. If an institution is unable to secure necessary supplies, they should contact their regional EOC for guidance. Refer to MODULE 2 Personal Protective Equipment for additional information on PPE supply chain management.*

F. TEMPORARY ENCLOSURES

The construction of INDIVIDUAL ISOLATION AREAS as a supplement or replacement for social distancing, face coverings, and standard precautions is NOT RECOMMENDED. Temporary enclosures do not serve a medical or infectious disease purpose.

Temporary enclosures can pose fire and safety concerns. The LIFE SAFETY CODE (NFPA 101) allows privacy curtains and plastic sheeting to be used in detention and correctional facilities with a number of restrictions.

- Temporary enclosures must comply with the requirements for new detention and correctional occupancies (NFPA 101, chapter 22).
- Material used in privacy curtains must be tested in accordance with NFPA 701 (Standard Method of Fire Tests for Flame Propagation of Textiles and Films, 2015 edition).
- Special emphasis must be placed on means of egress components (number, width, distance and arrangement) (NFPA 101, chapter 22 section 2.2, Means of Egress Requirements).
- Construction of temporary enclosures necessitates a review and possible modification of the facility fire plan.

Temporary enclosures may also impact compliance with other codes and standards.

- Without proper clearance, operation of the sprinkler and fire alarm systems may be impaired.
- Temporary structures may also affect the operation of the building heating, ventilation, and air conditioning system.

Before an institution determines some type of physical barriers are medically necessary, Regional Infection Prevention and Control Officers, as well as the Regional Safety Administrator, Regional Medical Director and Regional Health Services Administrator, should be consulted.

- If the decision is made to install TEMPORARY BARRIERS, the use of partial height dividers constructed of a non-combustible material such as gypsum board is recommended.
- If a decision is made to use PRIVACY CURTAINS OR PLASTIC SHEETING, review the fire test documentation and verify that the installation will not interfere with area egress or the operation of any building fire protection systems.
  - ➔ *Documentation of the fire tests, egress, and fire system reviews should be maintained by the institution.*

MODULE 2. PERSONAL PROTECTIVE EQUIPMENT (PPE)

WHAT'S NEW

- Updates to TABLE 1 and throughout document to clarify PPE requirements for inmate workers: PPE requirements for inmate workers are the same as they are for staff working in the same area. The Safety Data Sheet and local hazard assessment should be reviewed for any additional PPE requirements based upon the chemical hazard.
- Added GUIDANCE IN THE EVENT OF DISPOSABLE MEDICAL GLOVE SHORTAGES
- Clarified APPROPRIATE USES OF EYE PROTECTION: Use eye protection if direct or very close contact with ill inmates (e.g. temperature checks) or if splashes or spray is anticipated.

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TERMINOLOGY/DEFINITIONS

→ *CDC = Centers for Disease Control and Prevention; FDA = Food and Drug Administration; NIOSH = National Institute for Occupational Safety and Health*

- COHORTING: The practice of grouping patients infected or colonized with or potentially exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. In the BOP, this may refer to housing inmates of similar infection status together rather than in single cells.
- INCUBATION PERIOD: The stage of subclinical disease that extends from the time of exposure to the onset of disease symptoms.
- MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive point-of-care (POC) or commercial laboratory test) COVID-19 infection, either to single rooms or by COHORTING them with other viral infection patients.
- QUARANTINE: In the context of COVID-19, refers to separating (in an individual room or COHORTING in a unit) asymptomatic persons who may have been exposed to the virus to (1) observe them for symptoms and signs of the illness during the INCUBATION PERIOD and (2) keep them apart from other incarcerated individuals.
  - The BOP utilizes THREE CATEGORIES OF QUARANTINE: Exposure, intake, and release/transfer.
  - All BOP COVID-19 quarantine categories utilize a test in/test out strategy.

CLOTH FACE COVERINGS, SURGICAL MASKS, AND RESPIRATORS

- CLOTH FACE COVERINGS: Cloth face coverings serve as "source control" for the persons wearing them. They primarily protect others rather than the wearer by limiting dispersion of infectious respiratory droplets into the environment. "My mask protects you. Your mask protects me." Although they may offer some protection to the wearer, unlike FDA-approved surgical masks or N95 respirators, they are NOT considered to be PPE. (The CDC indicates that surgical masks and N95 respirators are critical

supplies that must continue to be reserved for healthcare workers and other medical first responders.) Refer to **MODULE 1** for guidance on cloth face coverings.

- **SURGICAL MASKS: This term refers to disposable facemasks that are FDA-APPROVED as PPE.** Surgical masks come in various shapes and types (e.g., flat with nose bridge and ties, duck billed, flat and pleated, and pre-molded with elastic bands).
  - ➔ *Surgical masks may sometimes be referred to as "facemasks." However, **"FACEMASKS" that are not FDA-approved for medical use are NOT considered to be PPE.** Individuals working under conditions that require PPE should **NOT** use a cloth face covering or a facemask that is not FDA-approved.*
- **RESPIRATORS: This term refers to N95 or higher filtering, face-piece respirators that are CERTIFIED BY CDC/NIOSH as PPE.**

STRATEGIES TO OPTIMIZE THE SUPPLY OF PPE

OPTIMIZATION STRATEGIES offer a continuum of options when PPE supplies are stressed, running low, or absent. The terms **EXTENDED USE** and **REUSE** apply to PPE that are normally "one-time use" items (i.e., N95 respirators, surgical masks, and gowns).

- **EXTENDED USE OF PPE may be utilized during periods when shortages are anticipated.** Extended use of PPE is the practice of wearing the same PPE for repeated close contact encounters with several different patients, **WITHOUT removing the PPE between patient encounters.**
- **REUSE OF PPE may be utilized when supply cannot meet demand.** Reuse of PPE is the practice of using the same PPE by one healthcare provider (**HCP**) for multiple encounters with different patients, but **removing it after each encounter.** The respirator is stored in between encounters to be put on again prior to the next encounter with a patient. As it is unknown what the potential contribution of contact transmission is for COVID-19, care should be taken to ensure that HCPs do not touch outer surfaces of the PPE during care, and that PPE removal and replacement be done in a careful and deliberate manner. (See *Donning and Doffing* below.)

➔ *A quick reference summary for CDC strategies to optimize personal protective equipment supplies is available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html*

RECOMMENDED LEVELS OF PPE

Recommended PPE for incarcerated/detained individuals and staff in a BOP facility will vary based on the type of contact with inmates, the type of procedure being performed, the type of separation (**QUARANTINE** vs. **MEDICAL ISOLATION**), the type of room utilized (single cell with solid doors and walls, open cells with bars, room without anteroom, or barracks-style space), and PPE availability.

This MODULE covers each type of recommended PPE, including appropriate use, supply optimization, and guidance in the event of a shortage.

➔ *Table 1 summarizes the appropriate use of each type of PPE.*

➔ *Table 2 summarizes length of use, re-use, disposal, and storage of PPE.*

TABLE 1. RECOMMENDED USE OF PPE

INDIVIDUAL WEARING PPE	N95 RESPIRATOR	SURGICAL MASK	EYE PROTECTION	GLOVES	GOWN/ COVERALLS
INMATES					
Inmates housed in **QUARANTINE**	Wear cloth face covering for source control, especially if housed as a cohort, when staff enter, when moving around unit to phones, computer, etc.				
Inmates housed in **MEDICAL ISOLATION**	Wear cloth face covering for source control, especially if housed as a cohort, when staff enter, when moving around unit to phones, computer, etc.				
Orderlies housed within and performing cleaning in **MEDICAL ISOLATION** and quarantine areas	Additional PPE may be needed based on disinfectant Safety Data Sheet (SDS)			X	X
Orderlies NOT housed within and performing cleaning in **MEDICAL ISOLATION** and quarantine areas	PPE requirements are the same as they are for staff working in these areas. The SDS and local hazard assessment should be reviewed for any additional PPE requirements based upon the chemical hazard.			X	X
Laundry and food service workers handling items from **MEDICAL ISOLATION** or **QUARANTINE**				X	X
STAFF	**N95 RESPIRATOR**	**SURGICAL MASK**	**EYE PROTECTION**	**GLOVES**	**GOWN/ COVERALLS**
Staff providing **ROUTINE HEALTH SERVICES** to inmates (COVID not suspected)		X[1]	X[1]	X[1]	X[1]
Staff performing **STAFF SCREENING** and temperature checks		X	X	X	
Staff performing non-contact **TEMPERATURE CHECKS** in **QUARANTINE**		X	X	X	
Staff having **DIRECT CONTACT** (including medical care, opening food trap door, entering room,escort or transport) with inmates in **QUARANTINE**		X	X	X	X
Staff working in a **QUARANTINE** unit that is an open dorm, barracks, or unit with barred cells	X[2]		X	X	X
Medical staff providing care to inmates in **MEDICAL ISOLATION,** or other correctional staff entering their rooms or opening food trap doors	X[2]		X	X	X
Staff in contact with medical isolation inmates during transport or within same compartment space.	X[2]		X	X	X
Staff present during **AEROSOL-GENERATING PROCEDURES** or **NASAL SWABBING**, regardless of whether or not COVID-19 is suspected	X		X	X	X
Staff handling laundry or food service items from **MEDICAL ISOLATION** or **QUARANTINE**				X	X
Staff cleaning a **COVID** case area	N95 if cleaning or disinfecting an isolation room. Additional PPE may be needed based on product SDS.			X	X

[1] Wear gloves for patient care (with gloves changed and hand hygiene performed between patients). An FDA-approved surgical mask is routinely recommended. Gowns and eye protection (face shields or goggles) should be worn if direct or very close contact with ill inmates (e.g., temperature checks) or splashes or spray is anticipated.

[2] A NIOSH-approved N95 is preferred. Based on local and regional situational analysis of PPE supplies, FDA-approved surgical masks may be an acceptable alternative when the supply chain of respirators cannot meet the demand. Consult with your regional EOC prior to the use of facemasks in lieu of N95 respirators.

TABLE 2 summarizes recommendations on PPE, including length of use, re-use, disinfection, disposal, and storage. More detailed information follows in the sections below.

→ *See previous discussion of optimization strategies (EXTENDED USE and RE-USE).*

TABLE 2. LENGTH OF USE, RE-USE, DISPOSAL, AND STORAGE OF PPE

PPE	LENGTH OF USE	RE-USE/ DISINFECTION	DISPOSAL	STORAGE FOR PPE TO BE REUSED
FACE SHIELD	Multiple times	YES/YES	Regular trash	Specified place for re-used PPE or paper bag with ID
GLOVES	One-time use only	NO	Regular trash	—
GOGGLES	Multiple times	YES/YES	Regular trash	Specified place for PPE after cleaning and disinfection
GOWN	One-time use only	NO	Regular trash	—
GOWN *SHORTAGE – CRISIS STRATEGY**	Multiple times	YES/NO	Regular trash	Hang in designated spot outside of doffing area with ID
SURGICAL MASK for general use	EXTENDED USE for shift; discard if soiled or damaged	NO	Regular trash	—
SURGICAL MASK for staff screening	EXTENDED USE for shift	NO	Regular trash	—
SURGICAL MASK for quarantine	EXTENDED USE for shift, doff upon exit	NO	Regular trash	—
N95 RESPIRATOR for Isolation	One-time use only, doff upon exit	NO	Regular trash	—
N95 RESPIRATOR for Isolation *SHORTAGE – CRISIS STRATEGY**	Doff upon exit; store for use up to 5x or until soiled or difficult to breathe through	YES/NO	Regular trash	Paper bag with ID

* *See CDC strategies for optimizing PPE during shortages: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html*

DONNING AND DOFFING

Staff who are wearing PPE—including masks and gloves—should be trained on its use.

- *CDC instructions, including posters and video training on donning and doffing (removing) PPE, are available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html*
- *See PPE donning and doffing skill tests in the Appendices that can be used for verification of the above training.*

- It is strongly emphasized that HAND HYGIENE (using soap and water or an alcohol-based hand sanitizer) be performed BEFORE AND AFTER **donning and doffing any PPE item.** This includes touching or adjusting the respirator if needed for comfort or to maintain fit.
- GLOVES: If a task requires gloves, hand hygiene should be performed prior to donning gloves—before touching the patient or the patient environment—and again immediately after removing the gloves.
- EYE PROTECTION: HCP should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing *eye protection* below.
- UTILITY BELTS: If utility belts are worn over PPE, they are removed and belt and items on belt cleaned and disinfected as appropriate.
- There should be an area for donning and doffing PPE at the entrance and exit from QUARANTINE and MEDICAL ISOLATION areas. It can be a designated taped area to stand in, or a makeshift anteroom created with barrier materials.
  - Under no circumstances should PPE worn in the medical isolation or quarantine areas be worn to other areas of the institution. **PPE must be removed in doffing area at exit.**
- Donning and doffing areas should include POSTERS demonstrating correct PPE donning and doffing procedures
- **The donning and doffing areas should NOT include:**
  - Microwaves
  - Food
  - Utensils used for drinking or eating
  - Coffee/water dispensers
- **The doffing area should include:**
  - An alcohol-based hand hygiene product or a sink with soap and water
  - A receptacle for reusable items (face shields or goggles)
  - A large waste bin with a clear trash bag
  - Cleaner/disinfectant
  - An area to hang or bag recycled items for reuse *if there is a critical shortage only* (i.e., a command strip hanger for reuse of gowns, with ID written on gown, or paper bags with IDs for N95s)
    - Create a system to clean and disinfect the equipment to be re-used (i.e., the person that used the equipment sprays and wipes it off—per manufacturer's wet time—and then places it in donning area for reuse).

N95 RESPIRATORS

- *Only **NIOSH-approved N95 respirators** should be utilized, whenever possible, to lessen the chance of counterfeit N95 respirator use. Verification of NIOSH approval can be found at: https://wwwn.cdc.gov/niosh-cel/*
- *More information regarding identification of counterfeit N95 respirators can be found at: https://www.cdc.gov/niosh/npptl/usernotices/counterfeitResp.html*

APPROPRIATE USE OF N95 RESPIRATORS

- N95 respirators should be used:
  - For all **AEROSOL-GENERATING PROCEDURES** (whether or not COVID-19 is suspected), e.g., nebulizer, high flow oxygen, CPR, nasopharyngeal swabbing for flu or COVID-19, etc.
  - When entering **MEDICAL ISOLATION ROOMS OR AREAS WITH SYMPTOMATIC CONFIRMED OR SUSPECT COVID-19 INMATES**.
  - Consider use of N95 respirators in **QUARANTINE** open dorm, barrack, and open-bar units if any positive cases have occurred (i.e., in exposed quarantine unit)
- N95 respirators must be used in the context of a **FIT-TESTING** program. Fit testing is specific to the brand/size of respirator to be used.
  - N95 respirators should NOT be worn with facial hair that interferes with the respirator seal. Images of appropriate facial hairstyles can be found at: https://www.cdc.gov/niosh/npptl/pdfs/FacialHairWmask11282017-508.pdf
  - Refer to the local institution compliance officer for any/all items related to N95 fit testing
  - Information regarding annual fit-testing requirements during the pandemic response can be found at:

    https://www.osha.gov/memos/2020-04-08/expanded-temporary-enforcement-guidance-respiratory-protection-fit-testing-n95

ISSUES ARISING OUT OF MANDATORY N95 FIT TESTING AND WEAR

OSHA regulations require that any tight-fitting respirator such as an N95 is to be worn with no more than one day's growth of hair where the seal of the respirator meets the face. Employers are required to enforce this shaving requirement not only during the fit testing process, but also during use of PPE where indicated.

As such, there are four scenarios that would need to be addressed to meet OSHA requirements:

A. Individuals who request accommodations under the religious exemption.

B. Individuals who clear the medical portion of the questionnaire (i.e., they have no medical conditions preventing them from wearing the respirator), but refuse to meet the grooming standards required by the respirator for fit testing.

C. Individuals who clear the medical portion, and meet the grooming standards required by the respirator for fit testing on the day of the fit test, but do not maintain a state of readiness and report to work with facial hair that will interfere with the seal of the tight-fitting respirator such as an N95.

D. Individuals who do not clear the medical portion of this process and/or cannot be fit tested due to medical/physical reasons.

Formal notice must be provided to all employees with law enforcement officer (LEO) designation that, when reporting to an institution for work, they are expected to comply with OSHA regulations as it relates to facial hair. The use of a tight-fitting respirator such as an N95 can be required at any time during the work day based on the hazard that is present.

- **For those cases where an individual fits into the (A) scenario**, requests will be considered on a case-by-case basis. Forward requests for religious accommodations to the Employment Law Branch. Staff will not be required to complete fit testing until their accommodation request is resolved.
- **For those cases where individual fits into the (B) scenario**, the supervisor should provide a direct order to the employee to report to fit testing appropriately shaved. If the individual fails to follow orders, and continues to refuse to meet the grooming standards, the individual should be referred to OIA for misconduct. The employee may request annual leave or LWOP until such time that they comply with the shaving requirement or at the conclusion of this public health emergency. If they refuse to request leave, the supervisor must enforce annual leave after consultation with the local Human Resources office.
- **For those cases where individual fits into the (C) scenario**, the Lieutenant/supervisor will evaluate all individuals as they report for their shift. If an individual fails to meet the appropriate grooming for respirator use, they should be directed to shave. If the individual fails to follow orders, the individual should be referred to OIA for misconduct. The employee may request annual leave or LWOP until such time that they comply with the shaving requirement or until the conclusion of this public health emergency. If they refuse to request leave, the supervisor must enforce annual leave, after consultation with the local Human Resources office.
- **For those cases where an individual fits into the (D) scenario**, either the local Health Services Department (Clinical Director) or the Safety Department will alert the Human Resource Manager or designee with the name of the individual that is unable to be fit-tested. This information is then forwarded to Occupational Safety & Health through email (BOP-HSD/Occupational Health) for review of a Temporary Job Modification (**TJM**) for the duration of the COVID-19 event. During the review, the individual is placed on Weather & Safety leave.
  - All TJMs will conform to the medical restrictions that are being posed by the individual's inability to wear a respirator, but would not have to conform to the individual's regular schedule, shift, or duties.
  - When a TJM is offered to the individual, they have the option to either accept or decline the TJM.
  - If the TJM is declined, these individuals will no longer qualify for Weather & Safety leave and would need to make an appropriate request for leave.
  - If there is no TJM available for the individual's medical restrictions, the employee would be placed on Weather & Safety leave.

SUPPLY OPTIMIZATION FOR N95 RESPIRATORS

The CDC and NIOSH recommend the following strategies for optimizing supplies of disposable N95 respirators.

→ *See the CDC and NIOSH recommendations at:*
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html

- Use alternatives to N95s (other classes of filtering facepiece respirators)
- Use of N95 respirators beyond stated expiration date.

- Extended use of N95 for repeated close contact encounters.
- Limited re-use of N95 for multiple contact encounters
- Use of a cleanable face shield (preferred) or a surgical mask over an N95 respirator and/or other steps (e.g., masking patients, use of engineering controls), when feasible, to reduce surface contamination of the respirator.
- Hanging of used respirators in a designated storage area or keeping them in a clean, breathable container such as a paper bag between uses.
  - To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified.
  - Storage containers should be disposed of or cleaned regularly.
- Discarding respirators in any of the following conditions:
  - After it has been used five separate times.
  - When visibly soiled.
  - When difficult to breathe through.
  - Following use during aerosol-generating procedures such as bronchoscopy or sputum collection.
  - Contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients, or if damaged.
- **Donning procedures for previously used N95 respirators:** Use a new pair of clean (non-sterile) gloves when donning a used N95 respirator and performing a user seal check. Discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.

GUIDANCE IN THE EVENT OF AN N95 SHORTAGE

In the event of a shortage, N95 respirators should be reserved for **CONFIRMED COVID-19** inmates and for use when an inmate is undergoing an **AEROSOL-GENERATING PROCEDURE,** including testing for COVID-19.

→ *Surgical masks are an acceptable alternative when the supply chain of N95 respirators cannot meet the demand.*

SURGICAL MASKS

APPROPRIATE USE OF SURGICAL MASKS

- Surgical masks should be worn by **ALL HEALTH CARE WORKERS** as both PPE and source control (protection of patients and co-workers).
- Surgical masks should be worn by **ALL OTHER STAFF** when performing enhanced screenings, screening inmates coming into the institution, during R&D encounters, when escorting asymptomatic persons to quarantine, when entering the **QUARANTINE** environment for temperatures or care, and when less than 6 feet from inmates in **QUARANTINE.***

★ ***Wearing of surgical masks applies to ALL TYPES OF QUARANTINE:*** *Intake, exposed, and pre-release/ transfer.*

- Surgical masks should be worn if an **INMATE WORKER FROM GENERAL POPULATION** is utilized as an orderly in quarantine. Alternatively, a fit-tested N95 may be worn.

SUPPLY OPTIMIZATION FOR SURGICAL MASKS

Prioritize surgical masks for selected activities such as:

- **ESSENTIAL PROCEDURES** when splashes and sprays are anticipated with suspected or confirmed COVID-19 case or when bloodborne pathogen exposure is anticipated.
- During **CARE ACTIVITIES** where splashes and sprays are anticipated.
- During activities where **PROLONGED FACE-TO-FACE OR CLOSE CONTACT** with a potentially infectious patient is unavoidable.
- For performing **AEROSOL-GENERATING PROCEDURES**, if respirators are no longer available.

The CDC recommends the following strategies for optimizing the supply of surgical masks.

→ *See the CDC's recommendations at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html*

- Use surgical masks beyond stated expiration date. If there is no expiration date on the facemask label or packaging, facilities should contact the manufacturer to determine if the facemask can be used. The user should visually inspect the product prior to use and, if there are concerns (such as degraded materials or visible tears), discard the product.
- Implement limited re-use of surgical masks.
  - Surgical masks with elastic ear hooks may be more suitable for re-use. Facemasks that fasten via ties may not be able to be undone without tearing and should be considered only for extended use, rather than re-use.
  - When removed, surgical masks should be carefully folded so that the outer surface is held inward and against itself to reduce the user's contact with the outer surface during storage. Store the folded mask between uses in a clean, paper bag, or breathable container.
  - The surgical mask should be removed and discarded if soiled, damaged, or hard to breathe through.

GUIDANCE IN THE EVENT OF A SHORTAGE OF SURGICAL MASKS

- Exclude staff and inmate workers at increased risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients.
- Instead of a surgical mask, use a face shield that covers the entire front (extending to the chin or below) and sides of the face.
- Use of cloth face coverings are not considered PPE, since their capability to protect HCP is unknown. **CAUTION** should be exercised when considering this option. Cloth face coverings should ideally be used in combination with a face shield that covers the entire front (extending to the chin or below) and sides of the face

GOWNS

APPROPRIATE USE OF GOWNS AND COVERALLS

- Gowns are used when in direct contact with inmates in **QUARANTINE** and **MEDICAL ISOLATION**, for performing care or activities where splashes and sprays are anticipated, and during use of aerosol-generating procedures, including swabbing inmates for COVID testing.

- If custody staff need to wear a duty belt over their protective gown or coverall (for access to equipment), ensure that the duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to re-use, using an EPA list N cleaning spray or wipe, according to the product label.
- Current CDC guidelines do not require use of gowns that conform to any particular standards. Gowns and coveralls that conform to international standards, including EN 13795 and EN14126, could be reserved for activities that may involve moderate to high amounts of body fluids.

SUPPLY OPTIMIZATION OF GOWNS

➔ *CDC contingency strategies for optimizing supplies of gowns may be found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html*

- **Gowns should be prioritized for the following:** Aerosol-generating procedures; patient care activities where splashes and sprays are anticipated; and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff (i.e., dressing, bathing/showering, transferring, provision of hygiene, changing linens, assistance with toileting, device care or use, and wound care).
- **Cloth gowns that can be rewashed are preferred over reusing disposable gowns.** Disposable gowns are not typically amendable to being doffed and re-used because the ties and fasteners typically break during doffing.
- **If a disposable gown must be used more than once during a shift:**
  - Wipe off any obvious contamination on the front of the gown while wearing new gloves.
  - Remove gloves, perform hand hygiene, and don new gloves. Then, remove gown:
    - Release the ties at neck and waist, then grasp the gown at the inside shoulder area, and pull the gown down and away from your body.
    - Once the gown is off your shoulders, pull one arm at a time from the sleeves of the gown so that the gown arms are bunched at your wrists. Pull gown away from body and off.
    - Hang gown up on designated hanger with inside facing out.
  - Re-don the gown with clean gloves on, only touching the inside of gown. Remove gloves, perform hand hygiene, and apply new gloves. Have someone secure back of gown with ties or tape.
  - Dispose of gown at the end of the shift.

GUIDANCE IN THE EVENT OF A SHORTAGE OF GOWNS AND COVERALLS

In situations where gowns are severely limited or not available, the following pieces of clothing can be considered as a last resort for care of COVID-19 patients, as **SINGLE USE:**

- Disposable laboratory coats
- Reusable (washable) patient gowns
- Reusable (washable) laboratory coats
- Disposable aprons
- Combinations of clothing can be considered for activities that may involve body fluids when there are no gowns available, for example:
  - Long-sleeve aprons in combination with long-sleeve patient gowns or laboratory coats
  - Open back gowns with long-sleeve patient gowns or laboratory coats
  - Sleeve covers in combination with aprons and long-sleeve patient gowns or laboratory coats

GLOVES

- Wear gloves when in direct contact with inmates, when transporting inmates, during food delivery or tray removal, upon entry to quarantine or medical isolation of COVID-19 suspected or confirmed cases—and when providing medical care of inmates, in general.
- **Gloves are not a substitute for hand hygiene.** Change gloves and perform hand hygiene during patient care if gloves become damaged or become visibly soiled with blood or body fluids following a task; when moving from work on a soiled body site to a clean body site on the same patient; or if another clinical indication for hand hygiene occurs.

➔ *Never wear the same pair of gloves in the care of more than one patient.*

GUIDANCE IN THE EVENT OF A SHORTAGE OF DISPOSABLE MEDICAL GLOVES

- The CDC does not recommend disinfection of disposable medical gloves however, in times of extreme shortages, alcohol-based hand sanitizer (ABHS) is the preferred method for performing hand hygiene of gloved hands when gloves are not visibly soiled.
- Disposable medical gloves can be disinfected or up to six (6) applications of ABHS.
- If ABHS is not available, soap and water may be used although washing may be impractical for short-cuffed gloves where water may enter inside the worn gloves.
- Disposable medical gloves can be cleaned with soap and water up to 10 times.

EYE PROTECTION

- Eye protection is defined as goggles or a disposable face shield that fully covers the front and sides of the face to protect the membranes of the eyes.
- Eye protection does NOT include personal eyeglasses.

APPROPRIATE USES OF EYE PROTECTION

Eye protection is used in a range of situations:

- If direct or very close contact with ill inmates (e.g. temperature checks) or if splashes or spray is anticipated.
- When performing temperature checks
- When screening inmates coming into the institution
- During R&D encounters
- While in QUARANTINE and MEDICAL ISOLATION units that are open, barracks-style, or cells with bars*
- When entering the room or opening the trap door of QUARANTINED or MEDICAL ISOLATION rooms*
- When escorting asymptomatic persons to QUARANTINE*

★ ***Wearing of eye protection applies to ALL TYPES OF QUARANTINE (intake, exposed, and pre-release/ transfer), as well as MEDICAL ISOLATION.***

SUPPLY OPTIMIZATION OF EYE PROTECTION

- **EXTENDED USE** of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with multiple patients, without removing eye protection between patient encounters. **Extended use of eye protection can be applied to disposable and reusable devices.**
- If a disposable face shield is cleaned and disinfected ("reprocessed"), it should be dedicated to one staff member and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. Refer to *Donning and Doffing* section for protocol for removing and reprocessing eye protection.
  - Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, or if visibility is obscured and reprocessing does not restore visibility).
  - Staff should take care not to touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene.

GUIDANCE IN THE EVENT OF A SHORTAGE OF EYE PROTECTION

Shift eye protection supplies from disposable to re-usable devices (i.e., goggles and reusable face shields). Ensure cleaning and disinfection between users if goggles or reusable face shields are used.

SUPPLY CHAIN MANAGEMENT

- At least once weekly, inventory current supplies of PPE and enter levels into the inventory capture dashboard as directed by the Central Office Emergency Operation Center.
- While Central and Regional Offices work to procure PPE in large quantities for disbursement, institutions should continue local efforts to procure all levels of PPE that meet applicable standards, working with local vendors to establish supply chains. If institutions cannot establish supply chains locally, notification should be made to the respective Regional EOC/Command Center by submitting the ICS 215 form.
- If Regional EOCs/Command Centers are unable to fulfill PPE requests, the regional EOC should notify the Central Office EOC. Regional EOC's/Command Centers should immediately request supplies from other Regional EOC's while awaiting further instruction from the Central Office EOC.

Facilities should implement the following to preserve PPE supplies including:

- Exclude non-essential staff from entering isolation or quarantine areas.
- Minimize the number of individuals who need to use respiratory protection by limiting persons in direct contact with suspected or confirmed COVID-19 cases.
- Reduce face-to-face encounters with inmates being screened at entry points, at R&D encounters, and at sick calls and triage.

MODULE 3. SCREENING AND TESTING

WHAT'S NEW

- Updates to SECTION B.1 DIAGNOSTIC TESTS to include BinaxNOW Ag card POC test
- Changes to SECTION B. 3 SPECIMEN COLLECTION: Abbott ID NOW respiratory samples must be processed within one hour of collection and may not be refrigerated for later testing.
- EXPIRATION DATES: All testing supplies should be checked for expiration dates prior to use and returned to Central Fill and Distribution (CFAD) if expired.
- New section C. INFLUENZA TESTING added
- Changes made throughout the document to include BinaxNOW Ag card testing where needed.
- COVID-19 Asymptomatic Novel Coronavirus lab order no longer an available test in BEMR. References to this test have been removed.

MODULE 3 TABLE OF CONTENTS

A. SCREENING INMATES FOR COVID-19

1. INDICATIONS FOR SCREENING

- **INTAKE SCREENING:** All new inmate arrivals at any BOP facility.
  - ➔ *Inmates returning from routine day trips ordinarily do not need to be screened upon return to the facility.*
  - ➢ Includes all new intakes (detainees and commitments, writ returns, parole violators, bureau intra-system transfers, etc.), regardless of their mode of arrival (voluntary surrender, USMS/JPATS, ICE, BOP, etc.).
  - ➢ COVID-19 screening is recommended early in the intake screening process, preferably before entering the building.
  - ➢ Documentation of the COVID-19 symptom screen and temperature check for new intakes will be recorded in the BEMR Intake note, along with disposition to either quarantine or isolation.
- **EXIT SCREENING:** All inmates leaving (i.e., transferring, going to RRC, releasing, etc.) a BOP facility.
- **SCREENING AS PART OF CONTACT INVESTIGATION:** Close contacts of a COVID-19 case.
- **QUARANTINE AND MEDICAL ISOLATION:** Refer to **MODULE 4** for monitoring of patients in quarantine and medical isolation.

2. SCREENING PROCESS

- **SYMPTOM SCREENING**
  - ➢ Chills, cough, shortness of breath
  - ➢ Fatigue, muscle or body aches, headache
  - ➢ New loss of taste or smell
  - ➢ Sore throat, congestion, or runny nose
  - ➢ Nausea, vomiting, or diarrhea

- Inmates who are symptomatic or have a temperature (see below) need to be isolated promptly. (Refer to **MODULE 4** and the **Medical Isolation Checklist** in the **APPENDICES**.)
- **TEMPERATURE CHECK** (see *Temperature Check Protocol* below): A "temperature" depends on the kind of thermometer used:
  - Oral: ≥ 100.4˚F
  - Ear: ≥101˚F
  - Forehead: ≥ 100˚F
- **PPE FOR INMATE SCREENINGS:** Staff who are conducting inmate screenings will wear PPE including gown, disposable gloves, surgical mask and face shield/eye protection (goggles or face shield that fully covers the front and sides of face), in accordance with CDC guidance.
- **USE OF NON-HEALTH CARE STAFF:** To assist health care staff in completing screenings, non-health care staff can be trained to obtain temperatures, record yes/no answers to a symptom screen, and document on a roster.
  - → *Any positive screening is reported promptly to health care staff for further assessment, planning, and intervention.*
  - Training videos for non-health care providers to check temperatures can be found on the BOP Sallyport COVID-19 guidance page.
  - Upon completion of a temperature video, staff should complete the Opinio Survey also found on the BOP Sallyport COVID-19 guidance page, so that the training can be added to the staff person's training record.

3. TEMPERATURE CHECK PROTOCOL

- Perform **HAND HYGIENE** (see **MODULE 1**)
- Don PPE (see **MODULE 2**)
- **CHECK INDIVIDUAL'S TEMPERATURE:**
  - Non-contact or disposable thermometers are preferred over reusable oral thermometers.
  - If **DISPOSABLE OR NON-CONTACT THERMOMETERS** are used and the screener did not have physical contact with the individual, the screener's gloves do not need to be changed before the next individual is temperature-checked.
    - → *Non-contact thermometers should be cleaned routinely for infection control.*
  - If performing **ORAL TEMPERATURE CHECKS** on multiple individuals, ensure that a clean pair of gloves is used for each individual being checked and that the thermometer is used with disposable probe tips.
- Remove and discard **PPE**.
- Perform **HAND HYGIENE**.

SOURCE CONTROL IS CRITICALLY IMPORTANT.

- If inmates are identified with symptoms of COVID-19, immediately have them put on a **FACE COVERING** and perform **HAND HYGIENE**.
- Escort staff will don appropriate PPE (refer to **MODULE 2**) and escort the inmate to the designated **RESPIRATORY MEDICAL ISOLATION** area.

B. COVID-19 TESTING

1. DIAGNOSTIC TESTS

The primary diagnostic test for the **SARS-CoV-2 VIRUS** that causes COVID-19 is a molecular test performed on respiratory secretions, using nucleic acid amplification technology (**NAAT**), usually a reverse transcriptase-polymerase chain reaction (**RT-PCR OR PCR**). COVID-19 viral antigen tests, are also available for testing of respiratory secretions.

- Based on the available evidence and published recommendations, the **BOP-PREFERRED SAMPLE** for symptomatic and asymptomatic cases is a swab from the **nasopharynx, mid-turbinate, or anterior nares**.
  - A lower respiratory tract specimen is usually reserved for testing in a hospital setting or for patients whose upper respiratory tract specimen has tested negative despite a high degree of clinical suspicion.
  - Sputum induction is not recommended in the outpatient setting due to increased risk for exposure to respiratory droplets or aerosols.
  - In general, the BOP does not recommend the use of antibody testing unless it is required by civilian health care entities for a patient to be evaluated.
- **COVID-19 COMMERCIAL PCR TESTS** are sent out to a lab for processing after institution staff collect the swab sample, and then appropriately label and package it. These "send-out" PCR tests are processed using an FDA-approved test.
  - *Utilization of the BOP national laboratory contract for COVID-19 testing is required for commercial testing.*
- **RAPID, POINT-OF-CARE (POC) TESTS** that are FDA-approved are also available for detection of viral nucleic acid or antigen.

  ABBOTT ID NOW SYSTEM
  - CLIA-waived for COVID-19 molecular testing.
  - Also equipped to test for influenza. See **MODULE 7** for additional information.
  - *The major advantage of using the Abbott ID Now system is obtaining rapid test results. Potential limitations include false negative test results, limited specimen viability (1 hour from time of collection), and the time required to run individual tests (10 to 15 minutes per test).*

  ABBOTT BINAXNOW COVID-19 AG CARD
  - CLIA-waived for COVID-19 antigen testing.
  - May be used for broad-based COVID-19 testing in a manner similar to the Abbott ID NOW.
  - *The major advantage of using the BinaxNOW COVID-19 AG CARD is obtaining rapid test results. Potential limitations include false negative test results and these tests may be less sensitive than NAAT tests. The amount of antigen in a sample may decrease as the duration of illness increases and specimens collected after day 7 of illness may be more likely to be negative compared to a RT-PCR assay.*
  - *Negative results from patients with symptoms should be treated as preliminary and confirmed with a molecular assay, if necessary, for patient management.*
- **Institutions are strongly encouraged to identify a variety of sources** for obtaining swabs/viral transport media, high volume PCR lab testing, and testing materials. If institutions require

additional testing supplies and are unable to obtain them, they should consult with their local contract laboratory representative, regional healthcare team —and then send the request to *BOP-HSD/AIMS@bop.gov*.

2. INDICATIONS FOR TESTING

With the increased availability of testing supplies and the increased understanding of the epidemiology of transmission, expanded **TESTING STRATEGIES** have become an important tool in the prevention and management of COVID-19 infections. This is especially true in congregate living and residential settings such as correctional facilities where social distancing may be difficult to achieve or maintain.

→ *The indications for testing for the SARS-CoV-2 virus in a correctional environment include both **ASYMPTOMATIC** and **SYMPTOMATIC** inmates with compelling reasons or priorities for testing.*

Specific INDICATIONS FOR TESTING in the BOP are listed below in FOUR (A–D) CATEGORIES. If there are limitations on the number of tests that can be performed at a given location, prioritization of testing indications may be needed and should be done in consultation with the Regional Medical Director, the Regional Health Services Administrator, and the Regional Infection, Prevention, and Control Consultant.

→ *Refer to **MODULE 4, MEDICAL ISOLATION AND QUARANTINE**, for further guidance regarding (1) testing inmates in and out of medical isolation and quarantine and (2) other criteria for releasing inmates from medical isolation and quarantine.*

A. SYMPTOMATIC INMATES

→ *Testing **SYMPTOMATIC INMATES** is the primary reason for use of the **ABBOTT ID NOW** or **BINAXNOW** COVID-19 tests in the BOP. However, a negative test result from an Abbott ID Now or BinaxNOW system should **NOT** be used as the sole basis for patient management decisions, due to concerns about **FALSE NEGATIVE RESULTS**.*

- Symptomatic inmates whose Abbott POC test (ID NOW or BinaxNOW) is **POSITIVE** should be placed in **MEDICAL ISOLATION**.
  - → *A **POSITIVE** Abbott POC test result does **NOT** require confirmation with a commercial PCR test.*
- Symptomatic inmates whose Abbott test is **NEGATIVE** require **CONFIRMATION**. Another specimen is collected and sent out for commercial **PCR** lab testing.
  - → *Until the confirmation commercial PCR test results are known, the symptomatic patient is placed into **MEDICAL ISOLATION**—but separate from symptomatic patients whose Abbott test was positive. If the commercial PCR test result is positive, the inmate may be cohorted in medical isolation with other COVID-19 positive cases. Clinical judgment will be needed if the commercial lab test result is negative and consultation with Regional Health Services staff is recommended.*
- **Testing for release from COVID-19 medical isolation is NOT recommended.**
  - → *Refer to **MODULE 4** for criteria used for releasing inmates from medical isolation.*

B. ASYMPTOMATIC INMATES WITH KNOWN OR SUSPECTED CONTACT WITH A COVID-19 CASE

- When a staff or inmate case of COVID-19 is identified at an institution, **CONTACT TRACING** of both inmates and staff should be performed expeditiously.

- All inmates identified as **CLOSE CONTACTS** of the index case should be assessed for symptoms and tested using either the Abbott ID NOW POC test, BinaxNOW POC test, or a commercial PCR test.
  - **SYMPTOMATIC CONTACTS** should be tested (and placed in medical isolation, as necessary), as described above under *2.A. Symptomatic inmates*.
  - **ASYMPTOMATIC CONTACTS** should be tested and placed into exposure quarantine, or into medical isolation if their COVID-19 test is positive. (See **MODULE 4** for more information.)
- **TESTING IN HOUSING UNITS:** Because COVID-19 is very contagious and may be spread by asymptomatic as well as symptomatic individuals, expanded testing of all inmates in an entire housing unit should be considered—especially if the unit has open sleeping areas (rather than cells with solid walls and doors) or common areas where inmates have close contact.
- **INSTITUTION-WIDE TESTING** of inmates may be considered where one or more inmate or staff cases of COVID-19 have been identified.
  - This is recommended especially if substantial transmission is confirmed beyond the index case, or if staff or inmates have moved about the institution.
  - Institutions should consult with their regional infection prevention and control (IPC) officer prior to initiating expanded testing strategies.
- **RETESTING DURING WIDESPREAD TRANSMISSION:** Retesting of close contacts who previously tested negative—or retesting more broadly—is recommended when there is widespread institution transmission. A testing frequency of every 3 to 7 days is recommended, whenever feasible, in consultation with the Regional IPC and the Regional Medical Director.

C. ASYMPTOMATIC INMATES WITH NO KNOWN OR SUSPECTED CONTACT WITH A COVID-19 CASE

- **A QUARANTINE TEST-IN/TEST-OUT STRATEGY** is used for all inmates being admitted to and discharged from any type of quarantine
  - → *See **MODULE 4**, for further guidance on testing in and out of quarantine.*
- **ALL INMATE INTAKES, RELEASES, AND TRANSFERS** (including to BOP Medical Referral Centers) should be tested.
  - → *Refer to **MODULE 6** for specific guidance regarding testing procedures for **INMATE MOVEMENT**.*
  - Regardless of the test result, all new BOP admissions/intakes must be placed in a full 14-day quarantine.
  - While a commercial PCR test for intake/release quarantine may be used instead of an Abbott test, outside processing has the disadvantage of a longer turnaround time, causing a possible delay of placement into isolation and/or a prolonged quarantine period for the inmate.
  - If test turnaround time (TAT) is greater than 7 days, the Abbott POC test may be used for **TRANSFERS** to other BOP facilities or in the case of **IMMEDIATE RELEASES**. (In such cases, a negative result on the Abbott POC test does not require confirmation with a PCR test.)
- **INMATES RETURNING FROM THE COMMUNITY** should be tested. Examples include an extended time in an emergency department or crowded waiting area; residing overnight in the community or alternative setting including hospitalization or furlough; work release; and court appearances.

→ *Inmates with frequent or regular trips to the community (e.g., court hearings, work release), may need to be housed in a separate housing group and tested periodically (e.g., once every three to seven days).*

- **HEALTH-CARE RELATED TESTING:**
  - Inmates may be required to be tested in order to be seen at a **CIVILIAN HEALTH CARE SYSTEM.**
  - For **RESIDENTIAL HEALTH CARE UNITS AT MRCs** (e.g., Nursing Care Center units) without any known or suspected cases of COVID-19, **BASELINE TESTING** of inmate residents is recommended by the CDC in conjunction with **PERIODIC RETESTING.** Institutions should consult with their regional IPC to determine frequency of testing.
- **INSTITUTION-WIDE SURVEILLANCE TESTING** involves testing all inmates at an institution without any known COVID-19 cases.
  - The effectiveness, feasibility, and role of this type of testing in a correctional setting is not clearly defined and requires considerable resources. Low participation rates are likely to limit its effectiveness, and institution health care staffing levels are likely to be insufficient to accomplish it.
  - **ALTERNATIVE STRATEGIES:** When institution-wide surveillance testing of inmates is not feasible, alternative strategies may be considered such as **PERIODIC TESTING OF CERTAIN GROUPS** such as inmates with risk factors for severe COVID-19 illness, CPAP users, inmates who work in groups or who may interact with large numbers of staff or inmates as part of their duties (e.g., food service, orderlies), inmates housed in a residential health care unit, etc.
  - Institutions should consult with their regional IPC to determine frequency of testing.

D. RELEASE FROM QUARANTINE

- The preferred method to test out of any quarantine status is a commercial PCR test no earlier than day 14.
- However, if TAT is greater than 7 days, an Abbott POC test (either ID NOW or BinaxNOW) may be used for **TRANSFERS** to other BOP facilities or in the case of **IMMEDIATE RELEASES.** (In such cases, a negative result on the Abbott POC test does not require confirmation with a PCR test.)

→ *Refer to* **MODULE 4** *for further guidance on releasing inmates from quarantine.*

3. SPECIMEN COLLECTION

The following information applies to specimen collection for either an Abbott POC test or a PCR test that is processed by an outside lab. Training videos, fact sheets and manufacturer website links for these tests are available on the Sallyport COVID-19 guidance page.

→ *Handle* ***LABORATORY WASTE*** *from testing suspected or confirmed COVID-19 patients the same as all other biohazardous waste in the laboratory. Currently, there is no evidence to suggest that this laboratory waste needs any additional packaging or disinfection procedures.*

A. USE OF THE ABBOTT POC TESTS (ID NOW AND BINAXNOW)

- All staff performing testing using the Abbott POC machines must demonstrate competency to perform testing.
  - → *Refer to the* ***APPENDICES*** *for the* ***Abbott ID NOW Competency and Performance Assessment*** *and* ***Abbott ID NOW Training Log*** *forms. BinaxNOW Assessment and training logs are forthcoming.*
- Staff using the Abbott ID NOW machines must perform quality control (QC) tests as specified by the CLIA waiver and the manufacturer.
  - → *Refer to the* ***QUICK REFERENCE INSTRUCTIONS*** *for using the Abbott ID NOW machine and running QC tests, available at:* *https://dam.abbott.com/en-us/homepage/coronavirus/38993-ID-NOW-QRG-r4-HD.pdf*
- Staff using the Abbott BinaxNOW COVID-19 Ag Card should refer to **PROCEDURE CARD** and **QUICK REFERENCE SHEET** available at: *https://www.globalpointofcare.abbott/en/product-details/navica-binaxnow-covid-19-us.html*

B. LOCATION FOR SPECIMEN COLLECTION

When collecting diagnostic respiratory specimens (e.g., nasopharyngeal (NP) swabs) from a patient with possible COVID-19, the following should occur:

- Specimen collection should be performed outdoors if possible. If not feasible, testing should be performed in an examination room with no carpet, solid walls, the door closed—and within a negative airflow room, if available.
- If a room is repeatedly used for consecutive testing of inmates, a method of purifying the air is recommended—such as an airborne infection isolation room (AIIR) or a room with a portable high-efficiency particulate air (HEPA) air purifier:
  - Use a HEPA filter that is sufficient for the size of the room (consult with HVAC), and base the wait time between individuals on the clean air delivery rate (CADR) for the filters.
  - In rooms without HEPA filtering, coordinate with the facilities department to determine if the air flow in the room(s) can be adjusted to vent to the outside or to increase the rate of air exchange.

C. PPE FOR STAFF

Staff performing the testing and/or handling of specimens should wear an N95 respirator, eye protection (face shield or goggles), gloves, and a gown.

- If the supply of N95 respirators is limited, they should be prioritized for procedures at higher risk for producing infectious aerosols (e.g., intubation). In this case, staff should use surgical masks.
- Staff should remove PPE when leaving the testing area.
- Gloves should be changed after each patient, and hand hygiene should be performed prior to donning new gloves.

- Avoid contact of the gown with inmates during swabbing, to minimize contamination of the gown. If a gown becomes soiled (e.g., inmate sneezes on the gown during specimen collection):

- Doff the gown in the collection room and perform hand hygiene.
- Doff the gloves (both pairs if double gloved) and perform hand hygiene.
- Proceed directly to exit and perform hand hygiene upon exiting.
- Don a new gown and gloves outside the testing area.

- If eye protection is also soiled:
  - Doff gloves and perform hand hygiene.
  - Don clean gloves.
  - Doff eye protection using strap from the back.
  - Eye protection can either be disposed of in trash or cleaned with an EPA disinfectant wipe.
  - Doff gloves and dispose of in trash and perform hand hygiene
  - Don new gloves and face shield or goggles outside the testing area.

→ *If a staff member needs to take a break and leave the testing area, the procedure will be the same as above, with all PPE doffed and hand hygiene performed inside the room before leaving.*

→ *Refer to MODULE 2 for additional information on PPE, including donning and doffing procedures.*

D. PREPARATION FOR SPECIMEN COLLECTION

- **INMATES** should wear their BOP-issued cloth face covering in the testing area and pull it down below their nose, leaving their mouth covered during the collection of the specimen.
- **ESSENTIAL STAFF ONLY:** The number of staff present during the procedure should be limited to only those essential for patient care and procedure support. Place a notice on the door that COVID testing is being conducted. Only authorized personnel can enter.
- **WAITING AREA:** Inmates will stand on marked areas, which will be ≥6 ft apart in front of the screening table, and maintain social distancing while waiting.
- **ROOM PREPARATION:**
  - 30 minutes prior to specimen collection, testing rooms will be disinfected.
  - Place a countertop splash guard (if available) in front of the machine, if collecting and running tests in same room.
  - Place a chux on the floor in front of the machine (if available), and dispose of it at the end of each day.
- **EXPIRATION DATES:** All testing supplies should be checked for expiration date prior to use. If expired, supplies should be returned to the BOP Central Fill and Distribution (CFAD).

E. SPECIMEN COLLECTION PROCEDURE:

- Orient the inmate being swabbed toward a wall so that, if they cough or sneeze, the respiratory droplets will not be directed toward another person or a space where others will walk.
- Before the NP swabbing, ask the inmate to blow their nose and provide them with tissues, as well as hand sanitizer to use afterwards.
- Proceed to the screening questions and explain the procedure, allowing time to answer the inmate's questions.
- Collect the NP swab (allow 3–5 minutes, including packaging of sample).
- Discard the used swabs as biohazardous waste.

- Work surfaces such as the chair and table within a 6-foot radius of the swabbing location should be cleaned and decontaminated after each inmate.
- If excessive coughing or sneezing occurs during the collection process, in addition to wiping down surfaces, there will be a 10-minute wait before the next individual enters the testing room.

→ *Abbott ID NOW and BinaxNOW Ag Card respiratory samples must be processed within* **ONE HOUR** *of collection and* **MAY NOT** *be refrigerated for later processing.*

F. DECONTAMINATION OF THE TESTING AREA

- Follow the manufacturer's guidelines for cleaning the Abbott ID NOW machines.
- At the end of the swab testing, the room will be cleaned and wiped down and mopped with appropriate EPA-approved disinfectant per manufacturers' directions for dilution, contact time, and safe handling.

→ *Refer to* **MODULE 1** *for additional cleaning and decontamination guidance.*

4. LABORATORY ORDERING AND DOCUMENTATION

A. POINT OF CARE (POC) ABBOTT TESTS

- COVID-19 RNA results (e.g. Abbott ID NOW test) are documented in the EMR Flow Sheets under COVID-19 RNA.
- COVID-19 antigen results (e.g. Abbott BinaxNOW) are documented in the EMR Flow Sheets under COVID-19 antigen.
- POC testing does not require an NMOS order.

→ *Refer to the BEMR user document "COVID-19 Flow Sheet" for step-by-step instructions, available on BOP Sallyport.*

B. SEND-OUT TESTING

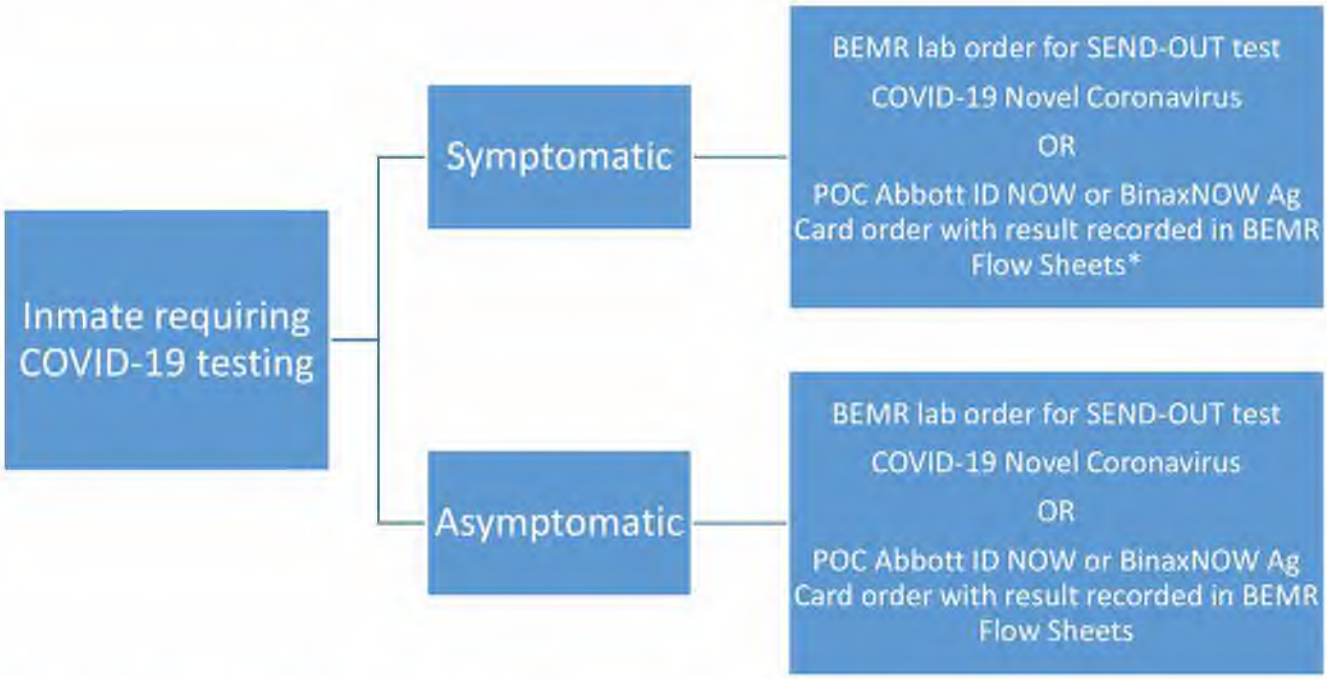
- There is only one SEND-OUT commercial COVID-19 Lab Test available under the Laboratory Information System (LIS) Tests tab in BEMR:
  - COVID-19 Novel Coronavirus
- Type **COVID** in the Lab Test Search box.

→ *If lab orders were incorrectly ordered using a different test and typing "COVID" in the comments, those must be D/C and reordered using one of the two tests listed above.*

PUBLIC HEALTH NOTIFICATION OF POSITIVE TESTS

- COVID-19 is a **REPORTABLE DISEASE** and must be reported to civilian health authorities in accordance with individual state reporting requirements.
- Contact the local health department to ascertain reporting requirements and methods for sharing data.

5. ALGORITHM FOR SELECTING THE APPROPRIATE LAB TEST



*** Negative POC test results for SYMPTOMATIC patients must be verified with a commercial PCR test.**

6. SCREENING AND TESTING PROCEDURES SUMMARY

WHO (TYPE OF QUARANTINE OR MEDICAL ISOLATION)	AT ADMISSION	DAILY SCREENING REQUIREMENTS	AT DISCHARGE	DOCUMENTATION
COMMUNITY RETURNS (community work details, court hearings, hospitalizations, etc.)[1] (INTAKE QUARANTINE) INTAKES (new commitments, detainees, writ returns, parole violators) regardless of mode of arrival (USMS, ICE, voluntary surrender, etc.) (INTAKE QUARANTINE) INMATES LEAVING A BOP FACILITY (transferring, going to RRC, releasing home, transfers to ICE, etc.) (RELEASE/TRANSFER QUARANTINE)	• SS/TC[2] • Abbott ID-NOW or BinaxNOW Ag Card or commercial PCR test[3,5]	• Documentation and daily medical rounds are not required.	• SS/TC within 24 hours of discharge from quarantine. • Commercial PCR test on day 14 or after. • SS/TC within 24 hours of discharge from quarantine. • Commercial PCR test[3]	• Document temperature and symptom screening in EMR chart or the screening section of the intake and exit summaries (intakes and transfers).[7] • Ordering of test and test results, dependent upon test type in BEMR.
ASYMPTOMATIC INMATES with known or expected exposure (EXPOSURE QUARANTINE)	• SS/TC[2] • Abbott ID-NOW or BinaxNOW Ag Card or commercial PCR test[3,5]	• SS/TC twice-daily is preferred. • Once-daily is acceptable when large numbers in quarantine or substantial staffing shortages.	• SS/TC within 24 hours prior to discharge from quarantine. • Commercial PCR test.	• Document temperature and symptom screening in the EMR chart upon intake and exit from exposure quarantine.[7] • Ordering of test and test results dependent upon test type.
SYMPTOMATIC INMATES (MEDICAL ISOLATION)	• SS/TC[2] • Abbott ID-NOW or BinaxNOW Ag Card or commercial PCR test[3,5]	• SS/TC and clinical assessment daily. • May include pulse oximetry, respirations, pulse, etc.	• Testing for release from COVID-19 medical isolation is **NOT** recommended.[6]	• Document daily SS/TCs and status in the clinical encounter note or the EMR chart.[7] • A clinical encounter in the EMR, reviewing time in isolation and symptom screen is required upon release from medical isolation. • Update health problem code to "resolved" and SENTRY code to "recovered."

(continued on next page)

WHO (TYPE OF QUARANTINE OR MEDICAL ISOLATION)	AT ADMISSION	DAILY SCREENING REQUIREMENTS	AT DISCHARGE	DOCUMENTATION
(continued from previous page)				
ASYMPTOMATIC INMATES with a positive COVID-19 test (MEDICAL ISOLATION)	• SS/TC[2] • Abbott ID-NOW or BinaxNOW Ag Card or commercial PCR test[3,5]	• SS/TC daily	• Testing for release from COVID-19 medical isolation is **NOT** recommended.[6]	• Document interval SS/TCs in the EMR chart.[7] • Clinical encounter reviewing time in isolation and symptom screen is required upon release from medical isolation. • Update health problem code to "resolved" and SENTRY code to "recovered."
INSTITUTION SURVEILLANCE[4]	Testing and screening procedures are dependent on recommendations from Regional Medical Director and Regional IPC.			

[1] **INMATES WITH FREQUENT OR REGULAR TRIPS TO THE COMMUNITY** (e.g., court hearings, work release) may need to be housed in a separate housing group and tested periodically (e.g., at intervals or weekly; 14 days after last court date, etc.). Certain workers may be screened prior to or at end of each work day (e.g., town drivers, milk delivery, inmates working at military bases, etc.).

[2] **SS/TC** = Symptom screen and temperature check; may be performed by health services staff or trained non-health services staff.

[3] **ABBOTT RAPID (POC) TESTS** are preferred when an inmate is symptomatic **OR** when the expected turnaround time (TAT) for a PCR test is prolonged (e.g. > 7days).

[4] **NEGATIVE POC TEST RESULTS** for symptomatic patients should be verified with a commercial PCR test.

[5] If inmates become **SYMPTOMATIC DURING QUARANTINE**, they should be re-tested (Abbott or PCR) and placed in medical isolation immediately.

[6] Patients must meet the CDC Isolation discontinuation time and/or symptom-based criteria. See: *https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html*.

[7] COVID-19 screening will be available through the BEMR intake, exit summary, and chart functions beginning October 6, 2020. Until that time, screening should be documented in BEMR flow sheets.

7. MANAGING INMATES WHO REFUSE TESTING

Inmate refusal of testing may be a concern that requires management, not just for the sake of the inmate's individual healthcare, but also to aid in management decisions that could involve the healthcare of others. **As such, it is considered not just a refusal for medical treatment, but also an act that affects the safe and orderly running of the institution.**

→ ***Program Statement 6190.04, Infectious Disease Management**, states, "The Bureau tests an inmate for an infectious or communicable disease when the test is necessary to verify transmission following exposure to bloodborne pathogens or to infectious body fluid. An inmate who refuses diagnostic testing is subject to an incident report for refusing to obey an order."*

A. ADMINISTRATIVE MANAGEMENT OF INMATES WHO REFUSE TESTING

Although not every potential scenario can be anticipated, the information below provides some guidance and principles for the management of inmates who refuse COVID-19 testing.

- A distinction should be made between those who simply refuse testing and those who are willing to be tested, but are unable to tolerate testing via nasopharyngeal, oropharyngeal, nasal mid-turbinate or anterior nares swabbing. Follow CDC instructions on proper sample collection and handling: https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html#specimen
- If an inmate refuses testing, the first action is to **EDUCATE** the inmate on the importance of testing, why it is being conducted, and the potential risks and benefits of testing vs. refusal.
- Except where noted under "B. Clinical Management" below, if an inmate continues to refuse COVID testing, they should be given a **DIRECT ORDER** to submit to testing.
  - If an inmate refuses the direct order, an **INCIDENT REPORT** should be generated. A sample **Incident Report** is provided in **APPENDICES**.
  - A **Medical Treatment Refusal Form** should also be completed.
  - Due to the risk of exposure for staff, a use of force to involuntarily obtain a sample is generally not recommended.

B. CLINICAL MANAGEMENT OF INMATES WHO REFUSE TESTING

Clinical management of inmates refusing COVID-19 testing will vary depending on a variety of factors:

- **SYMPTOMATIC PATIENTS:** Place in single-cell **MEDICAL ISOLATION** until they clear CDC symptom-based criteria for release from isolation. Ideally, this isolation should be separated from both suspected and known positive COVID-19 isolation cases.

  → *Refer to **MODULE 4** for information regarding medical isolation.*

- **ASYMPTOMATIC CLOSE CONTACTS:** Place in single-cell quarantine for 14 days.
  - If the inmate becomes **SYMPTOMATIC** at any time during the quarantine, follow guidance for symptomatic patients in the bullet above.
  - If the inmate remains **ASYMPTOMATIC**, testing should be made available throughout the 14-day quarantine.

- If the inmate submits to TESTING prior to the full 14-day quarantine and tests NEGATIVE, they may be placed in regular exposure quarantine for remainder of the 14-day quarantine period.
- If the inmate submits to TESTING prior to the full 14-day quarantine and tests POSITIVE, they should be placed in MEDICAL ISOLATION and follow time-based criteria for release from isolation.
- If the inmate continues to REFUSE TESTING, they should remain in single-cell quarantine for the full 14 days. On Day 14 of this initial quarantine, TESTING TO RELEASE from quarantine should be offered.
  - If the inmate submits to testing and tests NEGATIVE, they may release from quarantine.
  - If the inmate submits to testing and tests POSITIVE, they should be placed in medical isolation and follow CDC criteria for release from medical isolation.
  - If the inmate continues to REFUSE TESTING, they should be placed in CONTINUED QUARANTINE for another 10 days. They may submit to testing at any time during this 10-day period. If they test positive, they go to medical isolation. If they test negative, they may be released from quarantine. If they continue to refuse, they may be released at the end of 10 days if they remain asymptomatic.

- ASYMPTOMATIC NEW BOP INTAKES: Follow guidance for ASYMPTOMATIC CLOSE CONTACTS above.
- ASYMPTOMATIC INMATES REFUSING TO "TEST-OUT" PRIOR TO RELEASE FROM INTAKE QUARANTINE: Follow guidance above for ASYMPTOMATIC CLOSE CONTACTS who refuse testing to release from the first 14-day quarantine period.
- ASYMPTOMATIC INMATES REQUIRED TO BE TESTED IN ORDER TO BE SEEN AT A CIVILIAN HEALTH CARE SYSTEM: Educate the inmate on the need for testing in order to be seen at civilian health care system.
  - If inmate continues to refuse, have inmate sign refusal for testing and for the medical trip. Document in BEMR that inmate was educated on the testing requirements of the outside facility and that inmate refused.
  - Educate the inmate to notify Health Services if they change their mind about testing so that they can go on the medical trip. In this instance, since testing would not otherwise be indicated, **NO** direct order or Incident Report should be given for refusal.
  - It is also important to note that even if an inmate has previously refused COVID-19 testing, if experiencing a MEDICAL EMERGENCY, they should still be taken to a community hospital.
- ASYMPTOMATIC INMATES TRANSFERRING TO/ARRIVING AT A BOP MEDICAL REFERRAL CENTER (MRC):
  - When feasible, follow the above guidance for ASYMPTOMATIC CLOSE CONTACTS.
  - In some instances, the medical condition may preclude prolonged quarantine period at the sending facility. In these instances, MRCs may need to take the patient and perform quarantine on arrival. With these cases, it is imperative that the sending and receiving institutions are in direct communication to ensure a smooth, timely and appropriate transfer.

- **ASYMPTOMATIC INMATES DEPARTING A BOP FACILITY FOR HOME CONFINEMENT, REGIONAL REENTRY CENTER, OR FULL TERM/GOOD CONDUCT TIME RELEASE,** especially if there are any cases of COVID at the institution:
  - Follow the above guidance for **ASYMPTOMATIC CLOSE CONTACTS** prior to release. Note that this may delay an inmate's release, and inmate should be educated as such.
  - If circumstances require **IMMEDIATE RELEASE** or it is mandated without enough time to fulfill quarantine requirements, the receiving facility, home and/or local health department must be notified of the patient's COVID-19 status. Direct order and Incident Report for refusal of testing in this situation does **NOT** apply.
- **ASYMPTOMATIC INMATES DEPARTING A BOP FACILITY AS A TRANSFER TO ANOTHER BOP FACILITY OR OTHER CORRECTIONAL JURISDICTION:** Follow above guidance for **ASYMPTOMATIC CLOSE CONTACTS.**
- **TESTING INMATES AS PART OF AN INSTITUTION-WIDE SURVEILLANCE PROGRAM:** Follow above guidance for **ASYMPTOMATIC CLOSE CONTACTS.**

C. INFLUENZA TESTING

- For patients with acute respiratory symptoms, it may be difficult to distinguish between symptoms of influenza and COVID-19. This is an especially important consideration when high seasonal influenza activity overlaps with the COVID-19 pandemic. During such times, the BOP recommends testing for both COVID-19 and influenza A/B.
- Facilities may test for influenza via commercial (Quest) testing, department of health flu testing, or the Abbott ID NOW.
  - The Abbott ID NOW influenza tests have been CLIA waived for institutions with a current, valid CLIA certificate of Waiver. Similar to COVID-19 tests, influenza tests will be purchased through HSD and delivered to institutions as needed. Please submit requests for influenza tests to *bop-hsd/AIMS@bop.gov*
  - Information regarding the Abbott ID NOW Influenza test can be found here: *https://www.globalpointofcare.abbott/en/product-details/id-now-influenza-ab-2.html*
  - Training for the Abbott ID NOW influenza test processing must be completed prior to use. Institutions should contact the National Laboratory Administrator for training guidance.

MODULE 4. MEDICAL ISOLATION AND QUARANTINE

WHAT'S NEW

VERSION 2.0

- CLOSE CONTACT definition updated
- Updates to Medical Isolation Housing and General Considerations: *If medical isolation in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.*
- Updates to Housing Considerations for Quarantine: *If quarantining in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.*
- Updates to Symptomatic Persons in Medical Isolation: added reference to monoclonal antibodies for COVID-19, clarified documentation of daily assessments requirement.

MODULE 4 TABLE OF CONTENTS

A. DEFINITIONS

MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive point of care [POC] or commercial laboratory test) COVID-19 infection, either to single rooms or by **COHORTING** them with other viral infection patients.

QUARANTINE: In the context of COVID-19, refers to separating (in an individual room or **COHORTING** in a unit) asymptomatic persons who may have been exposed to the virus to **(1)** observe them for symptoms and signs of the illness during the incubation period, and **(2)** keep them apart from other incarcerated individuals.

- The BOP utilizes **THREE CATEGORIES OF QUARANTINE**: Exposure, intake, and release/transfer.
- All BOP COVID-19 quarantine categories utilize a test-in/test-out strategy.

CASE refers to an individual who has a positive test for COVID-19 **OR** who has symptoms consistent with COVID-19, but has not yet been tested or whose test results are pending.

CLOSE CONTACT: In the context of COVID-19, an individual is considered a close contact if they have not been wearing appropriate PPE **and**:

- Have been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) **OR**
- Had direct contact with infectious secretions of a COVID-19 case.

Considerations when assessing close contacts include the proximity to the infected person, duration of exposure, and the clinical symptoms of the person with COVID-19 (i.e., coughing likely increases exposure risk as does an exposure to severely ill persons).

COHORTING: The practice of grouping patients infected or colonized with or potentially exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. In the BOP, this may refer to housing inmates of similar infection status together rather than in single cells.

SYMPTOMATIC: People with confirmed COVID-19 have reported a wide range of symptoms that typically appear 2–14 days after exposure to the virus. People with confirmed or suspected COVID-19 infection presenting with any of the following symptoms are considered symptomatic:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

B. GENERAL GUIDANCE

1. GENERAL HOUSING CONSIDERATIONS FOR QUARANTINE AND MEDICAL ISOLATION

- Each institution will identify and designate specific **QUARANTINE** and **MEDICAL ISOLATION** areas within the institution—prior to need.
- Plan for separate physical locations (dedicated housing areas and bathrooms) to:
  - **ISOLATE** individuals with confirmed COVID-19 (individually or cohorted).
  - **ISOLATE** individuals with suspected COVID-19, separate from confirmed cases.
  - **QUARANTINE** close contacts (see *definition* above) of those with confirmed or suspected COVID-19 (ideally individually; cohorted if necessary).
  - **QUARANTINE** new intakes and release/transfer inmates—separately from inmates who are exposed close contacts in quarantine.
- The plan should include contingencies for identifying multiple locations if numerous infected individuals and/or close contacts are identified and require medical isolation or quarantine simultaneously. See **MEDICAL ISOLATION** and **QUARANTINE** sections below for more detailed cohorting considerations.
- When identifying spaces for isolation and quarantine, consider spaces not being utilized such as those used for education, religious services, visiting, recreation, or facilities. Tents, shower stations, and mobile hand hygiene stations may need to be obtained to create separate spaces at some facilities.
- When possible, it is recommended that a room be designated near each housing unit and intake area to evaluate and test individuals with COVID-19 symptoms.
- **RESTRICTIONS ON MOVEMENT:** To the extent possible, quarantined and medically isolated inmates should be restricted from being transferred, having visits, or mixing with the general population.

- **SIGNAGE:** The doors to both quarantined and medical isolation units should remain closed.
  - Print out color medical isolation and quarantine signs to be placed on the door of the room or unit, indicating isolation or quarantine, and the recommended personal protective equipment (**PPE**). Printable signs are available in the **APPENDICES**.
  - Cohorted groups should not be in contact with other cohorts. To prevent co-mingling of cohorts and to help correctional staff when moving inmates for showers, phone, computer time and recreation, consider quarantine signs in different colors for each separate cohorted group.
- Provide individuals under medical isolation or quarantine with tissues and, if permissible, a lined no-touch trash receptacle (the liner allows for easier, no-touch emptying). Instruct them to:
  - Cover their mouth and nose with a tissue when they cough or sneeze.
  - Dispose of used tissues immediately in the lined trash receptacle.
  - Wash hands immediately with soap and water for at least 20 seconds.

2. STAFF ASSIGNMENTS AND TRAINING

- **STAFF ASSIGNMENTS:**
  - Staff assignments to quarantine and medical isolation spaces should remain as consistent as possible. These staff should limit their movements to other parts of the facility as much as possible.
  - If staff must serve multiple areas of the facility, ensure that they change **PPE** when leaving the isolation or quarantine space.
  - If a shortage of **PPE** supplies necessitates reuse, ensure that staff always move from areas of low exposure to areas of high exposure risk while wearing the same PPE, to prevent **CROSS-CONTAMINATION**.
    - *For example, start in a housing unit where no one is known to be infected, then move to a space used as quarantine for close contacts, and end in an isolation unit.*
- **STAFF TRAINING:**
  - Train staff and inmate workers on appropriate **PPE** use in quarantine and medical isolation. (Refer to **MODULE 2** for information on PPE.)
  - Train staff and inmate workers on how to appropriately **CLEAN AND DISINFECT** high-touch hard and soft surfaces in quarantine and medical isolation areas. (Refer to **MODULE 1** for more information on cleaning and disinfection.)

3. PERSONAL PROTECTIVE EQUIPMENT (PPE)

MEDICAL ISOLATION and QUARANTINE have different requirements for the use of PPE. Refer to **MODULE 2** for the specific PPE to be used in each situation, as well as supply chain management.

- **LOCATIONS:** A **PPE DONNING OR DOFFING AREA** should be designated at the entry and exit to both quarantine and isolation. The **PPE DONNING AND DOFFING AREAS** can be created with assistance from the facilities department, or an area can be taped off for a visual indication of where to don and doff PPE.
- **SUPPLIES FOR PPE DONNING AREA:** The **DONNING AREA** (place where PPE is put on) should have the following: Hand hygiene supplies, gloves in different sizes, face shields, goggles or glasses for eye protection, surgical masks or N95 or other respirators in different sizes, and gowns or coveralls in different sizes.
- **SUPPLIES FOR PPE DOFFING AREA:** The **DOFFING AREA** (place where PPE is removed) should have the following: Hand hygiene supplies, a waste receptacle (with clear bags), a container to place reusable equipment that needs to be cleaned and disinfected, a disinfectant, and possibly hangers (3M stick-up hangers) to place reusable items (i.e., gown).
- **INSTRUCTIONAL POSTERS:** PPE **DONNING** and **DOFFING** areas should have signage designating the use of each space as well as instructions for donning or doffing PPE. CDC posters and fact sheets for donning and doffing PPE can be found here: *https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html*

4. LAUNDRY

- Laundry from individuals in COVID-19 medical isolation or quarantine can be washed with other individuals' laundry.
- Persons handling laundry from known or suspected COVID-19 cases should wear a gown/coveralls and disposable gloves, discarding them after use and performing hand hygiene.
- Do not shake dirty laundry—to minimize the potential of dispersing virus through the air.
- Clean and disinfect dirty clothes bins after use.

5. FOOD SERVICE ITEMS AND MEALS

- Meals should be provided to medically isolated or quarantined individuals in their spaces, if possible.
- In some facilities, cohorted quarantined inmates may be allowed to go together to meals when they can eat as a separate group and maintain social distancing (i.e., provide more space between individuals in the dining hall by removing every other chair and using only one side of the table).
  - Cohorted inmates should wear facial coverings (except when they are eating) and maintain social distancing any time they are out of their personal area.
  - The food service area must be cleaned and disinfected between groups.
- Disposable food service items can be disposed of in regular trash.
- Non-disposable food service items should be handled with gloves and washed as normal.
- Persons handling used food items from either quarantine or medical isolation should wear a gown or coveralls (to protect clothing from spills) and disposable gloves. Perform hand hygiene after removing gloves.

6. CLEANING AND DISINFECTION

Spaces where quarantined or medically isolated inmates have spent time must be cleaned and disinfected while in use and after discharge (see MODULE 1 for more detailed information):

- If possible, the inmate(s) should assist in cleaning and disinfecting their areas prior to their discharge from quarantine or medical isolation.
- Ensure that persons performing cleaning and disinfection of medical isolation or quarantine areas are wearing the recommended PPE for the product and the space being cleaned. Refer to MODULE 2 for required PPE.

7. RECREATION

- MEDICAL ISOLATION: Inmate recreation will be suspended while in medical isolation. The institution should provide other means for inmates to occupy their time such as reading materials, educational materials, etc.
- QUARANTINE: If recreation is allowed for quarantine and occurs as a group, it should be limited to established cohorts, whenever possible, and the recreation area cleaned and disinfected between and after use (see MODULE 1). If recreation is suspended, the institution should provide other means for inmates to occupy their time such as reading materials, educational materials, etc.

C. MEDICAL ISOLATION

MEDICAL ISOLATION is a critical infection control measure for COVID-19. It separates inmates who are symptomatic and/or who test positive for COVID-19 (symptomatic or asymptomatic) from the general population and other staff.

- As soon as an individual develops symptoms of COVID-19 or tests positive for SARS-CoV-2, they should be given a cloth face covering (if not already wearing one and if it can be worn safely), immediately placed under medical isolation in a separate environment from other individuals, and medically evaluated.

  ➔ *Anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance should not wear a cloth face covering.*
- Refer to the MEDICAL ISOLATION CHECKLIST in the APPENDICES for a summary of all medical isolation requirements.

MEDICAL ISOLATION for COVID-19 should be distinct in name and practice from the use of restrictive housing for disciplinary or administrative reasons—even though limited housing availability may require the use of cells normally used for restrictive housing. To avoid being placed in these conditions, inmates may hesitate to report their COVID-19 symptoms. This can lead to continued transmission within shared housing spaces and, potentially adverse health outcomes for infected individuals.

Ensure that MEDICAL ISOLATION is operationally distinct—with different conditions of confinement compared to restrictive housing, even if the same cells are used for both. For example:

- Ensure that individuals under medical isolation receive regular visits from medical staff.
- Ensure that individuals under medical isolation or quarantine have access to mental health services.
- Make efforts to provide similar access to radio, TV, reading materials, personal property, and commissary as would be available in the individuals' regular housing units.

- Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while isolated.

1. HOUSING AND GENERAL CONSIDERATIONS

- Ideally, MEDICAL ISOLATION will be in a single, well-ventilated room with a solid door and an attached bathroom.
- When housing inmates in medical isolation as a COHORT:
  - **ONLY** persons with LABORATORY-CONFIRMED COVID-19 should be placed under medical isolation together as a cohort.
  - Do **NOT** cohort CONFIRMED COVID-19 cases with inmates who are SUSPECTED of having COVID-19.
  - Ensure that cohorted groups of people with confirmed COVID-19 wear CLOTH FACE COVERINGS whenever anyone (including staff) enters the isolation space.
    - *Anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance should not wear a cloth face covering.*
  - When possible, use ONE LARGE SPACE for cohorted medical isolation, rather than several smaller spaces. This practice will conserve PPE and reduce the chance of cross-contamination across different parts of the facility.
- TRANSFERS: If possible, avoid transferring infected individuals to another facility, unless necessary for medical care. Refer to MODULE 6 for additional guidance.
- AEROSOL-GENERATING PROCEDURES: If a patient who is in medical isolation must undergo a procedure that is likely to generate aerosols (e.g., suctioning, administering nebulized medications, testing for COVID-19), they should be placed in a separate room. An N-95 respirator (not a surgical mask), gloves, gown, and face protection should be used by staff. (For more information, see MODULE 7.)
- DEDICATED MEDICAL EQUIPMENT: If possible, use disposable or dedicated medical equipment in medical isolation (i.e., blood pressure cuffs). Equipment should be left in the medical isolation area and decontaminated in accordance with manufacturer's instructions between cohorts.
- IN-PERSON COURT APPEARANCES: Inmates in COVID MEDICAL ISOLATION should not have in-person court appearances unless absolutely necessary. Having the inmate appear via telephone hearing should be strongly considered. A video teleconference (VTC), if accessible, can also be used as an alternative.
- MEDICAL ISOLATION IN SINGLE CELLS: If medical isolation in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.

2. MONITORING AND DOCUMENTATION

- *Only medical staff can screen and assess patients in* **MEDICAL ISOLATION**.
- *Refer to* **MODULE 3** *for additional information on screening and testing.*

SYMPTOMATIC PERSONS IN MEDICAL ISOLATION

- Assess at least daily for temperature and for symptoms of illness and decompensation, including asking about shortness of breath and cough. Other objective data may include respiratory rate, as well as pulse and oxygen saturation by pulse oximetry.
- Assessments for symptomatic inmates in medical isolation should be **DOCUMENTED** in the medical record.
- Date of entry into and out of isolation and daily assessments should be noted in the medical record.
- A physician or advanced practice provider (APP) will be notified for any of the following: pulse oximetry less than 94%, pulse greater than 100, temp > than 101°F, or respiratory rate > 22 per minute.
- **EMERGENCY WARNING SIGNS:** A low threshold should be used for deciding to transport an inmate to an **OUTSIDE HOSPITAL** if any of the following emergency warning signs for COVID-19 are noted:
  - Trouble breathing
  - Persistent pain or pressure in the chest
  - New confusion
  - Inability to wake or stay awake
  - Bluish lips or face
- **TREATMENT:** Two monoclonal antibody products, bamlanivimab and casarivimab/imdevimab, have received Emergency Use Authorization (EUA) for treatment of persons with mild to moderate COVID-19 symptoms who are at risk for severe disease. Providers should consult with their Regional Medical Director and monitor updates from the CDC on the latest treatment guidelines.
  - Refer to **Appendices** for *COVID-19 Clinical Assessment Protocol*
  - Refer to the **BOP MONOCLONAL Antibodies for COVID-19 Clinical Guidance Document**
- **ISOLATION INFIRMARY:** Under certain circumstances, establishment of an onsite infirmary at an institution may be necessary. Considerations include the number of symptomatic patients, institution resources and local healthcare resources. The decision to stand up an infirmary should be made in consultation between the institution with regional and central office leadership. Refer to **APPENDICES** for COVID-19 Medical Isolation Infirmary Guidance.

ASYMPTOMATIC, COVID-19 PATIENTS IN MEDICAL ISOLATION

- Asymptomatic inmates in medical isolation should be **ASSESSED DAILY** by health services staff for signs and symptoms of COVID-19.
- When feasible, the assessments for asymptomatic inmates in medical isolation should be **DOCUMENTED** in the medical record under temperature screening in flowsheets. The comment box is used for documenting that the inmate remains asymptomatic.
- **AT A MINIMUM**, asymptomatic inmates in medical isolation should have a clinical encounter reviewing their time in isolation and a symptom screen upon release from medical isolation.

RELEASE FROM MEDICAL ISOLATION

- Release from medical isolation should be noted in the medical record and the Health problem code updated to note "**RESOLVED**." Sentry coding is noted as "**RECOVERED**."
- Refer to the **COVID-19 Coding Clinical Reference Guide** located in the **APPENDICES** for the correct diagnosis codes.

3. RELEASE FROM MEDICAL ISOLATION

Testing for release from COVID-19 medical isolation is not recommended in most cases. The BOP follows the CDC guidance to determine when to discontinue medical isolation as discussed below:

→ *See Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings, available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html .*

TABLE 1. CDC DEFINITIONS OF COVID-19 ILLNESS SEVERITY

• **MILD ILLNESS:** Individuals who have any of the various signs and symptoms of COVID-19 (i.e., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging. • **MODERATE ILLNESS:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and an oxygen saturation (SpO2) > 94% on room air. • **SEVERE ILLNESS:** Individuals who have a respiratory frequency 30 breaths per minute, SpO2 <94% on room air (or for patients with chronic hypoxemia, a decrease from baseline of >3%), and lung infiltrates >50% • **CRITICAL ILLNESS:** Persons with respiratory failure, septic shock, and/or multiple organ dysfunction. • **SEVERELY IMMUNOCOMPROMISED:** Includes conditions such as being on chemotherapy for cancer, untreated HIV infection with CD4 lymphocyte count <200, combined primary immunodeficiency disorder, and receipt of prednisone > 20mg/day for more than 14 days.
SOURCE: *https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html#definitions*

- **ASYMPTOMATIC INMATES** who test positive and never develop symptoms **can be released from medical isolation** when at least 10 days have passed since the date of their first COVID-19 positive RT-PCR test.
- **INMATES WITH MILD OR MODERATE SYMPTOMS**, who tested positive or negative, **can be released from medical isolation** at least 10 days after symptom onset, resolution of fever for at least 24 hours without the use of fever reducing medications, **and** if symptoms (e.g., cough, shortness of breath) have improved.
- **INMATES WITH SEVERE SYMPTOMS REQUIRING HOSPITALIZATION, OR SEVERELY IMMUNOCOMPROMISED INMATES, can be released from medical isolation** 20 days after symptom onset, resolution of fever for at least 24 hours without the use of fever reducing medications, and if symptoms have improved
  - → *Although the above strategies are appropriate for COVID-19 patients who are severely immunocompromised, the CDC indicates a test-based approach may also be considered in these cases. Consultation with the Regional Medical Director is recommended prior to using a test-based strategy in this scenario.*

D. QUARANTINE

➔ *Refer to the **Quarantine Checklist** in the APPENDICES for a summary of all quarantine requirements.*

- **The BOP utilizes three categories of QUARANTINE:**
  - **EXPOSURE:** Close contacts of a suspected or confirmed case of COVID-19
  - **INTAKE:**
    - New admissions to a BOP facility
    - Inmates returning from the community to a BOP facility (e.g., an extended time in an emergency department or crowded waiting area; residing overnight in the community or alternative setting such as hospitalization, furlough, writ return, etc.)
  - **RELEASE/TRANSFER:**
    - Inmates being released back into the community (residential reentry center, home confinement, or full-term release)
    - Inmates being transferred to another BOP facility or correctional jurisdiction
- **All BOP COVID-19 quarantine categories** utilize a test-in/test-out strategy, with a quarantine duration of at least 14 days (the incubation period of the SARS-CoV2 virus).
- **Exceptions to quarantine requirements:**
  - Inmates previously diagnosed with COVID-19 do not need to be quarantined within 90 days of their initial symptom onset (for symptomatic cases) or their initial COVID-19 positive test (for asymptomatic cases) if they have met the current CDC release from isolation criteria.
  - Immediate releases from custody *and in consultation with regional medical director* because of statutory or judicial requirements. Refer to **MODULE 6** for additional guidance for immediate releases.

TABLE 2. COMPARISON OF QUARANTINE TYPES IN THE BOP

TYPE OF QUARANTINE	ADMISSION	INTERVAL BETWEEN ADMISSION & DISCHARGE	DISCHARGE	DOCUMENTATION
INTAKE	• SS/TC[1] • Testing (Abbott or commercial)[2]	No interval medical rounds if no known contacts and no exposures or positive tests at intake.	• SS/TC within 24 hours of discharge from quarantine • Testing (commercial lab)	BEMR documentation of admission and discharge SS/TC by HS staff; ordering of test; test results.
EXPOSURE		SS/TC twice-daily is preferred. Once-daily is acceptable; consider when large numbers in quarantine or substantial staffing shortages.	• SS/TC within 24 hours of discharge from quarantine • Testing (commercial lab)	BEMR documentation of admission and discharge SS/TC by HS staff; ordering of test; test results. Interval SS/TCs are documented in the flow sheet.
RELEASE/ TRANSFER		No interval medical rounds required unless inmate is in SHU.	• SS/TC within 24 hours of discharge from quarantine • Testing (commercial lab for most)[3]	BEMR documentation of admission and discharge SS/TC by HS staff; ordering of test; test results.

[1] **SS/TC** = Symptom screen and temperature check; may be performed by Health Services (**HS**) staff or trained non-Health Services staff

[2] **Abbott rapid tests are preferred** when an inmate is symptomatic or when the expected turnaround time (TAT) for a commercial test is prolonged (e.g. > 7days).

[3] **A commercial PCR lab test is preferred** for most discharges from quarantine. **Exceptions include: 1)** BOP inmates transferring to another BOP facility may have an Abbott ID Now COVID-19 test if the commercial lab test TATs is expected to be greater than 7 days and if the inmate will be quarantined upon arrival at their gaining facility. **2)** Immediate releases in which there is insufficient time to obtain commercial lab test results, regardless of TATs.

1. ADMISSION TO QUARANTINE

- **PPE:** An inmate being moved to quarantine should wear a facial covering. Escorting staff in contact with the person should wear gloves, surgical mask, face shield or goggles, and a gown or coveralls.
- **DURATION OF QUARANTINE** is a minimum of 14 days.

2. HOUSING CONSIDERATIONS FOR QUARANTINE

➔ *To reduce the risk of transmission while in quarantine, facilities should make every effort to quarantine inmates* ***INDIVIDUALLY*** *in cells with solid walls and doors.* ***COHORTING*** *should only be practiced if there are no viable options to house them individually.*

➔ ***Different categories of quarantine (Intake, Exposure, and Release/Transfer) should be housed separately.***

- **COHORTING:**
  - Inmates housed in a single or double cell who co-mingle (e.g. shower in a community bathroom, recreate as a group, etc.) are considered to be cohorted. To the extent possible, these groups

should be limited in number (e.g., 10) and kept consistent with the same inmates throughout the duration of quarantine.

- If an entire housing unit is being managed as an exposure quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.
- If a cohort co-mingles with any other cohort the 14-day quarantine period must be reset for all groups.
- If quarantined as a cohort, the 14-day quarantine period must be reset to zero if an inmate in the cohort becomes symptomatic or new inmates are added to the quarantine.

- **PLACEMENT OF BEDS IN COHORTED QUARANTINE:** As feasible, the beds/cots of inmates quarantined as a cohort should be placed at least 6 feet apart. Consider alternating head-to-foot sleeping positions, if feasible.
- **QUARANTINING IN SINGLE CELLS:** If quarantining in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.

HOUSING OPTIONS IN ORDER OF PREFERENCE

The CDC lists the following options for housing inmates in QUARANTINE, in order of preference from top to bottom:

- Separately, in single cells with solid walls and solid doors that close fully.
- Separately, in single cells with solid walls, but without solid doors.
- As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions.
- As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door.
- As a cohort, in single cells without solid walls or solid doors, preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals.
- As a cohort, in multi-person cells without solid walls or solid doors, preferably with an empty cell between occupied cells. Employ social distancing strategies.
- As a cohort, in the individuals' regularly assigned housing unit, but with no movement outside the unit. Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals. Place beds head-to-foot instead of head-to-head to create more space.
- Safely transfer to another facility with capacity to quarantine.

  → *Transfer should be avoided due to the potential to introduce infection to another facility; proceed ONLY if no other options are available.*

- **HIGHER-RISK INMATES:** Ideally, do **NOT** cohort individuals who are at higher risk of severe illness and mortality from COVID--19, including persons 65 and older or with certain co-occurring conditions.

  → *See the CDC's guidance "People Who Are at Higher Risk for Severe Illness" at: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html*

- **MEDICAL REFERRAL CENTERS:** At MRCs, the facility's exposure quarantine area for COVID-19 should be in a separate area from the medical units (Nursing Care Center [NCC] units, ambulatory care units, etc.), whenever possible. MRC intake transfers that need to be quarantined on a medical unit due to care

level for other medical conditions should be quarantined in a single room with solid walls and door, placed on droplet and standard transmission precautions, with full COVID-19 PPE worn by staff when entering the room. Donning and doffing PPE appropriately and practicing hand hygiene is critical. To the extent possible, staff interventions with the inmate in quarantine should be limited.

3. MONITORING AND DOCUMENTATION DURING QUARANTINE

- Each type of quarantine uses a test-in/test-out strategy.
- Refer to **MODULE 6** regarding inmate movement and the timing of the test-in/ test-out quarantine strategy.
- On admission to and discharge from any type of quarantine, inmates in quarantine should have their COVID-19 symptoms, temperature screening, and testing results documented in the medical record.
  - The screening for COVID-19 includes symptoms, temperature, and a COVID-19 PCR test from a nasopharyngeal, mid-turbinate, or anterior nares swab.
  - Either POC testing (Abbott ID Now) or a commercial lab may be used for testing into quarantine.
  - Refer to **MODULE 3** for guidance regarding testing of inmates in quarantine.
- It may be helpful to maintain a **ROSTER** of inmates who are in quarantine, including cell assignment, date of placement in quarantine, projected end date of quarantine, date of placement in that specific cell, cell mate or members of the cohort, and designated facility.
- **INTAKE AND RELEASE/TRANSFER QUARANTINE:** Daily COVID-19 symptom screens and temperature checks are not required routinely for intake and release/transfer quarantine.
- **EXPOSURE QUARANTINE:** Inmates in exposure quarantine should be screened at least once daily for COVID-19 symptoms, including a temperature reading. Twice-daily screening is preferred when feasible.
  - *Non-healthcare staff—trained to obtain temperatures and record yes or no answers to a symptom screen and documenting on a roster—can assist health services staff to complete daily screenings. Any positive screening is reported promptly to healthcare staff for further assessment, planning and intervention.*
  - A physician or Advanced Practice Provider (APP) will be notified for any of the following: Inmates who become symptomatic or have a temperature (Mouth) ≥ 100.4˚F, (Ear) ≥ 101˚F, or (Forehead) ≥ 100˚F need to be isolated promptly. Upon assessment, the physician or APP should document assessment in the medical record.
  - Refer to the **COVID-19 Coding Clinical Reference Guide** in the **APPENDICES** for correct diagnosis codes.

5. OTHER QUARANTINE CONSIDERATIONS

QUARANTINE OF INMATES PREVIOUSLY DIAGNOSED WITH COVID-19

- Current evidence indicates that people who have recovered from COVID-19 can continue to shed detectable levels of virus for up to 90 days after illness onset. However, the virus levels are considerably lower than during illness and are in ranges that are unlikely to be contagious. Patients that have met release from isolation criteria are no longer considered infectious, even though they may continue to test positive for up to 90 days. If at least 90 days has passed from the onset of their initial illness or positive test, they should be managed as any other individual with no prior history of infection.

- Refer to **MODULE 6** for guidance regarding intake and release/transfer for inmates previously diagnosed with COVID-19.

QUARANTINE ISSUES ASSOCIATED WITH COURT

A number of variables affect the risk of COVID-19 transmission during in-person court appearances and will determine some of the specific management strategies that are needed at each location.

- When possible, inmates in any type of **QUARANTINE** should delay in-person court appearances until they are tested and COVID-19 negative at the end of quarantine. Telephone or VTC appearances are recommended alternatives.
- The U.S. Marshalls Service (**USMS**) takes responsibility for the inmate from the time they leave the BOP institution until their return. Each USMS district may have their own procedures. Individual courts may also have different COVID-19 prevention/mitigation procedures and requirements. The risk or likelihood of mixing with non-quarantined, non-BOP inmates while BOP inmates are with the USMS and the courts is essential to determining their risk of COVID-19 exposure.
- The frequency of an inmate's court appearance and the number of inmates going to a court at any one time are also important factors to consider.
- **It is recommended that each BOP detention center contact the USMS and the court** to ascertain their COVID-19 mitigation procedures and consult with Regional Health Services staff on developing an individualized strategy. The following are general principles to follow:
  - **BOP officials will request that BOP inmates be cohorted only with their own housing or quarantine cohort** and not be mixed with inmates from other housing units or other institutions, or transported with inmates from other institutions to the extent possible while at court.
  - **Upon return to the detention center, inmates should test-in/ test-out of a 14-day quarantine** if they were exposed to other inmates from other housing units or locations (e.g., county jails).
  - **Inmates who were not previously in quarantine** prior to their court appearance, were outside of the institution for less than 24 hours, were not exposed to other inmates between departure and return to the facility and where proper precautions were maintained including use of face coverings, social distancing and PPE by transporting and court staff, may return to their housing unit upon return to their institution after being screened.
  - **Testing an inmate immediately after a one-day court appearance** would have little utility and is not recommended. However, an Abbott ID NOW test can be used before a court appearance on a case-by-case basis, especially if the test is required by the court.

MODULE 5. SURVEILLANCE

WHAT'S NEW

- Updates to Contact Tracing to include contact tracing guidance and references to revised appendices.

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The purpose of COVID-19 surveillance is to monitor the current state of the pandemic. It involves **measuring** epidemiological (disease-related) aspects of the pandemic in order to **manage** it appropriately. -Public health surveillance is the ongoing systematic collection, analysis, and interpretation of data, closely integrated with the timely dissemination of these data to those responsible for preventing and controlling disease and injury.

- Surveillance is essential during a pandemic to assist in reducing SARS-COV-2 transmission. It should involve a combination of facility and community monitoring.
- Institutions should develop a SURVEILLANCE PLAN addressing SYNDROMIC SURVEILLANCE, CONTACT TRACING, and SURVEILLANCE TESTING, which are described below.

A. SYNDROMIC SURVEILLANCE

Syndromic surveillance includes the following:

- Clinician reporting on inmates presenting to sick call with acute respiratory complaints, fevers, and pneumonias. The BOP's electronic surveillance dashboard can assist with monitoring of respiratory complaints.
- Reporting of staff not permitted entry to the institution upon COVID-19 screening
- Reporting on staff calling in sick related to COVID-19 symptoms.
- Clinician and laboratory reporting on the number of inmate and staff COVID-19 positive and negative cases.
- Reporting on inmate hospitalization and discharges
- Reporting on COVID-19 related deaths (inmates or staff)
- Community COVID-19 positive cases, hospitalizations, and death—including communities where staff members are known to live, visit, and commute

B. CONTACT TRACING

Contact tracing can be a useful tool to help contain disease outbreaks. When deciding whether to perform contact tracing, consider the following:

- Have a plan in place for how close contacts of individuals with COVID-19 will be managed, including quarantine or isolation, as appropriate. (Refer to MODULE 3 - *Screening and Testing*, and MODULE 4 - *Inmate Isolation and Quarantine*.)
- Contact tracing may be more feasible and effective in settings where incarcerated/detained individuals have LIMITED CONTACT with others (e.g., celled housing units)—compared to settings where close contact is frequent and relatively uncontrolled (e.g., open dormitory housing units).
- **Contact tracing can be especially impactful in the following situations:**
  - When there is a SMALL NUMBER OF INFECTED INDIVIDUALS (staff or inmate)—such as in a particular work unit or housing unit—aggressively tracing close contacts and separating them from the general population can help curb transmission before many others are exposed.
  - When the infected individual (staff or inmate) has had CLOSE CONTACT WITH INDIVIDUALS FROM OTHER HOUSING OR WORK UNITS, identifying close contacts can help prevent the infection from spreading throughout the entire facility.
  - When the infected individual (staff or inmate) has recently been in a COMMUNITY SETTING, identifying close contacts can help reduce transmission from the facility into the community.
- If there is a LARGE NUMBER OF INDIVIDUALS WITH COVID-19 in the facility, contact tracing may become difficult to manage:
  - When there is identified ongoing transmission in a specific area, formal contact tracing may not be indicated when new cases are identified.
  - Under such conditions, consider BROAD-BASED TESTING in order to identify infections and prevent further transmission. Decisions for expanded testing should be made in consultation with the Regional Infection Prevention and Control Officer (IPC) and Medical Director.

CONTRACT INVESTIGATION & TRACING GUIDANCE

PROMPTLY COMPLETE A CONTACT INVESTIGATION with SARS-CoV-2 positive inmates and staff to identify close contacts and complete contact tracings to stop transmission or decrease the number of cases within the institution. Utilize information from the contact investigation to identify and trace all close contacts of the source case(s) 48 hours prior to the source case's symptom onset or testing (if asymptomatic).

- Close contact is defined as a cumulative exposure time > 15 minutes in 24 hours and within < 6 feet of distance.
- Refer to the APPENDICES for a useful tool to help guide contact investigation and tracing.

- **STAFF CONTRACT TRACING:**
  - The HR department may need to be involved with the contact tracing to include assistance with obtaining staff member's phone number(s) for source contact investigation and extending to contact tracing of staff.
  - REPORT ALL STAFF POSITIVE CASES THROUGH YOUR EOC AND LOCAL HR DEPARTMENT as soon as possible utilizing the Staff Positive Case Form in the APPENDICES.
    - Include a copy/screen shot of laboratory results.

- Email (b)(6); (b)(7)(C) gov for confirmation and assimilation into the Bureau's database.
- The subject line for the email is to include: COVID-19 Staff + Results - Name of institution.

➢ Once staff contacts are determined:

- Check with the local DOH – they may want a list of staff tracing contacts to conduct their own investigation.
- Staff identified as close contacts should be notified that they are a contact to an identified COVID-19 case.
  - Utilize a standard email (see APPENDICES) or warden notification to staff who may have been exposed to assist with notification.
  - Refer to MODULE 11, SECTION C for staff guidance with potential exposure to SARS-CoV-2.
  - Facilities that do not have a staff testing laboratory contract should refer staff to the community for testing.

- **INMATE CONTACT TRACING:**
  - ➢ Run a Sentry roster of the inmate quarters to identify roommates and close contacts.
  - ➢ Determine work contacts and recreation/activity contacts.
  - ➢ Determine test results; last day of work, activities or visits.
  - ➢ Attempt to determine contacts within the last 48 hours since the development of symptoms or two days prior to the SARS-CoV-2 test, if asymptomatic. Have a plan in place for how close contacts of individuals with COVID-19 will be managed, including quarantine or isolation, whichever is appropriate. (Refer to MODULE 3 - *Screening and Testing*, and MODULE 4 - *Inmate Isolation and Quarantine*.)
  - ➢ If an entire work crew is identified or an open unit bay, it may be necessary to quarantine the entire unit for 14 days.

EDUCATE STAFF AND INMATES

- Provide training regarding signs and symptoms of infection, hand hygiene, social distancing, and proper wear and removal of facial coverings and PPE to prevent infection with SARS-CoV-2.
- Ensure education signage is posted at the facility via email, TRULINK and educational fliers.

C. SURVEILLANCE TESTING

Congregate settings such as prisons are at high risk for SARS-CoV-2 transmission. **SURVEILLANCE TESTING** assists in identifying asymptomatic or mildly symptomatic spread that may elude symptom-based surveillance.

It is recommended that facilities develop a **COVID-19 PCR SURVEILLANCE TESTING PLAN** for inmates who are at risk for increased exposure to SARS-CoV-2, including:

- Inmates admitted to long-term care units.
- Inmates on work details at high risk for contracting COVID-19 or transmitting it to others such as orderlies, sanitation workers, food service workers, town drivers, trash details, or UNICOR.
- Inmates returning from prolonged hospitalizations, writ returns, court appearances, furloughs, or any community activity.

D. DATA SHARING TO ASSIST IN SURVEILLANCE

- The COVID-19 pandemic has magnified the significance of a **MULTIDISCIPLINARY APPROACH** to managing the spread of SARS-CoV-2—requiring communication, collaboration, and data sharing within the facility and with the local health department.
- Utilize data sharing to disseminate information, assist in evidence-based clinical decisions, and expedite the deployment of resources needed to mitigate widespread transmission of SARS-CoV-2.
- Contact your local health department to ascertain reporting requirements and methods for sharing data. COVID-19 is a reportable disease and must be reported to civilian health authorities in accordance with individual state reporting requirements. The data systems listed below can assist in monitoring the current state of the COVID-19 pandemic.
  - BOP respiratory surveillance dashboard
  - BOP COVID-19 dashboard
  - BOP public website
  - Community, local, and state COVID-19 dashboards.

→ *If there are any questions related to what data may be shared with the local health department, contact your Regional IPC.*

MODULE 6. INMATE MOVEMENT

WHAT'S NEW

- Inmate movement is an important part of the BOP mission. In and of itself it is complex, but is made even more so by the infection prevention procedures needed to limit SARS-CoV-2 transmission during the COVID-19 pandemic. This module has been re-organized for greater clarity on what procedure to use with the various types of inmate movement.
- As COVID-19 vaccination rates increase and SARS-CoV-2 infection rates decrease, the risk of transmission is decreasing commensurately. In response to the improving epidemiology of the pandemic, the BOP is implementing a *BOP Intrasystem Transfer Procedure*, rather than Transfer Quarantine, for transfer of BOP inmates from one BOP facility to another BOP facility when rates of inmates in medical isolation at the originating facility are low.

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A. DEFINITIONS

- **BOP GROUP:** Includes inmates at BOP facilities who have completed **THE BOP INTRASYSTEM TRANSFER PROCEDURE** (see *Section G*) prior to their BOP intrasystem transfer.
- **NON-BOP GROUP:** Includes inmates from other agencies, correctional jurisdictions or contract and private correctional facilities and who have not completed an **INTAKE QUARANTINE** in the BOP. Inmates in detention centers (pre-designated) are considered in a non-BOP group until they have completed an **INTAKE QUARANTINE**.
- **NEW INTAKES:** Includes new commitments, voluntary surrenders, writ returns, and any inmate brought to a BOP facility by the U.S. Marshals Service including the Justice Prisoner and Alien Transportation System, U.S. Customs and Border Protection, or Immigration and Customs Enforcement. Inmates returning from day trips (e.g., hospital or court returns) *are not* new intakes.
- **POC TEST:** a SARS-CoV-2 rapid point of care viral test (e.g., Abbott ID NOW™ COVID-19 PCR test or Abbott BinaxNOW™ COVID-19 Ag card).
- **QUARANTINE:** In the context of COVID-19, refers to separating (in an individual room or cohorting in a unit) asymptomatic persons who may have been exposed to the virus to **(1)** observe them for symptoms and signs of the illness during the **INCUBATION PERIOD** and **(2)** keep them apart from other incarcerated individuals.
  - ➢ The BOP utilizes **THREE CATEGORIES OF QUARANTINE** – exposure, intake, and transfer
- **MEDICAL ISOLATION:** Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive POC or commercial laboratory test) COVID-19 infection, either to single rooms or by **COHORTING** them with other viral infection patients.
  - ➔ Refer to **MODULE 4** for additional guidance on COVID-19 pandemic-related **QUARANTINE** and **MEDICAL ISOLATION**.
- **TRANSFER QUARANTINE:** Inmates in the following situations will complete a 14-day test-in/test-out transfer quarantine: 1) BOP intrasystem transfers from originating facilities with evidence for widespread transmission; 2) inmates transferring out of the BOP (e.g., to another correctional jurisdiction, residential reentry center, home confinement); or 3) full term release.

B. PLANNING FOR INMATE MOVEMENT

Advanced and coordinated planning is required when transferring inmates to other BOP locations or other correctional jurisdictions, or when releasing inmates from BOP custody. Collaboration and coordination among departments, institutions, and regions is necessary to reduce the risk of SARS-CoV-2 exposure and transmission during inmate movement. Planning for inmate movement should be coordinated from the beginning with local Executive Staff, Case Management Coordinators (CMC), Unit Team, and Health Services staff—from all the institutions involved—in setting transfer dates and ensuring that all aspects of the transfer process are carried out efficiently. Coordination with other agencies (e.g., U.S. Marshals Service, Immigration and Customs Enforcement), as well as local or state health authorities, may also be necessary.

- Whenever possible, inmate move planning should occur enough in advance to accomplish the quarantine, testing and/or screening procedures appropriate to the specific type of inmate movement – either a **TRANSFER QUARANTINE** (*Section H*) or a **BOP INTRASYSTEM TRANSFER** (*Section G*).
  - ➢ A **TRANSFER QUARANTINE** may require approximately 21 days of advanced planning and a **BOP INTRASYSTEM TRANSFER** requires up to 72 hours.

- PPE appropriate for each setting (testing, transportation, etc.) should be worn by staff in accordance with established procedures. (See MODULE 2.)

C. GENERAL TRANSPORTATION CONSIDERATIONS

Movement of inmates can be a simple, short-distance transfer—or a complex, multi-day, multi-institution process. The risk of SARS-CoV-2 exposure and transmission increases as the complexity of the move increases.

Normal transport routes and schedules need to be reviewed and reconsidered during a pandemic, taking into consideration the current epidemiological context (e.g., infection and transmission rates). Inmate movement should be coordinated in a manner that considers the following:

- Even a BOP intrasystem transfer direct from one BOP facility to another is not without some degree of risk due to the characteristics and communicability of SARS-CoV-2.
- MOVEMENT VARIABLES that increase the risk of SARS-CoV-2 exposure and transmission should be avoided whenever possible, including: multiple stops, introduction of multiple staff, and mixing together of inmates from other BOP facilities or other correctional jurisdictions.
- To the extent possible, manifests should be generated that allow for appropriate SOCIAL DISTANCING during transport (e.g., loading a bus or plane at 50% capacity).
- DIRECT TRAVEL OR MINIMAL STOPS/HOLDOVERS should be arranged whenever possible (e.g., consider institutions meeting at a halfway point to pick-up inmates, rather than having multiple stops and holdovers).
- **Minimize the amount of time inmates are held in HOLDOVER**; the longer an inmate spends in transit, the greater the risk for exposure to the virus. The frequency of certain drop offs or pick-ups may need to be increased to minimize holdovers.
- **Avoid mixing inmate groups (BOP and NON-BOP) as much as possible:**
  - Maximize runs with **BOP GROUPS** only.
  - Make every effort to coordinate runs for **NON-BOP GROUPS** separately.
- An inmate who is currently in or meets the criteria for COVID-19 medical isolation (a current positive SARS-CoV-2 test or who has fever or symptoms of COVID-19) should **NOT** be transferred or released from BOP custody unless absolutely necessary (e.g., immediate release, completion of a sentence) and with coordination of appropriate medical precautions and care.
- An inmate who is currently in or meets the criteria for exposure or intake quarantine should **NOT** be transferred or released from BOP custody unless absolutely necessary (e.g., immediate release, court order, completion of a sentence).

D. DOCUMENTATION

- **It can be useful to maintain a COVID-19-related roster of inmates to facilitate management of release/transfer.** Helpful data points include cell assignment, start date of quarantine or medical isolation, projected end date of quarantine or isolation, date of placement in that cell, cell mate or members of a cohort, testing dates, type of test (POC or commercial), test results and designated facility.
- **The BEMR Exit Summary/transfer paperwork should be provided to the bus LT/USMS** to verify that required screening and testing has been completed.

- **Documentation on the BEMR exit summary/transfer paperwork (e.g., In-Transit Form) needs to include:**
  - For TRANSFER QUARANTINE – document the start and end dates of quarantine, SARS-CoV-2 test type, dates and results for both admission and discharge tests, and results of the symptom screen and temperature check within 24 hours of transfer.
  - For **BOP INTRASYSTEM TRANSFERS** – document the SARS-CoV-2 test type, date and result within 72 hours of a BOP intrasystem transfer and results of the symptom screen and temperature check within 24 hours of transfer.
  - **For inmates who have a history of COVID-19 illness and are recovered and ready to transfer:** Exit summary and clinical notes should include the inmate's most recent COVID-19 history (e.g., date of symptom onset, date of initial positive SARS-CoV-2 test, date and criteria used for release from isolation, and any complications or sequelae from the illness).

E. STRATEGIES TO LIMIT SARS-COV-2 TRANSMISSION DURING INMATE MOVEMENT

The BOP uses multiple strategies for limiting transmission of SARS-CoV-2 during inmate movement, depending on the type of movement and the epidemiology of SARS-CoV-2 at the institution. Procedures for movement are designed to address the risk for transmission in a variety of situations including new inmates arriving at a facility, outgoing inmates from a facility to different destinations, detainees and holdovers, as well as different origination sources of inmates (within the BOP and external to the BOP). The two primary movement procedures utilize either a 14-day test-in/test-out quarantine or a combination of POC test with symptom screen and temperature check prior to departure, described below in more detail with each movement type.

Movement Type	Movement Procedure
Intake into any BOP facility	Intake Quarantine
Full-term Release	Transfer Quarantine
Transfer to a non-BOP correctional facility	
Transfer to Residential Reentry Center or Home Confinement	
BOP intrasystem transfer where the originating institution's medical isolation rate is ≥ 2%	
Immediate Release	Immediate Release
BOP intrasystem transfer where the originating institution's medical isolation rate is < 2%	BOP Intrasystem Transfer

F. NEW INTAKE QUARANTINE

PRIOR TO ENTERING THE INSTITUTION, OR IN R&D: All new intakes to an institution, including voluntary surrenders, BOP intrasystem transfers, or transfers from outside the BOP system, will be screened by medical staff for SARS-CoV-2—including a COVID-19 symptom screen, a temperature check, and an approved viral test (either a POC or a commercial lab PCR test) performed on a sample obtained from a nasopharyngeal, mid-turbinate, or anterior nares swab.

- **Inmates who arrive symptomatic AND/OR test positive will be placed in MEDICAL ISOLATION.**

- **Inmates who arrive asymptomatic AND test negative will be placed in INTAKE QUARANTINE.**
  - If inmates become symptomatic during quarantine, they should be re-tested (POC or commercial test) and placed in **MEDICAL ISOLATION** immediately.
  - If inmates remain asymptomatic, they stay in **QUARANTINE** for at least 14 days. They are then tested out of quarantine with a commercial PCR test at 14 days or later. If the test is negative, the inmate can be released to the general population. If the test is positive, they should be placed in **MEDICAL ISOLATION** immediately.

→ *Refer to Section J for OKL movement procedures.*

→ *Refer to **MODULES 3 AND 4** for additional information regarding screening, testing, and medical isolation and quarantine of inmates.*

G. BOP INTRASYSTEM TRANSFERS (INMATE MOVEMENT FROM ONE BOP FACILITY TO ANOTHER BOP FACILITY)

When inmates move from one BOP facility to another BOP facility, and the sending (i.e., originating) institution's inmate medical isolation rate is less than 2%, the following procedure may be used.

- Prior to transfer from the originating BOP institution, the following are performed while the inmate remains in their current housing (e.g., general population):
  - The originating institutions will perform a POC test within 72 hours of inmate movement as close to the time of departure as is feasible.
  - A symptom screen and temperature check will be performed within 24 hours of inmate movement.
- Inmates with a negative POC test, a negative COVID-19 symptom screen, and a normal temperature do not need a **Transfer Quarantine**.
- A SARS-CoV-2 test is not required for inmates with a history of COVID-19 diagnosed within the past 90 days. Perform a symptom screen and temperature check within 24 hours of inmate movement.
- Institutions with current medical isolation rates ≥ 2% need to follow **TRANSFER QUARANTINE** procedures (*Section H*)
  - → *Refer to Section J for OKL movement procedures.*
  - → *Institution infection rates may be found on the COVID-19 Dashboard, accessed through the Sallyport COVID-19 Resources page*
- **DO NOT TRANSFER** inmates who are symptomatic and/or test positive and place in **MEDICAL ISOLATION.**
- **DO NOT TRANSFER** inmates who have been exposed to COVID-19 and test negative and place in **EXPOSURE QUARANTINE.**
- An **INTAKE QUARANTINE** is performed on **all** BOP intrasystem transfers when they arrive at their designated facility (refer to *Section H*).

→ *For this procedure to be effective, institutions will ensure that other aspects of the BOP COVID-19 Pandemic Plan are implemented, including but not limited to broad-based inmate testing strategies, exposure quarantine, and medical isolation.*

→ *Refer to **MODULES 3 AND 4** for additional information regarding screening, testing, and medical isolation and quarantine of inmates.*

H. TRANSFER QUARANTINE

- Whenever possible, 21-day advance planning is recommended to allow sufficient time to complete the **TRANSFER QUARANTINE**.
- A **TRANSFER QUARANTINE** will be used for 1) BOP intrasystem transfers from originating facilities with evidence for widespread transmission; 2) inmates transferring out of the BOP (e.g., to another correctional jurisdiction, residential reentry center, or home confinement); or 3) full term release.
- An inmate who is currently in COVID-19 medical isolation, or meets the criteria for medical isolation, should NOT be transferred or released from BOP custody unless absolutely necessary (e.g., immediate release, completion of a sentence).
- An inmate who is currently in COVID-19 exposure or intake quarantine, or meets the criteria for exposure or intake quarantine, should NOT be transferred or released from BOP custody unless absolutely necessary (e.g., immediate release, completion of a sentence).

➔ *Refer to **MODULES 3 AND 4** for additional information regarding screening, testing, and medical isolation and quarantine of inmates.*

All inmates meeting criteria for TRANSFER QUARANTINE, will be managed in one of the following three categories, which are discussed below:

1. Inmates with no prior history of COVID-19.
2. Inmates previously diagnosed with COVID-19 who have since recovered, and have met the current criteria for release from medical isolation (see **MODULE 4**).
3. Immediate releases.

➔ *Consultation with the Regional Medical Director, Regional Health Services Administrator, and Regional Infection Prevention Consultant is recommended for management of inmates who are not in one of these three categories.*

1. TRANSFER OR RELEASE OF INMATES WITH NO PRIOR HISTORY OF COVID-19

- Prior to transfer, these inmates should be tested with an approved test (either a POC or commercial lab PCR test) and, if negative, be placed in **TRANSFER QUARANTINE** and housed separately from inmates in **EXPOSURE OR INTAKE QUARANTINE**. See **MODULES 3 AND 4** for testing procedures and more information on quarantine and medical isolation.
- Inmates will remain in quarantine for a minimum of 14 days. They may be tested out of quarantine on day 14 with a commercial PCR lab test (or a POC test in circumstances outlined below).
  - If any inmate in a transfer quarantine cohort tests positive, the quarantine period must be restarted for all inmates in that cohort.
- Movement is preferred within five days of receiving the negative SARS-CoV-2 test result, regardless of the mode of travel (by ground or air). When this five-day window for movement cannot be achieved, the time frame for movement may be expanded to within 14 days of receiving the negative SARS-CoV-2 test result, as long as quarantine conditions are maintained for the entire time.
  - A symptom screen and temperature check need to be performed within 24 hours prior to departure from the facility.
  - Documentation of the symptom screen, temperature, and entry and exit date test results must be included in the exit summary/transfer paperwork. (See *Documentation* above.)

- Inmate movement that needs to occur more than 14 days after receipt of a negative test result should be discussed with regional health services staff.

2. TRANSFER OR RELEASE OF INMATES WITH A HISTORY OF COVID-19 INFECTION

- **WITHIN 90 DAYS OF INITIAL SYMPTOM-ONSET OR POSITIVE TEST:** Inmates with a history of SARS-CoV-2 infection within the last 90 days who have met criteria for release from medical isolation do not need to be placed in **TRANSFER QUARANTINE** and should not be tested.
- **MORE THAN 90 DAYS SINCE INITIAL SYMPTOM-ONSET OR POSITIVE TEST:** Inmates who have met criteria for release from medical isolation and are more than 90 days from their initial symptom onset or initial positive SARS-CoV-2 test are managed as inmates who have not had COVID-19 (see #1 above).
- **INMATES NOT CLEARED FROM MEDICAL ISOLATION:** Inmates with COVID-19 currently in medical isolation should not be released or transferred unless absolutely necessary (e.g., immediate release, completion of sentence). Special precautions and coordination are necessary for such cases, including use of appropriate PPE, source control, and notification of appropriate civilian health authorities or the receiving correctional jurisdictions.

→ *For the above scenarios, institutions will complete the Documentation requirements outlined above. Notification should be made to the receiving facility, jurisdiction, or local health authorities of the transfer.*

3. IMMEDIATE RELEASES

The following actions should be taken when an inmate being released cannot be managed as described above under #1 or #2 because of statutory or judicial requirements.

- A symptom screen, temperature check, and rapid POC test should be performed on the day of departure and documented in the electronic health record, exit summary, and/or transfer paperwork. (See *Documentation* above.)
- The local health authorities in the receiving locality should be notified, and the travel arrangements coordinated with them, if necessary (e.g., if quarantine or isolation conditions are required during transportation or upon their arrival).
- The inmate should wear a face covering when departing the facility and while in route to their destination.

→ *Due to the ongoing changes to guidelines for home confinement, readers are referred to the most recent guidance from Reentry Services Division regarding release to home confinement.*

I. HOLDOVER SITES, BUS HUBS AND DETENTION CENTERS

- An important aspect of infection control at a holdover site, bus hub or detention center is distinguishing between **BOP GROUPS** and **NON-BOP GROUPS.**
  - **BOP GROUP:** Includes inmates at BOP facilities who have completed the **BOP INTRASYSTEM TRANSFER PROCEDURE** (see *Section G*) prior to their BOP intrasystem transfer.
  - **NON-BOP GROUP:** Includes inmates from other agencies, correctional jurisdictions or contract and private correctional facilities and who have not undergone an **INTAKE QUARANTINE** in the BOP. Inmates in detention centers (pre-designated) are in a non-BOP group until they have completed an **INTAKE QUARANTINE.**
  - To the extent possible, **BOP GROUPS** should not be mixed with **NON-BOP GROUPS.**

  - If necessary, multiple **BOP GROUPS** originating from different BOP facilities may be housed together.
- **HOLDOVER AREAS:** Holdover sites and bus hubs should designate specific holdover areas for cohorting of inmates in advance, in numbers commensurate with anticipated levels and frequency of incoming inmates. Smaller cohorts may be housed together within these holdover areas (e.g., 10 inmates in five 2-person cells) and moved to recreation, food services, showers, etc. without mixing with other cohorts.
- **ON ARRIVAL TO THE HOLDOVER SITE**, all inmates being placed in holdover status will have a symptom screen and temperature check.

HOLDOVERS FOR BOP GROUPS

- **BOP GROUPS NOT** mixed with **NON-BOP GROUPS** may be placed into a holdover unit setting without a test-in/test-out process. They do **NOT** need to complete a **TRANSFER QUARANTINE** prior to moving on to their next destination.
  - **OVERNIGHT REBOARDS (< 24 HOURS):** POC tests, symptom screen and temperature check are **NOT** required for movement.
  - **INMATES IN HOLDOVER STATUS 24 TO < 72 HOURS:** perform a COVID-19 symptom screen and temperature check within 24 hours of transfer.
  - **INMATES IN HOLDOVER STATUS 72 HOURS OR MORE:** perform a POC test and temperature and symptom screen prior to transfer.
  - **PROLONGED HOLDOVERS BEING CONSIDERED FOR GENERAL POPULATION HOUSING:** Inmates who are expected to be housed at a holdover site, bus hub, or detention center for a prolonged period of time (> 14 days) will complete an **INTAKE QUARANTINE** and be moved to the general population, when appropriate and in accordance with established institution procedures upon meeting criteria for release from intake quarantine.
    - After relocation to the general population and, prior to transferring to another BOP facility, inmates should undergo the transfer procedure appropriate for their type of transfer and the epidemiological situation at the institution (e.g., **BOP INTRASYSTEM TRANSFER PROCEDURE** or a **TRANSFER QUARANTINE**).
  - BOP groups can move together, but they should not mix with non-BOP groups in transit to their destination facilities. Different procedures are utilized by OKL for management of BOP intrasystem transfers (refer to Section J).
- On arrival to their designated facility, all BOP groups must complete the **INTAKE QUARANTINE**.

HOLDOVERS FOR NON-BOP GROUPS

- If a holdover site, bus hub or detention center OFTEN receives **NON-BOP GROUPS**, the facility should consider having designated quarantine and isolation units for these non-BOP groups and manage them as new intakes with screening, quarantine, and testing (as recommended in **MODULES 3 AND 4**).

→ *The non-BOP group should **NOT** be mixed with the BOP-only holdover groups.*

  - Once a **NON-BOP GROUP** has completed an **INTAKE QUARANTINE** at the holdover site or detention facility, they can be considered a **BOP-GROUP.**
  - Inmates who complete an **INTAKE QUARANTINE** at the holdover site or detention facility and are expected to transfer within a reasonable period of time (i.e., 30–45 days), should remain in

quarantine until their transfer date and then undergo the transfer procedure appropriate for their type of transfer and the epidemiological situation of the institution (e.g., **BOP INTRASYSTEM TRANSFER PROCEDURE** or a **TRANSFER QUARANTINE**).

- Inmates who complete an **INTAKE QUARANTINE** at the holdover site or detention facility and are expected to remain for a prolonged period of time may be released to a general population unit when appropriate and in accordance with established institution procedures. After release to the general population they are considered a BOP inmate and need to undergo the transfer procedure appropriate for their type of transfer and the epidemiological situation of the institution (e.g., **BOP INTRASYSTEM TRANSFER PROCEDURE** or a **TRANSFER QUARANTINE**).

→ On arrival to their designated facility, all non-BOP groups must complete the **INTAKE QUARANTINE**.

MIXED GROUPS

- If a holdover site, bus hub or detention center receives a **mixed group of BOP and NON-BOP GROUPS**, or a BOP group that has **PREVIOUSLY MIXED** with a non-BOP group, they must **ALL** be managed as a **NON-BOP GROUP** at the holdover site—with screening, 14-day **INTAKE QUARANTINE**, and testing prior to transfer (as outlined in **MODULES 3 AND 4**).

J. FEDERAL TRANSFER CENTER, OKLAHOMA CITY (OKL)

There are two primary groups of holdover inmates arriving at OKL – BOP instrasystem transfers and sentenced inmates still in USMS custody (non-BOP group). Ordinarily, inmates in these two groups are not mixed while housed at OKL, with the exception listed below (non-BOP inmates quarantined at OKL for at least 14 days and a negative commercial test).

- **BOP inmates** are kept in "move-ready" units organized into smaller cohorts within the housing units and do not mix with other cohorts. These inmates arrive from other BOP facilities where they were quarantined and tested consistent with the most recent guidance. Upon arrival at OKL, they are symptom screened, temperature checked, and placed in "move-ready" units once cleared.
- **Non-BOP inmates** are transported from various non-BOP correctional facilities to OKL. They are kept separate from the BOP inmates and organized into smaller cohorts within the housing units. They do not mix with other cohorts.
  - Non-BOP holdovers may be moved to "move-ready" units if they have been quarantined for at least 14 days and completed an **INTAKE QUARANTINE**.

- Some inmates also arrive designated to OKL as part of the work cadre (OKL CAD). The following procedures do not apply to these inmates, all of whom require an **INTAKE QUARANTINE** prior to entering general population.

INTAKE PROCEDURES FOR NON-BOP HOLDOVERS

- All non-BOP holdovers are symptom screened, temperature checked and POC tested upon arrival prior to being housed in a non-BOP housing unit (i.e. they are not mixed with BOP holdovers).
- All non-BOP holdovers will be kept at OKL for a minimum of 7 days.
- Unvaccinated non-BOP holdovers will be offered vaccination with the COVID-19 vaccine, when available.

OUTGOING MOVEMENT PROCEDURES

- BOP inmates will be symptom screened and temperature checked within 24 hours prior to departure.
- Non-BOP inmates will have a POC viral test within 72 hours prior to departure (as close to the time of departure as is feasible) and symptom screening and temperature check within 24 hours prior to departure.

INFECTION CONTROL GUIDANCE FOR TRANSPORTATION OF OKL INMATES

This guidance is based on an analysis of exposure risk between BOP and non-BOP inmates. To minimize risk of exposure between inmates who have completed a full quarantine, keeping BOP groups and Non-BOP groups separated during movement is recommended to the extent possible.

- While being processed for outgoing movement at OKL, the two groups will be kept separate to the extent possible. Any instances in which BOP inmates are in close proximity to non-BOP inmates should be minimal based on the limitations of holding cells in the R&D area at OKL and the specialized needs of the inmates (e.g., max custody, designated to FLM ADX, SMU, RU, etc.)
- Inmates will be issued surgical masks without metal nose pieces (donned in R&D) to wear underneath a cloth face cover (double masking) and worn until their intake at the gaining facility, at which time they would resume wearing their cloth face cover.
- Outgoing flights and buses may include BOP and non-BOP inmates as required by the movement. To the extent possible, these groups will be kept separate or physically distanced from each other. Inmates will board the JPATS flight or bus by group (BOP and non-BOP), with the non-BOP inmate section of the bus toward the rear part of the bus. Each group will be seated in separate sections of the plane or bus and each section will be separated by enough empty rows to account for 6 feet.
- The following PPE is required for movement of BOP and non-BOP groups who have not completed a **TRANSFER QUARANTINE** but have been POC tested, symptom screened and temperature checked (i.e. a **BOP INTRASYSTEM TRANSFER PROCEDURE**).
    - **INMATES:** double masking with a surgical mask underneath and a cloth face covering worn on the outside.
    - **STAFF:** N95, face shield or goggles, and gloves

K. MEDICAL TRANSFERS TO MRCS

The same strategies to limit SARS-CoV-2 transmission for non-medical transfers are applied to medical transfers to MRCs and Care level 3 facilities. The inmate should undergo the transfer procedure appropriate for their type of transfer and the epidemiological situation of the institution (e.g., **BOP INTRASYSTEM TRANSFER PROCEDURE** or a **TRANSFER QUARANTINE**).When **TRANSFER QUARANTINE** is required for a transfer to an MRC, the following procedures are recommended for emergency and routine urgent designations.

EMERGENCY DESIGNATIONS

Upon receipt of an emergency designation approval by the Office of Medical Designations and Transport (**OMDT**) at the sending facility, the patient must complete a **TRANSFER QUARANTINE** at the sending facility.

- **IF TEST-IN IS POSITIVE:** The patient should be placed in **MEDICAL ISOLATION**. The sending institution and the receiving MRC should discuss the specifics of the case and determine the most appropriate course of action regarding transfer, including acuity of the patient's medical condition and appropriateness of transfer in light of the patient's COVID-19 status. However, there may be rare instances where the nature and acuity of the patient's medical condition necessitates a more expeditious transfer. These cases should be discussed among the sending institution, the receiving MRC, and the Chief of Health Programs.
- **IF TEST-IN IS NEGATIVE:** The patient will complete the **TRANSFER QUARANTINE** as specified above under *Transfer or Release of Inmates with No Prior History of COVID-19*. See also *Other Considerations for Medical Transfers* below.

ROUTINE URGENT DESIGNATIONS

- Since **ROUTINE URGENT** designations may take a longer period from the date of designation approval to the actual transfer date, designated patients may generally await transfer in their current housing unit.
- When the date of transfer has been provided by the MRC, the patient should undergo the transfer procedure appropriate for their type of transfer and the epidemiological situation at the institution (e.g., **BOP INTRASYSTEM TRANSFER PROCEDURE** or a **TRANSFER QUARANTINE**).

OTHER CONSIDERATIONS FOR MEDICAL TRANSFERS

- **HOSPITALIZED PATIENTS AND THOSE IN LTC:** There are times when the patient awaiting transfer is being managed at an outside hospital or long-term care facility (LTC), so that quarantine within the BOP institution prior to transfer is not possible. In these circumstances, the patient may be transferred without a **TRANSFER QUARANTINE**, but should be tested for SARS-CoV-2 preferably with a commercial viral PCR lab test within 72 hours prior to transfer (as close to the time of departure as is feasible) and have a symptom screen and temperature check within 24 hours prior to transfer.
- **SPECIALIZED NEEDS:** In some instances, due to the medical condition and/or needs of the patient, placement in transfer quarantine may pose a challenge (e.g., need for assistance with ADLs, wound care). Unique solutions may need to be developed to appropriately accommodate the patient's needs. Considerations may include: temporary placement at an LTC facility, housing patient in quarantine with other transfer quarantine group inmate(s) that may assist with minor needs, or a designated inmate companion.

- In the case of a DESIGNATED INMATE COMPANION, the companion will need to test negative immediately prior to the TRANSFER QUARANTINE period with either a POC or a commercial lab test. The companion will house with the patient for the duration of the transfer quarantine period until the patient transfers. Since the companion is not expected to be transferred, they do not need to undergo the temperature and symptoms screening process or a SARS-CoV-2 test at the end of the transfer quarantine period to return to general population.
  - ➔ *However, if the patient whom the companion is assisting or housing with becomes symptomatic or tests positive, the companion is considered a CLOSE CONTACT and must test-in/test-out of an EXPOSURE QUARANTINE.*

L. IN-PERSON COURT APPEARANCES

Court appearances are important aspects of the U.S. criminal justice system, but create potential risks for SARS-CoV-2 transmission from close interactions that may occur. Refer to MODULE 6 – INMATE ISOLATION & QUARANTINE for specific recommendations regarding court appearances during quarantine and isolation.

- Inmates in COVID MEDICAL ISOLATION should not have in-person court appearances unless absolutely necessary. Having the inmate appear via telephone hearing should be strongly considered. A video teleconference (VTC), if accessible, can also be used as an alternative.
- Inmates in COVID-19 EXPOSURE QUARANTINE should delay in-person court appearances until they are COVID-tested at the end of quarantine. Telephone or VTC appearances are recommended alternatives. In general, testing an inmate immediately before or after a legal visit would have little utility and is not recommended. However, a POC test can be used on a case-by-case basis, especially if the test is required by the court.
- Inmates should wear face coverings and perform hand hygiene just before departure and upon return to the institution.

M. INFECTION CONTROL GUIDANCE FOR VEHICLE TRANSPORTATION OF INMATES

➔ *See MODULE 2 for more details on the use of PPE. See MODULE 1 for more information about hand hygiene, social distancing, and cleaning and disinfection.*

The following PPE is required for BOP groups who have completed a TRANSFER QUARANTINE:

- INMATES: Face coverings
- STAFF: Face coverings and gloves

The following PPE is required for movement of BOP and/or non-BOP groups who have **not** completed a TRANSFER QUARANTINE but have been POC tested, symptom screened and temperature checked (i.e. a BOP INTRASYSTEM TRANSFER PROCEDURE).

- INMATES: Face coverings
- STAFF: Surgical mask, face shield or goggles, and gloves

The below guidance should be implemented for the safe transportation of the following groups:

- Inmates with signs and symptoms of respiratory illness or a positive SARS-CoV-2 test where movement is necessary prior to clearance from medical isolation.
- Non-BOP or mixed groups, where infection has not been ruled out (i.e. has not completed INTAKE QUARANTINE or TRANSFER QUARANTINE)

- **VEHICLE SET-UP PRIOR TO TRANSPORT**
  - Place vehicle indoor fan on FRESH AIR ONLY, and NOT re-circulation mode.
  - Set fan to HIGH.
  - Driver side-window should be rolled down to the lowest position possible
  - Rear and side windows on both sides of the vehicle should be propped opened (weather permitting).
  - When the vehicle being used is a bus: Open the hatch on the ceiling of the vehicle.

- **INMATE ACTIVITY PRIOR TO BOARDING THE VEHICLE:**
  - The inmate is given a direct order to:
    - Place surgical mask on their face and then,
    - Perform hand hygiene by washing hands or sanitizing with an institution-approved hand sanitize solution

- **PPE FOR DRIVER AND OFFICER**
  - All staff must wear an N95 or equivalent
  - When performing any action within close proximity to the inmate (e.g., putting on or removing restraints), eye protection, gloves, and gown, along with N95 or its equivalent, must be worn.
    - Once the inmate is placed into the vehicle, gloves and gown should be removed outside of the vehicle and discarded into a bio-medical waste bag and perform hand hygiene.
    - Officer in contact with inmate(s) puts on new gown and gloves before helping inmates disembark from vehicle.

- **INMATES BOARDING THE VEHICLE**
  - Fill bus starting from the back to maximize distance of the nearest inmate from the driver.

- **AFTER THE END OF TRANSPORT**
  - Introduce fresh air into the vehicle for one hour by opening all doors and windows on the vehicle
  - While wearing all required PPE mentioned above, the vehicle should be cleaned and sanitized using the institution's approved hospital grade disinfectant (EPA Schedule N)

MODULE 7. NON-COVID ROUTINE MEDICAL & DENTAL SERVICES

WHAT'S NEW

- Guidance is updated on safely resuming non-urgent / routine dental services.

MODULE 7 TABLE OF CONTENTS

A. ROUTINE HEALTH CARE DELIVERY DURING THE COVID-19 PANDEMIC

Many aspects of routine health care delivery may become disrupted during the COVID-19 pandemic. Each facility should develop a plan of action that addresses health care delivery during the pandemic, based on the degree of disruption to the Health Services Unit (HSU) and the institution as a whole.

→ *See MODULE 1, INFECTION PREVENTION AND CONTROL MEASURES, for more information on hand hygiene, social distancing, cleaning and disinfection, cloth face coverings, and supply management.*

→ *See MODULE 2, for more information on PERSONAL PROTECTIVE EQUIPMENT (PPE).*

- **When there is known COVID-19 transmission within a facility and moderate to severe disruptions of normal operations:** In consultation with the Regional Medical Director, it is recommended that health care services be limited to urgent health care needs and that routine services be postponed.
  → *Refer to the APPENDICES for "Prioritization of Health Care Services Based on Degree of Disruption to Normal Operations."*
- **PPE use when delivering health care to an inmate NOT suspected of COVID-19:** See MODULE 2, Table 1.
- **Cloth face coverings for inmates:** All inmates in the HSU should wear a cloth face covering at all times except when physical examination requires access to the mouth/nose.
- **Waiting area:** Chairs should be at least 6 feet apart and hand hygiene stations should be available.
- **Staggered appointments:** Limit the number of persons in the HSU to promote social distancing. Consider grouping persons to be evaluated by housing unit.
- **Signage:** Post signage within the HSU to emphasize important behavior (distancing, respiratory etiquette, wearing of face coverings, hand hygiene).
  → *Posters are available from the CDC at: https://www.cdc.gov/coronavirus/2019-ncov/communication/toolkits/shared-congregate-housing.html*
- **Increase frequency of cleaning and disinfection on the health services unit:** See the section on *Environmental Cleaning and Disinfection* in MODULE 1, and post a schedule in the HSU.

B. CHRONIC CARE

Prioritize CHRONIC CARE evaluations during the COVID-19 pandemic to focus on the identification and monitoring of inmates with poorly controlled conditions, who are pregnant, or who are at risk for more severe COVID-19 illness such as the following:

- People age 50 years and older
- People admitted to a nursing care unit or long-term care facility
- Other high-risk individuals, including:
  - People with chronic lung disease or moderate to severe asthma
  - People who have heart disease with complications
  - People who are immunocompromised, including those receiving cancer treatment
  - People of any age with underlying medical conditions such as obesity (BMI ≥ 30), diabetes, sickle cell disease, renal failure, or liver disease, particularly if not well-controlled

C. SICK CALL

- **Inmates should have continued access to health care during a pandemic.** Triage inmates based on medical acuity, as outlined in the **PATIENT CARE PROGRAM STATEMENT 6031.04**, with a focus on evaluating the acutely ill and scheduling appointments for those requesting routine medical care.
- **Priority should be given to those with COVID-like symptoms or urgent medical conditions.** Inmates who come to sick call with respiratory symptoms should immediately be placed in a separate room and directed to wear a mask, if not already doing so, and perform hand hygiene. Suspend co-pays for inmates seeking medical evaluation for complaints of fever or respiratory symptoms.

  → *Refer to the **APPENDICES** for "Triage of Certain Medical and Mental Health Conditions During COVID-19 Disruptions."*

- **Consider alternate methods of running sick call so that the waiting room is not crowded with inmates waiting to be triaged:**
  - Organize sick call by housing unit.
  - Consider transitioning to an electronic sick call process only.
  - Scheduling "routine" sick call for issues other than acute illness (requests for medication renewal, medical idle, issuing of supplies, etc.) at a different time.

D. AEROSOL-GENERATING PROCEDURES (AGPS)

Strong consideration must be taken to minimize as much as medically possible the use of AGPs to mitigate the risk of COVID-19 transmission. Among the AGPs that may be utilized within a BOP institution are nebulizer treatments, continuous positive airway pressure (**CPAP**), bi-level positive airway pressure (**BiPAP**), and pulmonary function testing (**PFT**). Institutions should retrieve a report from BEMR identifying inmates who have been issued a nebulizer or CPAP machine and follow the recommendations below.

NEBULIZER TREATMENTS

- **To the maximum extent possible, the use of a metered dose inhaler (MDI) should be used instead of a nebulizer.** Even in the acute setting, the use of an MDI with a spacer has been shown to be at least as effective as a nebulizer when used correctly.
  - ➔ *Be aware that it may be necessary to use more doses per event, or more frequent dosing than the baseline prescription for the medication.*
- **If a nebulizer MUST be used:**
  - Administer the treatment in an airborne infection isolation (**AII**) room when possible. If an AII room is not available, use a single room with solid walls and a solid door.
  - Attach an in-line viral filter (e.g., Airlife 001851) at the end of the 6-inch flex tube that extends from the nebulizer kit.
  - Minimize the number of staff involved in administering the nebulizer, and the amount of time the staff spends in the room.
  - When in the room, staff should use appropriate PPE (refer to **MODULE 2**).
  - The room and equipment must be disinfected when finished (refer to the section on *Environmental Cleaning and Disinfection* in **MODULE 1**).

CPAP/BiPAP

➔ *As of the writing of this guidance, there are no special or increased cleaning recommendations for CPAP/BiPAP equipment or machines. Patients should be reminded to perform their usual regularly scheduled daily and weekly cleaning regimens as recommended by the equipment manufacturers.*

Most patients who use a CPAP machine do so for sleep apnea. In many of these cases, it may be reasonable to consider that the **RISKS OF AEROSOLIZATION** of the SARS CoV-2 virus (leading to transmission) outweigh the risks of the short-term discontinuation of CPAP use during the pandemic.

MILD TO MODERATE SLEEP APNEA

In cases where CPAP is used for mild to moderate sleep apnea with no significant co-morbidities, the CPAP machines should be retrieved from the patient until the risks of COVID-19 transmission at the institution have abated.

SEVERE SLEEP APNEA WITH CO-MORBIDITIES

In patients with severe sleep apnea with co-morbidities—such as morbid obesity, pulmonary hypertension, cardiomyopathy, etc.—even the temporary discontinuation of BiPAP or CPAP may constitute a higher risk. When the decision is made to allow the patient to continue using CPAP/BiPAP, the following procedures should be considered to mitigate the spread of COVID-19:

➔ ***It is highly recommended that these patients should be tested for COVID-19.***

- Patients that **TEST POSITIVE** should be placed in **ISOLATION** and a contact investigation should be performed. Any identified close contacts, as well as inmates bunking nearby, should be tested for COVID- 19, have a symptom screen and temperature check, and be placed in quarantine or isolation as indicated.
- For patients that **TEST NEGATIVE**, the following **HOUSING ADJUSTMENTS** (*listed in order of preference*) should be made as feasible:
  - CPAP wearers should be single-celled in a room with solid walls and a solid door that closes.
    - The door should be closed when BiPAP or CPAP is in use.

- When in the room, and CPAP/BiPAP are in use, staff should use appropriate PPE: N95 mask, face shield or eye protection, gown, and gloves. (See **MODULE 2** for proper use of PPE.)
- A CPAP/BiPAP sign should be posted on the door to alert staff to the PPE required for entering the room. (Refer to the **APPENDICES** for the sign.)
- Minimize the number of staff and the amount of time spent in rooms when CPAP/BiPAP are in use.
- Room and equipment must be disinfected prior to a new patient occupying a room previously used by a CPAP/BiPAP user.
- If single cells are limited, prioritize use of these rooms to patients under quarantine.

➢ Cohort CPAP/BiPAP wearers to one area of a unit in a lower bunk.

➢ House CPAP/BiPAP wearers maximally distanced from others.

SET-UP AND USE OF CPAP/BIPAP

- CPAP/BiPAP must be set up and used with a full-face, non-vented CPAP mask with an in-line viral filter attached to the intake and exhalation ports. The viral filters should be changed daily. (See the **APPENDICES** for a set-up diagram.)
- If the recommended setup is not readily obtainable, the humidifier chamber should be removed from the device, when possible, or the device be used without humidification.

SUPPLEMENTAL OXYGEN

- Within BOP institutions, the use of supplemental oxygen is typically **LOW FLOW** via the use of nasal cannula. This is **NOT** considered to be an AGP and should **NOT** require specific precautions.
- Use of **HIGH FLOW OXYGEN**, **HUMIDIFIED TRACH MASKS**, or **NON-REBREATHERS** do involve AGPs and their use should be performed with the same precautions and measures described above for CPAP/ BiPAP use.

PULMONARY FUNCTION TESTING (PFT)/PEAK FLOWS

The performance of PFTs and peak flow testing are generally considered **NOT NECESSARY** in the acute setting and should be deferred until concerns of the pandemic have abated.

E. DIRECTLY OBSERVED THERAPY

- When feasible, **administer medications by unit or cell** to encourage social distancing and to reduce risk of exposure.
- **Reduce staff exposure at insulin line** by encouraging inmate self-injection of insulin when feasible. When inmates cannot inject themselves, advise employees to change gloves between each patient and wear appropriate PPE (see **MODULE 2**).

F. RESPONSE TO EMERGENCIES

- **ADDITIONAL PPE:** In addition to the PPE normally required for emergency response, staff should prepare to respond to emergencies with a **SURGICAL MASK AND EYE PROTECTION**, in the event that a patient requiring an emergency response is infected with COVID-19.
- **FOR CPR:** Staff performing CPR on a suspected or confirmed COVID-19 case should wear an **N95 RESPIRATOR AND GOGGLES**, and use a bag-valve-mask (e.g. an **AMBU®-BAG**) for breaths.

- *It is reasonable for staff to start with compressions-only CPR until health services staff arrive with an Ambu®-bag.*

- **Place PPE in areas where staff can easily access it for emergencies:**
  - Add "PPE to-go" bags (4 pairs of gloves, masks, gowns, N-95s, eye wear, 1 Ambu® bag) to emergency bags and response kits and carts.
  - Add PPE to areas where AED is housed.

G. INFLUENZA VACCINATIONS

All staff and inmates should be encouraged to accept the 2020–2021 influenza vaccine.

- Influenza vaccine is recommended for all persons who do not have contraindications during the 2020-2021 influenza season
- Please contact your Regional Chief Pharmacist for any questions regarding supplies of vaccine.
- Please see the CDC *Vaccination Guidance During a Pandemic* for additional information vaccinating those with COVID-19, available at: *https://www.cdc.gov/vaccines/pandemic-guidance/index.html*.
- During the flu season it may be difficult to discern between symptoms of influenza and COVID-19 necessitating testing for both. The BOP has approved rapid testing for influenza. Facilities can utilize commercial Quest rapid testing, public department of health assistance for flu testing or the Abbott ID Now.
  - Additional guidance regarding obtaining influenza testing supplies for the Abbott ID NOW machines and procedures for testing of inmates will be forthcoming in future versions of this module.

H. OUTSIDE MEDICAL AND DENTAL CONSULTATIONS

An important area of consideration is the risk of exposure to COVID-19, as well as other concerns, posed by the medical and dental trips that are typically required on a daily basis at BOP institutions nationwide. These trips present a potential point of exposure for staff and inmates at local hospitals and health centers. They may also require significant staffing resources, particularly for escorts, at a time when staffing levels may be low as a result of COVID-19. In addition, local hospitals and clinics may be limiting their own operating hours and procedures, making these community health resources difficult to access.

- Staff responsible for scheduling and coordinating outside consultations should maintain regular COMMUNICATION with outside providers to ensure health services and escort staff are complying with guidance from provider offices and hospitals.
- Leveraging TELEHEALTH modalities, when possible, is an important way to reduce the need for outside medical trips. Institutions should explore ways to increase telehealth options.
- Consider POSTPONING OR RESCHEDULING non-urgent consultations (see discussion of CONSIDERATIONS below).

CONSIDERATIONS IN DECIDING TO POSTPONE OR RESCHEDULE CONSULTATIONS

The decision to **POSTPONE OR RESCHEDULE** medical care in the community is considered an important and necessary **response to this national emergency and is NOT made lightly**. This decision is affected by several variables, including the category and urgency of the care, the safety and health of inmates and staff, and good clinical judgment.

- Care for **ACUTE, EMERGENT, OR URGENT CONDITIONS** is medically necessary and should **NOT** be postponed or rescheduled.
  - **MEDICAL** examples include, but are not limited to, myocardial infarction, hemorrhage, stroke, severe trauma, etc.
  - **DENTAL** examples include, but are not limited to, uncontrolled bleeding, cellulitis/swelling that potentially compromises the airway, trauma involving major facial bones, complications after oral surgery, significant pathology, etc.
- **NON-EMERGENT BUT MEDICALLY NECESSARY CARE** is prioritized in part by the risk of deterioration, the likelihood of successful repair at a later time, and significant pain that impairs activities of daily living. The following **SUGGESTED TIME FRAMES** are based on the severity of the condition and the urgency of the intervention:
  - **HIGHER PRIORITY**: Schedule/re-schedule within 30 days. **For example:** Scheduled blood transfusion or IV infusions, unresolved pericoronitis.
  - **INTERMEDIATE PRIORITY:** Schedule/re-schedule within 30–90 days. **For example:** Routine pacemaker check, cancer surveillance imaging, tooth impactions with intermittent pain.
  - **LOW PRIORITY:** Re-schedule within 90–180 days. **For example:** Routine scheduled follow-up with specialty clinic, necessary dental procedures outside the scope of a provider's skill.
- **ROUTINE, ELECTIVE, OR MEDICALLY ACCEPTABLE MEDICAL CARE** may be postponed for three to six months on a case-by-case basis, or re-scheduled as reasonably available, e.g., elective orthopedic evaluation and testing.

UTILIZATION REVIEW COMMITTEE

The Clinical Director or designee should convene the **UTILIZATION REVIEW COMMITTEE** as outlined in **PATIENT CARE PROGRAM STATEMENT 6031.04**. Certain institutions may require involvement of Regional resources. In the context of the current COVID-19 pandemic, the purpose of the group is to:

- Review the **AVAILABLE RESOURCES** of the institution for trips (scheduled and unscheduled).
- Review **HISTORICAL TRENDS OF DAILY TRIPS** to estimate and plan for the number of unscheduled, emergent trips.
- Perform an **INITIAL REVIEW OF UPCOMING SCHEDULED MEDICAL TRIPS.** The initial focus should be on the trips already scheduled for the next thirty days, keeping in mind that operations are likely to be affected for a longer period.
- Perform **REVIEWS OF SCHEDULED MEDICAL TRIPS ON A REGULAR BASIS**, as needs and available resources are likely to continue to change. If the period of affected operations is protracted and goes beyond the initial thirty days, trip scheduling challenges are likely to be compounded.
- **RE-SCHEDULE PLANNED MEDICAL TRIPS** as much as reasonably possible to minimize staff and patient exposure to community healthcare settings, to accommodate potential staff resource limitations, and to avoid over-burdening local resources with elective visits.

- **EVALUATE NEW MEDICAL CONSULTATION REQUESTS** in light of the above timeframe guidelines when inputting Target Dates.

→ *If you need further guidance, please contact your respective Regional Medical Director. Their contact information is available on the Health Services Division Sallyport page.*

H. DENTAL SERVICES DELIVERY CONSIDERATIONS

The following restrictions for dental services are intended to minimize the production of aerosols and the possible spread of infection to patients and health services staff. The limitation of procedures at this time also aims to assure that adequate PPE is available for use during urgent and emergent dental treatment.

- **EMERGENCY/URGENT** dental care will continue to be provided.
  → *See Examples of Urgent/Acute Dental Care below.*
- **NON-URGENT / ROUTINE** dental treatment and preventive dental services.
  - All institutions are to resume non-urgent / routine dental services. COVID-19 transmission rates at the institution and surrounding communities as well as the patient's SARS-CoV-2 infection status are important factors to consider. The following recommendations are intended to guide dental programs in safely providing non-urgent / routine dental care.
  - **Inmate population transmission status**. The institution's epidemiologic status of SARS-CoV-2 infection and transmission is an important consideration for making decisions about the provision of dental services during the COVID-19 pandemic. Deferral of non-urgent dental care is prudent when there is widespread transmission occurring throughout a facility. As a general rule, non-urgent / routine dental services will be provided when institution SARS-CoV-2 transmission rates are lower or when transmission occurs only in limited areas. Regular consultation with institution Health Services leadership is recommended to determine whether the transmission status at the institution has changed. Altering the strategy for non-urgent / routine dental services may be necessary if there is an increase of COVID-19 cases in the inmate population.
  - **Community transmission**. The level of community transmission may be indicative of the risk for staff introducing SARS-CoV-2 into the inmate population. Rates of known or suspected infection in staff may also be a good indicator of this risk. When SARS-CoV-2 infection is widespread among institution staff, consider deferring non-urgent / routine dental care. Decisions to provide routine dental care based on community and staff transmission rates are made in conjunction with institution Health Services leadership.
  - **Patient infection status.** After considering local institution and community transmission rates, the individual patient infection status should be considered. Non-urgent / routine patient care will be provided to those who are not known or suspected to have active SARS-CoV-2 infection or who are not a close contact of a SARS-CoV-2 infection. Non-urgent / routine dental care should be deferred for those who are currently known or suspected to be infected with SARS-CoV-2 or who are in medical isolation or quarantine.
- Dental Admissions and Orientation (A&O) examinations should be scheduled in coordination with medical staff to limit the number of inmates in medical waiting areas.
  - Inmates who have been waiting the longest for their A&O examinations shall be prioritized as much as possible.
  - Cohorted scheduling of Dental A&O inmates who are receiving History and Physical examinations should be implemented in order to reduce visits to the HSU, as applicable. Physical / social distancing needs to be ensured when inmates are cohorted for such evaluations.

- *The BOP Clinical Guidance on Infection Control and Environment of Care in Dental Health-Care Settings, available at https://www.bop.gov/resources/pdfs/infection_control_in_dental_healthcare_guidance.pdf, should be followed at all times.*
- *Additionally, institutions should follow the CDC's Summary of Infection Prevention Practices in Dental Settings, available at: https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care2.pdf*

SUPPLEMENTARY RECOMMENDATIONS FOR DENTAL CARE

- When SARS-CoV-2 transmission is occurring at an institution, dental staff should work with medical staff to establish triage procedures.
- The patient's temperature will be measured and symptoms reviewed for every patient encounter. Follow medical staff guidance if COVID-19 symptoms are present or temperatures are elevated.
- Patients should wear a cloth face covering for source control whenever possible (immediately prior to and following any intraoral procedure).
- For all patients, avoid aerosol-generating procedures (AGP), which include the use of a dental handpiece, ultrasonic scaler, or an air/water syringe, whenever possible.
- To help minimize aerosols or spatter, use four-handed dentistry with high-volume evacuation suction and rubber dams when applicable.
- COVID-19 is spread primarily via droplets through close contact from person-to-person and less commonly through contact with contaminated surfaces. It is paramount during this time that all dental staff follow CDC Transmission-Based precautions for droplet and contact precautions—in addition to BOP guidance for infection control as it pertains to sterilization, hand washing, and disinfecting surfaces (see **MODULE 1**).

EXAMPLES OF URGENT/ACUTE DENTAL CARE

- Extraction of symptomatic non-restorable teeth
- Management of active infections/swelling/cellulitis
- Pulpectomy of symptomatic teeth that otherwise meet policy criteria for endodontic therapy (root canal therapy should be completed when the patient is asymptomatic)
- Caries removal and temporization of symptomatic cavitated lesions

- Acute trauma/lesion/pathology that requires immediate evaluation/treatment
- Dental treatment required prior to life-saving medical treatment such as radiotherapy/chemotherapy

DENTAL MANAGEMENT OF COVID-19 SYMPTOMATIC/DIAGNOSED PATIENTS

- If a dental patient is suspected or confirmed to have COVID-19, defer dental treatment when possible.
- If emergency dental care is medically necessary, airborne precautions should be followed, with care provided in a hospital or other facility with an isolation room with negative pressure.
- If a symptomatic/diagnosed patient requires immediate evaluation/treatment by an outside provider, work closely with your Clinical Director to ensure that all parties (custody, transportation, receiving facility, etc.) are aware of the patient's symptoms/diagnosis.

DENTAL MANAGEMENT OF ASYMPTOMATIC PATIENTS/NON-INFECTED PATIENTS

Due to the close proximity of providers to dental patients, treatment should be conducted using PPE as recommended in the section *Dental Engineering Controls* below. In addition, keep in mind the following considerations.

- Ensure the appropriate amount of PPE and supplies are stocked to support your patient volume. If PPE and supplies are limited, prioritize dental care for the highest need, most vulnerable patients.
- Extended use of N95 can be considered if there is a PPE shortage.
- Dental Health Care Personnel such as dentist, dental hygienist, and dental assistants) may wear their cloth face covering when they are not engaged in direct patient care activities and then switch to a respirator or a surgical mask when PPE is required.
- Dental student rotations should be suspended until SARS-CoV-2 infection risks are more completely mitigated.
- Inmates should not be assigned to work duties or training activities that are exclusive to the dental clinic during the COVID-19 pandemic. This includes inmates enrolled in the dental assistant apprenticeship program and inmates functioning solely within sterilization areas.
- Inmate orderlies should not enter the dental clinic while procedures are ongoing.

DENTAL ENGINEERING CONTROLS

In addition to the guidance provided above, **ENGINEERING CONTROLS** aim to further decrease the potential spread of COVID-19 in a patient treatment setting. In the interest of safely increasing the number of dental patients that can be treated, the BOP Dental Program—in conjunction with the Occupational Safety & Health Branch (OSH) —has put together a list of recommendations for engineering controls in line with CDC recommendations.

- All AGPs will require a N95 respirator, high-evacuation suction, and dental dam when applicable.
- Standard PPE to be worn by dental health care personnel during aerosol generating procedures includes: gloves, gown, eye protection or face shield, and N95 respirator.

- The HVAC systems air changes per hour (ACH) in the dental clinics is ideally set at 15 ACH.
  - Consult with HVAC/facilities staff to determine if your clinic's HVAC unit can be programmed to 15 ACH.
  - If the clinic's HVAC system cannot achieve 15 ACH, it is recommended that the clinic supplements with a portable solution (e.g., portable HEPA filtration units).
- Patient chairs should be at least 6 feet apart, and operatories should be separated by a physical barrier. When determining the best patient separation for your clinic, consider implementing the following:
  - Spacing out individuals receiving care to every other chair as necessary to achieve six feet of distance between chairs.
  - Using "Shields on Wheels" described as a piece of Plexiglas wider than the length of the chair and no higher than 7 feet, on wheels that can be moved around so as not to interfere with the sprinkler system.
  - Consult with your safety department regarding egress requirements and building fire protection systems.
  - Consult with Correctional Services regarding the safety and security of the dental clinic with altered sight lines.

→ *Recommendations may change as additional information becomes available. Additional questions should be referred to the respective Regional Chief Dental Officer. Refer also to the CDC's Guidance for Dental Settings, available at:*
https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html

MODULE 8. INMATE PROGRAMING AND SERVICES

WHAT'S NEW

- Added Section B.7 guidance for BARBERSHOP

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A. INMATE SERVICES

- Develop a local daily cleaning schedule utilizing your housekeeping plan to clean and disinfect, when indicated, equipment used by multiple inmates (kitchen, UNICOR, barber shop tools, etc) and areas where inmates gather (dining hall, recreation, etc.)
  - Refer to **MODULE 1** – *Infection Prevention and Control Measures* for specific guidance regarding cleaning and disinfection.

1. RECREATION

- Stagger time in recreation spaces. Generally, inmates in groups of no more than 100 should access the recreation yard for a minimum of one hour at a time, so long as they maintain social distancing and wear cloth face coverings when indicated.
- Inmates should have access to the recreation yard at least three times per week, and attend with inmates from their designated housing units.
- Group sports are prohibited.
- Use of gym equipment (e.g., weights, basketballs) are prohibited.
- Small classes that do not involve physical contact may be offered at the discretion of the Warden. If this occurs, all equipment / materials must be thoroughly sanitized after each use.
- Recreation will continue in Special Housing, consistent with standards outlined in policy.

2. UNICOR

- In consultation with the Safety and Health Services departments, Wardens will develop plans to safely have UNICOR operations at their institutions.
- Plans should include the use of appropriate face coverings or PPE, as necessary, as well as disinfection and cleaning procedures, etc. Refer to **Module 1**- *Infection Prevention and Control Measures*.
- Space inmates six feet apart for work details, with facial coverings in place, and, if possible, provide some type of barrier between workers

- Consider a modification of UNICOR detail assignments or shifts with two or more details, each working a separate shift. House each individual detail together and on a separate unit from the other details or shifts so that if one unit/shift is affected by COVID-19, another detail/shift can cover the same assignment.
- Consider cross-training individuals for increased job coverage within UNICOR. House these individuals separately from the primary work group.

3. WORK DETAILS

- Consider a modification of work detail assignments so that each detail includes only individuals from a single housing unit.
- Cross-train individuals for increased job coverage for details such as food service, laundry, and orderlies. House these individuals separately from the primary work group.
- Screen orderlies assigned to health service units (HSUs) for COVID-19 symptoms and temperature prior to each shift.
  - ➔ *Consider a weekly testing schedule for inmate workers in long-term care or in-patient units.*
- In facilities with active COVID-19 cases (staff or inmate), consider screening inmate food service workers and orderlies for COVID-19 symptoms and temperature prior to each shift, as well as periodic testing for COVID-19.
- Space inmates six feet apart for work details, with facial coverings in place, and, if possible, provide some type of barrier between workers.

4. FOOD SERVICE / DINING HALL

The following options may be considered to reduce the interaction between individuals, especially when masks are removed for the purposes of eating.

- Require that masks not be removed unless the person is actually eating their food.
- Stagger meals (for instance, one housing unit at a time) to allow for social distancing.
- In lines, enforce the need to be six-feet apart. Consider marking the floors at six-foot intervals.
- Rearrange dining hall seating to increase space between individuals, e.g., remove every other chair and use only one side of a table so individuals are not facing each other.
- Minimize self-serve foods, e.g., eliminate salad bars.
- Provide meals inside housing units or cells.

5. LAUNDRY

There are no requirements to separate laundry between risk groups. Laundry from a COVID-19 case can be washed with other individuals' laundry.

- Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard the gloves after each use (e.g., after putting laundry into the washing machines), and perform hand hygiene—before performing other duties.
- Do not shake dirty laundry, to minimize the possibility of dispersing virus through the air.
- Launder items using the hottest appropriate water setting, and dry items completely.

6. ELECTRONIC LAW LIBRARY (ELL) AND DISCOVERY MATERIALS

- Whenever possible, consistent with social distancing protocols and safe institution operations, inmates should be permitted access to the ELL under conditions determined by the Warden at each facility.
- Similarly, inmates will need access to discovery materials relevant to pending cases, beyond those which are personally maintained by the inmates in their cells. It is recommended that a schedule be established to permit fair and timely access to ELL terminals and discovery materials upon inmate request, and that the schedule be provided to inmates at the facility.

7. BARBERSHOP

- **LIMITED SERVICES:** Barbershops will provide limited services to include haircuts only – no shaves.
- **REQUIRED PPE:** Barbers will be required to wear facial coverings, gowns, gloves and face shield at all times. Inmates will wear cloth face coverings to the extent possible while receiving haircuts. Inmates receiving services will wear disposable or re-washable capes, smocks, neck strips, etc. These items will be disinfected or disposed of between each haircut.
- **SOCIAL DISTANCING:** Haircuts will be done by housing unit/cohorts. The number of inmates in the barbershop at any given time will vary by facility space and waiting areas. **All stations must be spaced at least six feet apart.** Inmates will wait outside the barbershop, adhering to social distancing and with facial covering in place, until the barber is ready to for them. Inmates will not interact with each other in the barbershop.
- Consider a station barrier between the work stations if it doesn't interfere with egress or fire code standards.
- To prevent cross-contamination, remove all unnecessary items (magazines, newspapers, and any other unnecessary paper products/decor).
- **HAND-WASHING** – Barbers must wash hands with soap and warm water, for a minimum of 20 seconds between every haircut given. Barbers should wash hands immediately after touching their face, nose, eyes, mask or any non-sanitized surface. Inmate clients should wash hands or hand sanitize as they enter the barber shop.
- **DISINFECTION AND SANITATION:**
  - All shops will be thoroughly cleaned and disinfected prior to reopening each day. Refer to **MODULE 1** – for guidance on cleaning and disinfection.
  - Disinfect all surfaces, tools, and linens, even if they were cleaned before the shop was closed the day before.
  - Shops will maintain regular disinfection of all tools, shampoo bowls, and workstations.
  - All tools will be disinfected between each use. Disinfectant for immersion of tools must be mixed daily and replaced sooner if it becomes contaminated throughout the work day (e.g., hair or debris floating in solution or cloudy color).
  - Electrical equipment that cannot be immersed in liquid shall be wiped clean and disinfected, per the manufacturer's instructions before and after each use.
  - Use disposable towels when possible and dispose of them after every use. Wash any non-disposable towels, drapes, etc. in hot water setting and dry completely at warmest temperature setting.

- The barber chair will be disinfected between each client. Floors will be thoroughly cleaned each day. All trash containers will be emptied daily.

- **SIGNAGE:** COVID 19 signage will be posted in the shop to include signs and symptoms, handwashing signs and social distance signs.
- **SUPPLIES:** Only the assigned barber will be allowed to handle any supplies. All clean supplies and tools will be kept in a clean dry place when not in use.
- **WORK ATTIRE:** Inmate Barbers should arrive at the barbershop showered and wearing clean clothing. Inmates should shower and change clothes as soon as they return from work.
- **BARBER TRAINING PROGRAMS:** Barber training programs may include training on specific types of cuts and shaves. Before implementing these programs, facilities should evaluate the epidemiological picture of the institution and develop plans in collaboration with the region and facility infection prevention and control leads.

B. PROGRAMMING CONSIDERATIONS

- *Institutions with **ACTIVE COVID-19 CASES** may make exceptions to the following programming requirements for the safety of staff and inmates. Modification requests are sent to the Regional Director and concurrence given by the Reentry Services Division.*
- *CDC guidance for schools and gatherings may be found at* https://www.cdc.gov/coronavirus/2019-ncov/community/index.html

Programming is an essential function in our facilities; furthermore, delivery of the **FIRST STEP ACT (FSA)**-approved **EVIDENCE-BASED RECIDIVISM REDUCTION (EBRR)** programs and **PRODUCTIVE ACTIVITIES (PAs)** are required by law. Institutions will offer programming in the following ways:

- **RESIDENTIAL PROGRAMS** (i.e., RDAP, BRAVE, SOTP, TCU, FIT, etc.) will continue as required by policy. Programs may resume groups with more than 10 participants, so long as other social distancing modifications remain in place (e.g., holding groups in larger spaces; suspending community meetings, etc.)
- **NON-RESIDENTIAL** EBRR programs and PAs (e.g., GED, Anger Management) will continue. These services will be offered at no less than half of their regular capacity.
  - Institutions should continue to deliver EBRR and PA programming consistent with the curriculum. However, for purposes of safety/social distancing, staff may offer programs in the housing unit or in outdoor or unused spaces.
- **GED TESTING**, in groups of six or less, will resume with priority given to inmates releasing within 120 days. Other inmates may be tested if resources allow.
- **EDUCATIONAL CURRICULUM** may be converted to self-study modalities when able.
- Consider suspending group programs not required by law.
  - *With discontinuation of group activities, it is vitally important to creatively identify and provide **ALTERNATIVE FORMS OF ACTIVITY** to support the mental health of incarcerated individuals during the pandemic.*

C. HOUSING CONSIDERATIONS

- Arrange bunks so that individuals sleep head-to-foot to increase the distance between their faces.
- Rearrange scheduled movements to minimize mixing of individuals from different housing units.
- Ensure thorough cleaning/disinfection of living space when assigned to a new occupant.
- If space allows, reassign bunks to provide more space between individuals (ideally six feet or more in all directions). Ensure that bunks are cleaned thoroughly if assigned to a new occupant.
- Minimize the number of individuals housed in the same room as much as possible.
- Consider opening vacant housing units to decrease population density, when feasible.

D. PSYCHOLOGY SERVICES

While protecting the health of inmates and staff, institutions must also ensure that:

- Mental health emergencies are prevented.
- Appropriate care is provided to vulnerable inmates.

The following recommendations will support these objectives:

- If inmates are confined to their cells, single cells should be eliminated to the greatest extent possible, to reduce the isolation and privacy that can facilitate suicide. Psychology Services staff should be consulted regarding any inmates proposed for single celling to ensure they are not particularly vulnerable individuals and/or to make recommendations.
- Psychologists must conduct daily rounds in all areas where inmates are housed or confined, to observe and communicate with inmates; psychologists may make recommendations regarding vulnerable inmates to ensure that their needs are met. If psychologist staffing levels necessitate, Treatment Specialists may assist with rounds.
- Psychologists must remove inmates from their cells for private sessions when providing crisis intervention or suicide risk assessments.
- Psychologists must offer to remove inmates with CARE3-MH and CARE4-MH assignments from their cells at least weekly for individual clinical contact.
- If suicide watch is recommended by a staff member and the usual suicide watch room is not available, **PS5324.08, SECTION 12, SUICIDE PREVENTION PROGRAM**, states that under emergency conditions a room other than the designated suicide watch room may be used, as long as an inmate on watch is returned to the approved room when it becomes available. Emergency suicide watch rooms may not be in the Special Housing Unit.
- Institutions may elect to continue using suicide watch companions at the discretion of the Warden.

MODULE 9. INMATE VISITATION

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A. GENERAL GUIDANCE FOR ALL VISIT TYPES

- Depending upon factors such as local community transmission rates and institution COVID-19 epidemiological status, consider suspending or modifying visitation programs, if legally permissible. This decision is an executive level decision made by the agency's Central Office Executive Staff.
- Post signage at the entrance to the facility and communicate with potential visitors instructing them to postpone visits if they have respiratory illness.
- The status of visitation for the agency and for each institution should be posted on the bop.gov website.
- All visitors should be screened for symptoms and a temperature taken prior to entry.
  - ➔ *Screening for COVID-19 symptoms and a temperature check should be performed by trained non-medical staff whenever possible.*
  - ➔ *If possible, a Plexiglas barrier should be installed at the location of visitor screening to prevent direct droplet exposure.*
  - ➔ *See the Visitor/Volunteer/Contractor COVID-19 Screening Tool in the APPENDICES.*
  - ➔ *See MODULE 2 – PPE for guidance for performing COVID-19 screenings.*
- All visitors must wear a non-vented face covering while at the institution (from the time they arrive to the time they depart) and must maintain at least 6 feet of separation with the person they are visiting.
- A handwashing or hand sanitizing station should be established and available for use by all visitors at all visitor points of entry and exit and within the visiting room area. Visitors should be encouraged to wash their hand before and after visitation.

B. SOCIAL VISITS

- **Inmate social visits are important to inmate well-being but also create a risk for introducing COVID-19 infection into the work force and incarcerated population by civilian visitors from the community.**
  - ➔ ***An agency-level decision to suspend or resume inmate social visits is made and communicated by the BOP Executive Staff based on agency- and pandemic-specific circumstances.***
  - ➔ ***The current status of visitation should be reflected both on the Bureau's public website as well as each individual institution's website.***

- **Arrangements should be made to increase options** for incarcerated persons to communicate with their families via telephone or video teleconferences (VTC), especially when in-person visitation is limited or suspended.
- **The following criteria should be considered when making the decision to not allow in-person inmate social visitation.**
  - Visitation should not occur at institutions with a COVID-19 movement moratorium or when active institution transmission is occurring. If an institution develops active COVID-19 transmission after visitation has been scheduled, the visitation may need to be cancelled and rescheduled at a later date when transmission abates.
  - Individual inmates should not be allowed in-person visits when they are in medical isolation or quarantine.
  - Visitors who are sick, have symptoms of COVID-19, a non-contact forehead temperature ≥ 100 °F, decline symptom screen and temperature check, or refuse to wear a face covering should not be allowed to visit in-person.
- **In addition to the GENERAL GUIDANCE listed above, the following procedures should be followed to limit the spread of COVID-19 when visitation is allowed.**
  - Institutions will need to prepare in advance and develop procedures prior to starting in-person visitation.
  - Identify a specific location where visitation will occur and determine how many visitors and inmates will be allowed in that space in order to achieve at least six feet of physical / SOCIAL DISTANCING. State and local restrictions on group size may apply.
  - Develop an appropriate flow or staging of visitors to maintain at least six feet of physical / SOCIAL DISTANCING during entry to the facility, screening, and movement to the visitation room. Having a visitation schedule booked in advance is recommended to prevent crowding of visitors at all points in the visitation process.
  - All visitation with inmates should be NON-CONTACT. PLEXIGLAS OR SIMILAR BARRIER will need to be installed to prevent contact during the visit. Consultation with an environmental and safety compliance officer is recommended to ensure life safety and fire code requirements are met.
  - To prevent mixing of different groups of inmates, scheduled visitation by housing unit or cohort is encouraged.
  - Inmate searches before and after visitation are conducted according to policy. **PPE** for the officer performing the search includes a face covering and gloves.
  - The visiting rooms and barriers should be CLEANED AND DISINFECTED between individual visitors or groups and cleaned / disinfected after visitation is over. Refer to MODULE 1 - *Infection Prevention and Control,* for specific recommendations on cleaning and disinfection procedures.

C. LEGAL VISITS

Legal visits are important aspects of the U.S. criminal justice system, but they create potential risks for COVID-19 transmission from the close interactions that may occur. In addition to the many general

infection prevention measures recommended by the CDC, the BOP uses quarantine, medical isolation, and testing for COVID-19 to limit the risk of transmission.

The following recommendations apply these established infection prevention procedures and principles in a way that accommodates legal visits as safely possible.

- **INMATES IN COVID ISOLATION** should **NOT** have in-person legal visits unless absolutely necessary. Inmates in medical isolation have, or are suspected to have, COVID-19 and may transmit the infection through close or direct contact with others. Strongly consider rescheduling until the inmate has met release from medical isolation criteria or utilizing legal telephone calls and, if available, VTC.
- **INMATES IN COVID QUARANTINE** should **NOT** have in-person legal visits unless absolutely necessary. Quarantined inmates may have asymptomatic COVID-19 infection or be in the incubation period, and should delay legal visits until they have COVID-tested negative at the end of quarantine. Legal telephone calls or VTC with attorneys, if available, are recommended as alternatives.
- Considerations for in-person legal visits:
  - *In general, testing an inmate for COVID-19 immediately after a legal visit would have little utility and is not recommended.*
  - Inmates and attorneys/legal visitors should wear **FACE COVERINGS** (cloth or surgical mask) and should perform **HAND HYGIENE** (washing hands with soap and water or using hand sanitizer) just before and after in-person visits.
  - Use of **PLEXIGLAS OR SIMILAR BARRIER** between inmate and attorney is strongly recommended for in-person visits. In the alternative, if a barrier is not present, **SOCIAL DISTANCING** (i.e., 6 feet apart) should be used.
  - Attorneys/legal visitors should be **SYMPTOM-SCREENED** and **TEMPERATURE-CHECKED** upon entry into the facility. Legal visitors who are sick or symptomatic should not be allowed to visit.
    - *See the Visitor/Volunteer/Contractor COVID-19 Screening Tool in the Appendices.*
  - If necessary, documents should be passed back and forth in a manner to **AVOID CONTACT** between individuals.
  - When legal attorney rooms are available, they should be utilized to allow for **SOCIAL DISTANCING** among all present in the room. If there is no legal attorney room available and if there is more than one attorney/inmate pair present, all participants should also be separated by more than six feet to the extent possible, while protecting attorney-client communications.
  - Tables, chairs, and other high-touch surfaces should be **CLEANED AND DISINFECTED** after each use.

MODULE 10. VOLUNTEER AND CONTRACT STAFF MANAGEMENT

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GENERAL CONSIDERATIONS

- Contractors and volunteers provide important services to the inmate population and to the agency during routine operations. During a pandemic, the importance of on-site services must be balanced with the risk of infection being introduced into an inmate population or office setting by a visitor from the community.
- Pandemics may also create a greater need for such services when contingency or crisis situations arise due to a higher demand for services, increased numbers of sick employees or contractors, a need for alternate care facilities at an institution, etc... Thus, contractors and volunteers need to be considered as viable options for addressing agency and institution needs.
- Central Office Executive Staff will need to make overall agency decisions related to the role of contractors and volunteers during a pandemic. However, within the framework of those general decisions, individual institution needs and contracting decisions will be made locally in consultation with Regional leadership.

ESSENTIAL VOLUNTEERS AND CONTRACTORS

- ESSENTIAL SERVICES MAY INCLUDE: Medical services, mental health services, religious services (if unable to provide remote services), and critical infrastructure repairs.
- Volunteers and contractors performing essential services or maintenance on essential systems may continue entering the institution. All General Guidance for Inmate Visitation applies to contractors and volunteers, including screening for COVID-19 symptoms using the same procedures for staff prior to entry.
  - ➔ *Refer to MODULE 9, Inmate Visitation, for general information and procedures regarding visits.*
  - ➔ *See the Visitor/Volunteer/Contractor COVID-19 Screening Tool in the Appendices.*
- Volunteers and contractors who feel ill should be instructed not to report to the institution, but notify their point of contact at the institution.

BACKGROUND INVESTIGATIONS AND SECURITY CLEARANCE

- When determining clearance requirements for non-BOP individuals, refer to the following **BOP Information Security Programs policy (PS1237.16):**

  3.3 Non-BOP Individuals (Contractors and Volunteers)

  Certain non-BOP individuals do not require a clearance to perform the following:

  - Low-risk services such as an initial installation of IT systems where no data is resident.

- Low-risk services such as infrequent maintenance or repairs of IT systems where no data is resident.
- Moderate-risk medical non-BOP individuals, working in Health Services, as long as the individual is only accessing information normally used in the course of providing professional medical services (no computer/system access).
- Individuals who enter a BOP facility no more than 52 days in a 12-month period.

- In deployment of this PANDEMIC RESPONSE PLAN, laws and regulations applicable to background investigations and security clearance must be followed. Institutions are encouraged to begin this clearance process upon identification of the volunteer or contractor, so as to avoid delays in allowing access to the institution or performing work.
- Human Resources staff should be available to quickly and efficiently obtain all documentation, including a pre-employment waiver, to initiate and complete the clearance process as quickly and efficiently as possible.
- For Health Services contractors requested or utilized under this plan, computer access and electronic health record (EHR) training should be initiated as soon as permissible so that contractors can perform their work with the appropriate documentation.
- All non-BOP individuals must always be monitored and escorted by staff knowledgeable about the work being performed.
- A signed non-disclosure agreement and an Information Security briefing must be completed prior to work being performed. All pre-employment requirements, as stated in HSPD-12 DOJ regulations, and BOP employment policy apply (an NCIC, fingerprint check, or any other local entrance or visiting procedures).
- All non-BOP individuals not meeting the categories listed in PS 1237.16 Section 3.3 must have a security clearance commensurate with their access. Non-BOP individuals who access a BOP IT system also need a PIV card. Documentation is maintained in the contractor/volunteer security file.
- NATIONAL GUARD ASSISTANCE: In some cases, it may be necessary to utilize National Guard assets authorized by their respective state governors. In this instance, additional clearances may not be required.
- Any questions regarding clearances should be directed to Security and Background Investigation Section of the Human Resources Management Division or to the Chief Information Officer in Information, Policy, and Public Affairs Division.

NON-ESSENTIAL VOLUNTEERS AND CONTRACTORS

Consideration should be given to limit access to the facility by non-essential volunteers and contractors.

→ *Refer to MODULE 9, Inmate Visitation, for information regarding personal and legal visits.*

MODULE 11. BOP EMPLOYEE MANAGEMENT

WHAT'S NEW

VERSION 2.0

- "COVID-19 Enhanced Screening Form" title changed to "COVID-19 Screening Tool for Staff/ Contractors/Visitors"
- Reference to Appendix "COVID-19 Tips for Official Travel Using Commercial Vendors" added

VERSION 3.0

- SECTION C. GUIDANCE FOR STAFF WITH POTENTIAL EXPOSURE TO COVID-19: the following statements added:
  - *The BOP relies on the local Health Department or the individual's healthcare provider to delineate the method used to release COVID-19 positive staff back to work in accordance with CDC guidance.*
  - *A negative COVID-19 test is not required for staff to return to work. Follow guidance below for return to work requirements.*
- Added **Section C. 3 and C.4 Asymptomatic Staff with a Positive COVID-19 Test**
- Updates to SECTION D. ALGORITHM FOR SYMPTOMATIC BOP STAFF to clarify procedures for positive COVID-19 test and no hospitalization.

VERSION 4.0

- Updates to SECTION E. STAFF TESTING to include additional information regarding BOP National Contract for staff testing
- References added to Staff Positive Case Form (located in Appendices)

VERSION 5.0

- Addition of SECTION I. PERSONAL TRAVEL
- Removal of references to Families First Coronavirus Response Act (FFCRA) – expired December 31, 2020

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A. DEFINITIONS

- **BOP INSTITUTION STAFF:** BOP employees who work within the correctional setting.
- **BOP NON-INSTITUTION STAFF:** BOP employees who work outside the correctional setting, i.e., Regional Office, Central Office, Grand Prairie, Staff Training Academy, Management and Specialty Training Center.
- **POTENTIAL EXPOSURE:** Having close contact within 6 feet of an individual with confirmed or suspected COVID-19 for greater than 15 minutes while not wearing recommended PPE. The timeframe for potential exposure includes the 48-hour period before the individual became symptomatic.

B. ENHANCED EMPLOYEE SCREENING FOR GAINING ENTRY

- *COVID-19 could gain entrance to a facility through infected employees. Staff should be educated to stay home if they have fever and/or respiratory symptoms. If employees become sick at work, they should be advised to promptly report this to their supervisor and go home. Institutions should work with executive staff and human resources to develop a local contingency plan for reduced staffing.*

  All employees must be screened upon arrival with a temperature check, as well as questions about respiratory and other COVID-related symptoms and whether they have had contact with a known COVID-19 case.

- *A **COVID-19 ENHANCED SCREENING TOOL FOR STAFF/CONTRACTORS/VISITORS** is available in the Appendices. This form can be laminated so that the screening staff can read the questions to the employees being screened and accept their responses verbally.*
- *Given the public health emergency, **staff who REFUSE the enhanced health screening will be denied entry and charged leave—and may be subject to disciplinary action.***

- Employee screenings do not require written documentation unless the person responds "YES" to any question or has a temperature, as described below.
- The temperature check should ideally be taken with a no-touch, infra-red thermometer. If an employee registers a temperature of greater than or equal to 100 degrees (Fahrenheit), they will be denied entry to the facility and put on sick leave. They should be advised to consult with their healthcare provider. (See the *Algorithm for Symptomatic BOP Staff*.)
- If the temperature is out of range, (<93.7°F or >108.1°F or screen reads "HI" or "LOW") the employee should be asked to stand aside for 10 minutes and then the temperature should be remeasured.
- Temperature and symptom screening can be performed by non-health care personnel trained to measure temperature.
  - Training videos for non-healthcare providers to check temperatures can be found on the BOP Sallyport COVID-19 Guidance page.
  - Upon completion of the Temperature Video(s), staff should complete the Opinion Survey also found on the BOP Sallyport COVID-19 guidance page so that the training can be added to the training record.
- Information regarding screening of volunteers and contract staff can be found in **MODULE 10**.

C. GUIDANCE FOR STAFF WITH POTENTIAL EXPOSURE TO COVID-19

- The Infection Control person in charge will determine whether the employee has had **POTENTIAL EXPOSURE** (see *definition* above) to a COVID-19 case and requires further assessment.
- Any staff (civil service or PHS) who are subject to or received movement restrictions at the direction of public health authorities should provide this information to their supervisor and institution Human Resources and not return to work until instructed to do so.
- Per **PS6701.01**, all employees are required to report a COVID-19 positive test to their institution human resources department. Reporting should include completion of the **STAFF POSITIVE CASE FORM** located in the Appendices in addition to the lab report or screen shot indicating diagnosis.
- Any questions regarding leave flexibilities should be forwarded to the Staffing and Employee Relations Section (SERS) for further guidance.
- The BOP relies on the local Health Department or the individual's healthcare provider to delineate the method used to release COVID-19 positive staff back to work in accordance with CDC guidance.
- A negative COVID-19 test is not required for staff to return to work. Follow guidance below for return to work requirements.

→ **If the employee becomes symptomatic in any of the below scenarios, see the *Algorithm for Symptomatic BOP Staff* below.**

1. ASYMPTOMATIC INSTITUTION STAFF REPORTING POTENTIAL EXPOSURE TO COVID-19

BOP employees are considered to be part of the critical infrastructure of the institution. To ensure continuity of operations of essential functions, the CDC advises that **CRITICAL INFRASTRUCTURE WORKERS** are permitted to continue work following potential exposure to COVID-19, provided they remain asymptomatic.

- The exposed employee should report to work and go through the enhanced screening at the institution.
- The employee should monitor their health status with continual awareness of development of COVID-19 symptoms and twice daily temperature self-checks.

2. ASYMPTOMATIC NON-INSTITUTION STAFF REPORTING POTENTIAL EXPOSURE TO A COVID-19

- Staff who currently have an approved telework agreement (regular or situational) are expected to continue telework at their home.
- The employee should monitor their health status with continual awareness of development of COVID-19 symptoms and twice daily temperature self-checks.

3. ASYMPTOMATIC INSTITUTION STAFF WITH POSITIVE COVID-19 TEST

- Asymptomatic staff who test positive for COVID-19 may return to work after 10 days have passed since first positive COVID-19 test.

4. ASYMPTOMATIC NON-INSTITUTION STAFF WITH POSITIVE COVID-19 TEST

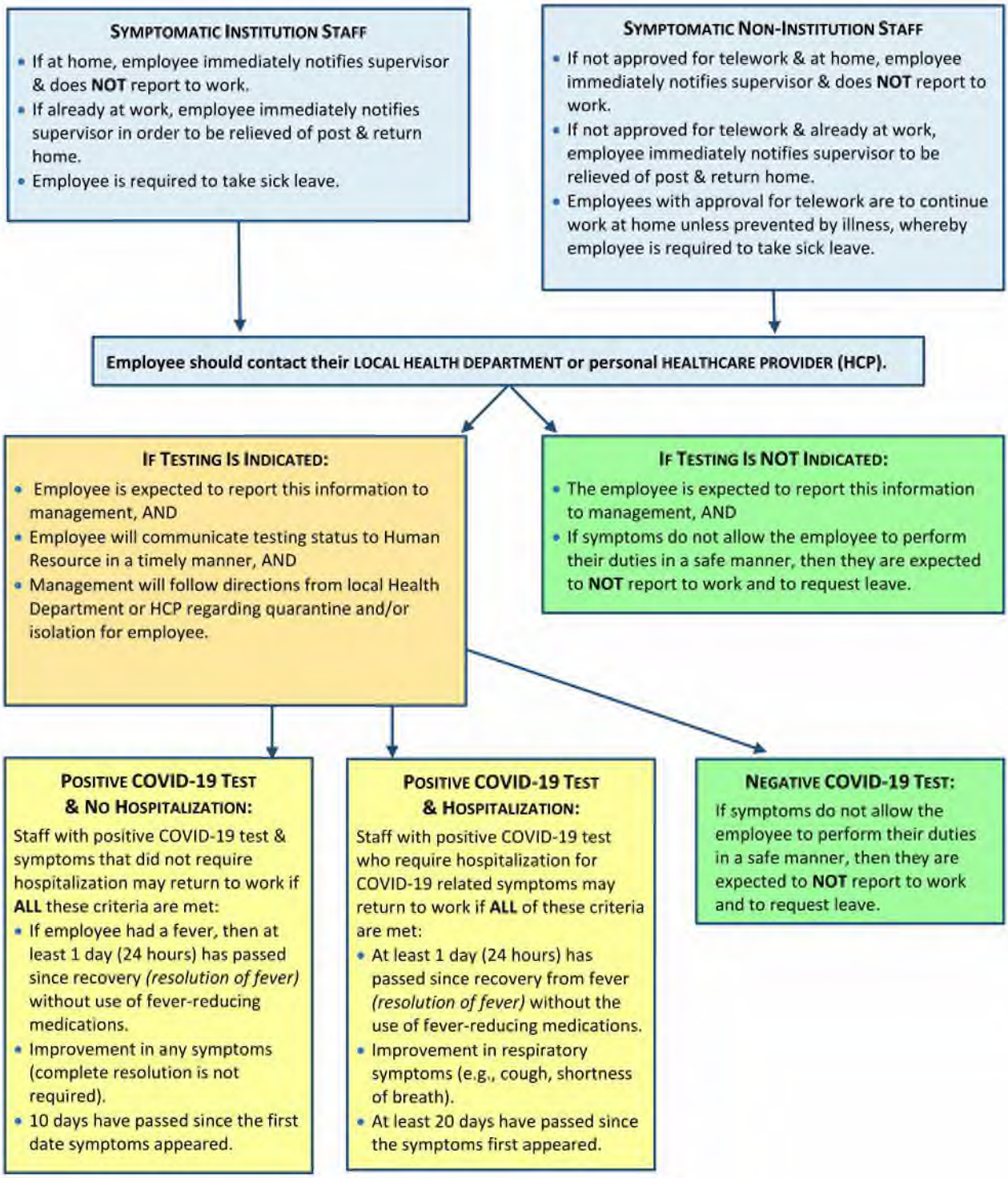
- Staff who currently have an approved telework agreement (regular or situational) are expected to continue telework at their home.
- The employee should monitor their health status with continual awareness of development of COVID-19 symptoms and twice daily temperature self-checks.

5. SYMPTOMATIC STAFF

Due to the widespread prevalence of COVID-19-infected persons, staff with symptoms suggestive of COVID-19 infection may not be aware if a potential exposure has occurred. The *Algorithm for Symptomatic BOP Staff* on the following page shows the steps that should be taken if a BOP employee has symptoms suggestive of COVID-19.

- The BOP relies on the local Health Department or the individual's healthcare provider to release COVID-19 positive staff from isolation *in accordance with CDC guidance*.
- If the provider has cleared a staff member to return to work and the staff member refuses, the individual should be charged AWOL. The individual can also be issued an 8-point letter after consultation with the Occupational Safety and Health Branch.

D. ALGORITHM FOR SYMPTOMATIC BOP STAFF



E. GUIDANCE FOR STAFF TESTING

Refer to **MODULE 3 SCREENING & TESTING** for information regarding types of COVID-19 tests available.

All institutions are advised to identify methods for staff to be voluntarily tested for COVID-19.

- Institutions are strongly encouraged to establish relationships with the local health department for testing. Utilization of a staff specific BOP national contract for COVID-19 testing is a secondary option.
  - ➔ *Staff may locate community testing sites through the following link: https://www.hhs.gov/coronavirus/community-based-testing-sites/index.html.*
- **Several locales have established additional procedures to allow first responders to be tested for COVID-19.** Institutions are encouraged to become familiar with the procedures and locations of these resources to augment, or in lieu of, testing with DOHs or BOP national contract. Some of these locations may require a memo or letter from the individual's employer verifying their status as someone working in a Critical Infrastructure Industry. Please use the *Critical Infrastructure Memo to Local DOH for Employee Testing* memo template located in the Appendices to satisfy this requirement, as needed.
- Once testing options are identified, staff should be made aware of their options in a direct and prominent fashion.
- Per **PS6701.01,** all employees are required to report a COVID-19 positive test to their institution human resources department. Reporting should include completion of the **STAFF POSITIVE CASE FORM** located in the Appendices in addition to the lab report or screen shot indicating diagnosis.
- **Questions related to staff testing**, should be routed through the regional Emergency Operations Center.

1. INDICATIONS AND PRIORITIES FOR TESTING

Specific indications for testing staff in the BOP are listed below in **TWO MAIN CATEGORIES.** If there are limitations in the number of tests that can be performed at a given location, prioritization of testing indications may be needed and should be done in consultation with the Central Office Occupational Safety & Health Branch and Infectious Disease Prevention & Control Staff.

- **SYMPTOMATIC**
  - ➢ All staff with symptoms consistent with or suggestive of COVID-19 should be referred to their private physician or health department for evaluation/testing.
- **ASYMPTOMATIC WITH KNOWN OR SUSPECTED CONTACT WITH A COVID-19 CASE**

  ➔ *As a reminder, the primary testing modality used in this category should be that of the local health department when possible.*
  - ➢ When a case of COVID-19 is identified at an institution, a contact tracing of both staff and inmates should be performed expeditiously.
  - ➢ All staff identified as close contacts of the initial case will be referred to local Department of Health or contract testing provider (if activated at the local institution).
  - ➢ **Asymptomatic staff will continue to report to work** and go through enhanced screening to gain entrance to the institution while awaiting testing results and complying with all local requirement regarding use of face covering at all times.

- Institution-wide testing of staff may be considered by the Warden, in consultation with the local health department, where one or more staff cases of COVID-19 have been identified, where there is substantial transmission confirmed beyond the initial (index) case, or if the individual has moved about the institution.

2. STAFF TESTING NATIONAL CONTRACT

The BOP has awarded a national contract with Quest Diagnostics to provide COVID-19 molecular diagnostic (PCR). For institutions that utilize/activate the national contract, Quest Diagnostics will provide an initial shipment of self-collection kits to each BOP facility which will be replenished based on availability.

Wardens at each facility will assign an ADMINISTRATOR and BACKUP ADMINISTRATOR for this contract.

- ADMINISTRATOR responsibilities will include:
  - Provide contact information to Quest Diagnostics in order to set-up a username and password for administrator online access.
  - Receive initial training by Quest.
  - Provide self-collection kits to BOP staff meeting indications for testing listed above, utilizing Quest Diagnostic's online pre-registration process, and assisting in the shipment of self-collection kits.
  - Review registration information for completion.
  - Create testing requisitions and provide to staff, along with the self-collection kit, utilizing Quest Diagnostic's online portal.
  - Hold all signed consents at each BOP facility in Human Resources Department.
  - Arrange FedEx Overnight pick-up of the packages/samples that have been collected on that day.
- BOP STAFF meeting indications for testing listed above will:
  - Be provided a link to complete registration by locally assigned Administrator.
  - Register via Quest Diagnostic's online portal with their demographic information as prompted.
  - Sign the required Consents for testing and release of results to the BOP per Employee Health care Policy (PS6701).
  - Package the sample/paperwork according to provided instructions once the specimen is self-collected and paperwork is complete.
  - Provide the completed package to the ADMINISTRATOR to arrange for pick-up by FedEx
- Once the sample has been collected, Quest Diagnostics will manage shipment, processing, testing, and resulting of all samples.

3. QUEST DIAGNOSTICS STAFF TEST RESULTS

- Staff will have access to their results through a secure on-line portal provided by Quest Diagnostics.
- All staff with a positive test result will be notified via phone immediately by a Quest Diagnostics provider. In the event the staff is not available by phone, he/she will be notified via overnight mailing of results.
- Through a secure electronic method, Quest Diagnostics will provide a nightly aggregate report of staff results to the appropriate BOP representative.
- Report will be provided in Excel format (csv) with de-identified and/or identified information as per consent signed.

F. TDY AND OFFICIAL TRAVEL

- Guidance for **COVID-19 TIPS FOR OFFICIAL TRAVEL USING COMMERCIAL VENDORS** is available in the Appendices
- **Regardless of duty location, upon returning from travel, staff should self-monitor their health status twice per day** through temperature checks and evaluation for symptoms such as coughing, shortness of breath, chills, muscle pain, or new loss of taste and smell.
- Also, regardless of duty location, staff shall notify their supervisor immediately if they believe they had prolonged contact with any COVID-19 positive individual in the workplace while they were not properly supplied and/or protected with PPE.

1. FOR EMPLOYEES RETURNING TO AN INSTITUTION FROM TDY AND OFFICIAL TRAVEL

(Where screening *is* performed to gain entrance)

- **If ASYMPTOMATIC and had been assigned to one of the following duty locations:** a Quarantine Unit, Medical Isolation Unit, Hospital Duty, or Inmate Transport, they shall be placed on Weather & Safety Leave for 14 calendar days, unless otherwise determined by the CEO of their home institution because of critical staffing needs.
- **If ASYMPTOMATIC and had not been assigned to a post described above**, staff are to report to work, wear a cloth face covering and proceed through the enhanced screening at the institution per CDC guidance on critical infrastructure workers found here: *https://www.cdc.gov/coronavirus/2019-ncov/downloads/critical-workers-implementing-safety-practices.pdf*
- **If an employee in any scenario becomes SYMPTOMATIC at any time during the 14 days post-TDY:**
  - They should not report to work.
  - They should give notice to their Supervisor.
  - They should alert the Local Health Department or their personal Healthcare provider.
  - → *See the Algorithm for Symptomatic BOP Staff above.*

2. FOR EMPLOYEES RETURNING TO A NON-INSTITUTION SETTING FROM TDY AND OFFICIAL TRAVEL

(Where screening IS NOT performed to gain entrance such as Regional Office, Central Office, Grand Prairie, Staff Training Academy, or Management and Specialty Training Center)

- **If telework ready and ASYMPTOMATIC**, staff should telework.
- **If not telework ready and ASYMPTOMATIC and had not been assigned to a post described above**, staff should return to work and wear a cloth face covering while at work in addition to any required enhanced screening.
- **If not telework ready and asymptomatic and had been assigned to such a post described above**, they should be placed on Weather & Safety Leave for 14 calendar days unless otherwise determined by the CEO of their home institution because of critical staffing needs.
- **If an employee becomes symptomatic at any time:**
  - They should not report to work.
  - They should give notice to their supervisor.
  - They should alert the Local Health Department or their personal Healthcare provider.
  - → *See the Algorithm for Symptomatic BOP Staff above.*

G. TEMPORARY JOB MODIFICATIONS (TJM)

Staff who have indicated high-risk medical issue(s) should be given the **COVID-19 Medical Condition Self Reporting Tool** (in the Appendices) to submit to the OSH mailbox: BOP_HSD/Employee Health for processing. The subject line of the email should be "High risk staff declaration form- [Last name, First name]." The employee should continue to report to work or use personal leave until the employee is notified that a determination has been made.

H. GUIDANCE FOR LEAVE ASSIGNMENTS

WEATHER & SAFETY LEAVE

- Weather and Safety Leave is to be used for TDY leave until the staff member becomes symptomatic. It is not appropriate to use Weather and Safety Leave for staff who have tested positive for COVID-19.
- Staff are entitled to Weather & Safety Leave if they are placed in quarantine status by the Agency
- The granting official for Weather and Safety leave is the local Warden.

CONTINUATION OF PAY (COP)/OFFICE OF WORKERS' COMPENSATION PROGRAM (OWCP) LEAVE

- Once a staff member files for OWCP, they must use COP. COP leave is for a maximum of 45 days when medically indicated.

SICK LEAVE

As a reminder, supervisors have the authority to approve advanced sick leave for a maximum of 240 hours (30 days) to full-time employees in accordance with DOJ Order 1630.1B, Leave Administration, and P.S. 3630.02, Leave and Benefits.

I. PERSONAL TRAVEL

- **Regardless of duty location, upon returning from travel, staff should self-monitor their health status twice per day** through temperature checks and evaluation for symptoms such as coughing, shortness of breath, chills, muscle pain, or new loss of taste and smell.
- **If an employee becomes symptomatic at any time:**
  - They should not report to work.
  - They should give notice to their supervisor.
  - They should alert the Local Health Department or their personal Healthcare provider.
  - → *See the Algorithm for Symptomatic BOP Staff above.*
- CDC levels of infectivity by region can be located here: *https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html*

1. FOR EMPLOYEES RETURNING TO AN INSTITUTION (WHERE SCREENING *IS* PERFORMED TO GAIN ENTRANCE)

- **If ASYMPTOMATIC and has traveled from a low infectivity region,** staff can report to work, wear a cloth face covering and proceed through the enhanced screening at the institution per CDC guidance on

critical infrastructure workers found here: *https://www.cdc.gov/coronavirus/2019-ncov/downloads/critical-workers-implementing-safety-practices.pdf*

- **If ASYMPTOMATIC and has traveled from a high infectivity region designated by the CDC, and the CEO of the home institution *does not* require staff to report to work** as there is adequate staffing at the institution at the time:
  - Staff can be offered testing for COVID-19 through the BOP, three days or greater after their return
    - If test results are negative, staff can return 10 days after returning from travel. Leave assigned may be annual, sick, advanced sick or leave without pay (LWOP). Weather and Safety leave *is not* permitted.
    - If test results are positive, follow return to work guidance after a positive COVID-19 test. Leave assigned may be annual, sick, advanced sick or LWOP. Weather and Safety leave *is not* permitted.
      - ➔ See the *Algorithm for Symptomatic BOP Staff* above.
  - If staff choose not to participate in COVID-19 testing as offered by BOP, then staff should be placed on leave for 14 days after their return. Leave assigned may be annual leave or LWOP. Weather and Safety leave *is not* permitted.
- **If ASYMPTOMATIC and has traveled from a high infectivity region designated by the CDC, and the CEO of the home institution *does* require staff to report to work** because of critical staffing needs:
  - Staff are to report to work, wear a cloth face covering and proceed through the enhanced screening at the institution per CDC guidance on critical infrastructure workers found here: *https://www.cdc.gov/coronavirus/2019-ncov/downloads/critical-workers-implementing-safety-practices.pdf*

2. FOR EMPLOYEES RETURNING TO A NON-INSTITUTION SETTING (WHERE SCREENING *is not* PERFORMED TO GAIN ENTRANCE SUCH AS REGIONAL OFFICE, CENTRAL OFFICE, GRAND PRAIRIE, STAFF TRAINING ACADEMY, OR MANAGEMENT AND SPECIALTY TRAINING CENTER)

- **If telework ready and ASYMPTOMATIC**, staff should telework.
- **If not telework ready and ASYMPTOMATIC and has traveled from a low infectivity region,** staff can return to work and wear a cloth face covering while at work and monitor their symptoms at work and home.
- **If not telework ready and ASYMPTOMATIC and has traveled from a high infectivity region as designated by the CDC:**
  - Staff can be offered testing for COVID-19 through the BOP, three days or greater after their return
    - If test results are negative, staff can return 10 days after returning from travel. Leave assigned may be annual, sick, advanced sick or leave without pay (LWOP). Weather and Safety leave *is not* permitted.
    - If test results are positive, follow return to work guidance after a positive COVID-19 test. Leave assigned may be annual, sick, advanced sick or LWOP. Weather and Safety leave *is not* permitted.
      - ➔ See the *Algorithm for Symptomatic BOP Staff* above.
  - If staff choose not to participate in COVID-19 testing as offered by BOP, then staff should be placed on leave for 14 days after their return. Leave assigned may be annual leave or LWOP. Weather and Safety leave *is not* permitted.

J. RECOMMENDATIONS FOR FAMILY OR OTHERS IN THE EMPLOYEE'S HOUSEHOLD

Employees in isolation or quarantine should be directed to the CDC guidelines on practicing social distancing and good hand-hygiene for the 14-day period. See also the CDC recommendations for coping with daily life at: *https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/index.html*

K. RIDESHARE/VANPOOL GUIDANCE

- **Practice every-day protective measures:**
  - Wear a cloth face covering over nose and mouth.
  - Use proper hand hygiene. Wash your hands regularly with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer containing at least 60% alcohol.
  - Avoid touching your eyes, nose, or mouth.
- **Avoid Ridesharing and Vanpools when possible.**
- **When using vanpools, implement the following measures:**
  - Wear a cloth face covering over nose and mouth at all times during the ride.
  - Maximize physical distancing among passengers when possible.
  - Windows should be cracked open at least one inch.
  - The air conditioning unit should be set on FRESH AIR, and NOT on recirculated air.
  - To the extent possible, avoid contact with surfaces frequently touched by others such as door frame/handles, windows, seat belt buckles, steering wheel, gearshift, signaling levers, and other vehicle parts before they are cleaned and disinfected. These surfaces should be cleaned and disinfected after each use. Avoid touching your face until you have washed or sanitized your own hands.

L. RESOURCES FOR STAFF

As a result of COVID-19, staff have most likely been rebalancing personal, family, school, work, and community demands to protect themselves and loved ones. Staff may have concerns about becoming infected, passing on an infection, being isolated at home, spouses and family members losing jobs, and having children out of school. Times of great change, such as these, can cause fear, worry, moodiness, sleeplessness, and agitation. These are normal reactions to a new and constantly changing situation. Resources to help support efforts at healthy coping maybe located on the Sallyport COVID-19 Guidance page and through the CDC.

1. STAFF SUPPORT LINE

During the current COVID-19 pandemic, the lives of all persons around the globe and, in particular, BOP staff, are being touched directly and indirectly by this deadly disease. Some staff have been infected with COVID-19 already. Many know someone who is, or has been infected. With a pandemic of this magnitude, it is possible that staff will lose loved ones, or even that the Bureau may suffer the loss of staff members to the virus. The stress evoked by COVID-19 weighs on us all.

We recognize that most staff have COVID-related concerns. Some concerns may be related to the workplace. Other concerns may be connected to their family or home life. These concerns can cause stress, worry, or other difficult emotions. As law enforcement professionals, Bureau staff are

accustomed to working under stressful conditions. However, the COVID-19 pandemic presents challenges that may, at times, appear overwhelming to many staff members.

To offer a helpful outlet for staff members to openly discuss their concerns, the agency activated a **24-HOUR STAFF SUPPORT LINE** - contact information available on Sallyport. You will not be asked to identify yourself, but you may if you wish. The person you speak to will be a Bureau staff member, with institution experience. You will be given an opportunity to share your concerns, receive support, and engage in problem solving. We believe that talking about your concerns, rather than silently carrying them inside, is a better way to cope with the stress of the COVID-19 pandemic.

The Bureau recognizes its responsibility to the workforce that fulfills its custody mission day after day, no matter how challenging. **WE ENCOURAGE YOU TO USE THE 24-HOUR STAFF SUPPORT LINE**. This is one way we take care of our own.

What's New

Version 2.0

- Added Appendix Z. COVID-19 Tips for Official Travel using Commercial Vendors

Version 3.0

- Amendments to Appendix S. Triage of Medical and Mental Health Conditions During Disruptions - removed references to dental services

Version 4.0

- Updates to Appendix V. COVID-19 Screening Tool for Staff, Contractors, and Visitors

Version 5.0

- Updates to add additional diagnoses to Appendix Q. COVID-19 Coding Clinical Reference Guide
- Added Appendix AA. Staff Positive Case Form

Version 6.0

- Update to Appendix T. CPAP or BiPAP in USE Signage to clarify doors should be close when in use
- Added Appendix AA. Staff and Inmate COVID-19 Contact Investigation and Tracing Worksheet
- Added Appendix AC. Standard Email for Notification of Staff Contacts
- Reassigned Staff Positive Case Form to Appendix AB

Version 7.0

- Update to Appendix AA. Staff and Inmate COVID-19 Contact Investigation and Tracing Worksheet to include history of vaccination
- Update contact information and added history of vaccination in Appendix AB. Staff Positive Case Form

List of Appendices

APPENDIX A. RECOMMENDED CLEANING AND DISINFECTION SCHEDULE

AREA TO BE CLEANED	FREQUENCY OF CLEANING	FREQUENCY OF DISINFECTION
Windows/Window Ledges	Daily	Daily
Toilets/Sinks	Daily	Daily
Trash Receptacles	Empty three times daily, or as needed; clean daily	Daily
Floors, Stairs, and Other Walking Surfaces	Sweep and damp-mop daily	Daily
Telephones	Multiple times daily	After each use
Microwave Ovens	Clean daily and when visibly dirty	Daily
Drinking Fountains	Multiple times daily	Disinfect when cleaning
Door/Door Jams	Multiple times daily	Disinfect when cleaning
Mop Sinks	Rinse and clean after every use	After each use
Mop Buckets	Empty and rinse after every use	After each use
Wet-Mop Heads	Replace with a clean mop head after each use	Launder used mop heads daily
Dust-Mop Heads	Replace with a clean mop head after each use	Launder used mop heads daily
Furnishings	Daily cleaning of multi-use common area furniture (chairs, tables, etc.)	Disinfect when cleaning

APPENDIX B. DISINFECTING WITH HALT™

Consult the manufacturer's recommendations and the safety data sheet for appropriate PPE to be worn during preparation and use of this product.

CONTROL OF HALT CONCENTRATE AND SOLUTION

- **STORAGE OF HALT CONCENTRATE:** Must be stored in accordance with institution policy on the storage of hazardous products (secured, bin cards, etc.). Must be under **DIRECT STAFF SUPERVISION** at all times or in locked dispensers.
- **MIXING HALT DILUTED SOLUTION FOR DISINFECTING:** Mix using dilution dispensers provided by the manufacturer. If a dispenser is not available, mixing must be done under **DIRECT STAFF SUPERVISION**. (See **PREPARATION OF HALT SOLUTION** below.)
- **USE OF DILUTED SOLUTION:** Once the solution is diluted, no special supervision is required for inmate use.

PREPARATION OF HALT SOLUTION USING MANUFACTURER'S GUIDANCE

- **IF A DISPENSER IS AVAILABLE:** Connect the dispenser and distribute the concentrate as needed into spray bottles or mop buckets, following the manufacturer's instructions.
- **IF NO DISPENSER IS AVAILABLE:** A gallon jug may be used. Under **DIRECT STAFF SUPERVISION**, add 2 ounces of HALT concentrate to the jug and fill the rest of it with cold water. Label the jugs as "HALT solution," with the date that the solution was prepared.
- The manufacturer recommends that a fresh solution be mixed daily for greatest efficacy however, they indicate that mixed solutions may be able to last up to a week and maintain efficacy.

HOW TO USE SOLUTION

- If surfaces are dirty, they should first be cleaned with detergent or soap and water—prior to disinfection with HALT solution.
- Apply HALT solution to hard, non-porous surfaces.
- All surfaces must **REMAIN WET FOR 10 MINUTES** for maximum disinfection. After the 10-minute we time, allow to air-dry or wipe surfaces to dry and remove any residue.
  - **FLOORS** do not need to be rinsed unless they are to be coated with finish or restorer.
  - **FOOD CONTACT SURFACES**—such as appliances and kitchen countertops—must be **RINSED WITH POTABLE WATER.**
  - **Do NOT use HALT on glassware, utensils, or dishes!**

APPENDIX C. DISINFECTING WITH HDQC®2

Consult the manufacturer's recommendations and the safety data sheet for appropriate PPE to be worn during preparation and use of this product.

CONTROL OF HDQC 2 CONCENTRATE AND SOLUTIONS

- **STORAGE OF HDQC 2 CONCENTRATE:** Must be stored in accordance with institution policy on the storage of hazardous products (secured, bin cards, etc.). Must be under **DIRECT STAFF SUPERVISION** at all times or in locked dispensers.
- **MIXING HDQC 2 DILUTED SOLUTION FOR DISINFECTING:** Mix using dilution dispensers provided by the manufacturer. If a dispenser is not available, mixing must be done under **DIRECT STAFF SUPERVISION**. (See **PREPARATION OF HDQC 2 SOLUTION** below.)
- **USE OF DILUTED SOLUTION:** Once the solution is diluted, no special supervision is required for inmate use.

PREPARATION OF HDQC 2 SOLUTION USING MANUFACTURER'S GUIDANCE

- **IF A DISPENSER IS AVAILABLE:** Connect the dispenser and distribute the concentrate as needed into spray bottles or mop buckets, following the manufacturer's instructions.
- **IF NO DISPENSER IS AVAILABLE:** A gallon jug may be used. Under **DIRECT STAFF SUPERVISION**, add 2 ounces of hdqC 2 concentrate to the jug and fill the rest of it with cold water. Label the jugs as "hdqC 2 solution," with the date that the solution was prepared.
- The manufacturer recommends that a fresh solution be mixed daily for greatest efficacy; however, they indicate that mixed solutions may be able to last up to a week and maintain efficacy.

HOW TO USE SOLUTION

- If surfaces are dirty, they should first be cleaned with detergent or soap and water—prior to disinfection with hdqC 2 solution.
- Apply hdqC 2 solution to hard, non-porous surfaces.
- All surfaces must **REMAIN WET FOR 10 MINUTES** for maximum disinfection. After the 10-minute we time, allow to air-dry or wipe surfaces to dry and remove any residue.
  - **FLOORS** do not need to be rinsed unless they are to be coated with finish or restorer.
  - **FOOD CONTACT SURFACES**—such as appliances and kitchen countertops—must be **RINSED WITH POTABLE WATER.**
  - **Do NOT use hdqC 2 on glassware, utensils, or dishes!**

APPENDIX D. DISINFECTING WITH VIREX® II/256

Consult the manufacturer's recommendations and the safety data sheet for appropriate PPE to be worn during preparation and use of this product.

CONTROL OF VIREX II/256 CONCENTRATE AND SOLUTIONS

- **STORAGE OF VIREX II/256 CONCENTRATE:** Must be stored in accordance with institution policy on the storage of hazardous products (secured, bin cards, etc.). Must be under **DIRECT STAFF SUPERVISION** at all times or in locked dispensers.
- **MIXING VIREX II/256 DILUTED SOLUTION FOR DISINFECTING:** Mix using dilution dispensers provided by the manufacturer. If a dispenser is not available, mixing must be done under **DIRECT STAFF SUPERVISION**. (See **PREPARATION OF VIREX II/256 SOLUTION** below.)
- **USE OF DILUTED SOLUTION:** Once the solution is diluted, no special supervision is required for inmate use.

PREPARATION OF VIREX II/256 SOLUTION USING MANUFACTURER'S GUIDANCE

- **IF A DISPENSER IS AVAILABLE:** Connect the dispenser and distribute the concentrate as needed into spray bottles or mop buckets, following the manufacturer's instructions.
- **IF NO DISPENSER IS AVAILABLE:** A gallon jug may be used. Under **DIRECT STAFF SUPERVISION**, add ½ ounce of Virex II/256 concentrate to the jug and fill the rest of it with cold water. Label the jugs as "Virex II/256 solution," with the date that the solution was prepared.
- The shelf life of the diluted solution is 1 year.

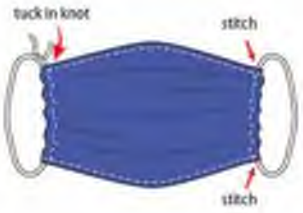
HOW TO USE SOLUTION

- If surfaces are dirty, they should first be cleaned with detergent or soap and water—prior to disinfection with Virex II/256 solution.
- Apply Virex II/256 solution to hard, non-porous surfaces.
- All surfaces must **REMAIN WET FOR 10 MINUTES** for maximum disinfection. After the 10-minute we time, allow to air-dry or wipe surfaces to dry and remove any residue.
  - **FLOORS** do not need to be rinsed unless they are to be coated with finish or restorer.
  - **FOOD CONTACT SURFACES**—such as appliances and kitchen countertops—must be **RINSED WITH POTABLE WATER.**
  - **DO NOT use Virex II/256 on glassware, utensils, or dishes!**

APPENDIX E. INFORMATION FOR ALL STAFF – CLOTH FACE COVERINGS

Cloth Face Coverings

Help Slow the Spread of COVID-19



- The BOP now requires all staff to wear cloth face coverings whenever possible.
- All staff will receive a cloth face covering to use at work.
- The covering is re-useable and should not be thrown away.
- It is still important to maintain social distancing of 6 feet, when possible.

How to Wear a Cloth Face Covering

- Make sure it fits snugly, but comfortably, against the side of the face. Secure with ties or ear loops.
- Use a covering with multiple layers of fabric, but make sure it allows for breathing without restriction.
- It should withstand laundering and machine drying without damage or change to shape.
- Be careful not to touch your eyes, nose, or mouth when removing—and wash hands immediately after.
- Do not put used face coverings where others can touch them.
- Do not touch or use anyone else's face covering. Assume that used masks are contaminated until they are laundered. Keep a bag with you to store your face covering if you will be taking it off in the car or other non-social space.
- If you take off your face covering (e.g., to eat) and then put it back on, be sure that the outside stays on the outside (consider marking the outside or inside).

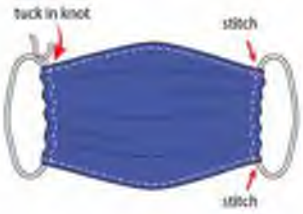
Routinely Wash Cloth Face Coverings

- The covering should be washed before the first use.
- It is recommended that staff wash cloth face coverings at home after each shift. They can be washed with other clothing.
- Launder items using the warmest water setting, and dry completely.
- Clean and disinfect clothes hampers or use a liner that can be washed or thrown away.

APPENDIX F. INFORMATION FOR INMATES – CLOTH FACE COVERINGS (ENGLISH)

Cloth Face Coverings

Help Slow the Spread of COVID-19



- Based on guidance from the CDC, the BOP now recommends all inmates wear cloth face coverings.
- All inmates will receive a cloth face covering.
- This covering is re-useable and should not be thrown away.
- It is still important to maintain social distancing of 6 feet, when possible.

How to Wear a Cloth Face Covering

- Make sure it fits snugly, but comfortably, against the side of the face. Secure with ties or ear loops.
- Use a covering with multiple layers of fabric, but make sure it allows for breathing without restriction.
- Be careful not to touch your eyes, nose, or mouth when removing—and wash hands immediately after.
- Do not put used face coverings where others can touch them.
- Do not touch or use anyone else's face covering. Assume that used masks are contaminated until they are laundered.
- When not using your cloth face covering, store it in your personal locker where the cover will not become soiled or picked up by others.
- If you must take off your face covering and then put it back on before laundering, be sure that the part of the covering that was facing out stays facing out. (Consider marking the outside or inside).

Routinely Wash Cloth Face Coverings

- The covering should be washed before the first use.
- Inmates should send cloth face coverings through the institution wash cycles with other clothing.
- Launder face coverings using the warmest water setting, and dry completely.

APPENDIX G. INFORMATION FOR INMATES – CLOTH FACE COVERINGS (SPANISH)

Máscara faciales de tela

Ayuda a disminuir/evitar la propagación de COVID-19

- Basado en la guía del CDC, el BOP ahora recomienda que todos los reclusos usen cubiertas/máscaras de tela para la cara.
- Todos los reclusos recibirán una cubierta/máscara de tela para la cara.
- Esta cubierta/máscara es reutilizable y no debe desecharse.
- Todavía es importante mantener el distanciamiento social de 6 pies, cuanda sea posible.

Cómo usar una cubierta/ máscara facial

- Asegúrese de que quede ajustada y comoda a los lados de su cara. Asegúrelo con las tiras o las bandas elasticas para las orejas.
- Use una máscara con varias capas de tela pero asegúrese de que permita respirar sin restricciónes.
- Tenga cuidado de no tocarse los ojos, la nariz, o la boca cuando se retire y lavese las manos inmediatamente despues de retirarla.
- No coloque la cubierta facial usada donde otros puedan tocarla.
- No toque ni use la cuberta facial/máscara de otra persona. Suponga que las máscaras usadas estan contaminadas hasta que sean lavadas.

- Cuando no use la cubierta de máscara de su cara, guárdela en su casillero personal, donde la cubierta/máscara no se ensucie ni sea accesible a otra persona.
- Si debe quitarse la máscara y luego volvérsela a poner antes de lavarla, asegúrese de que la parte de la cubierta que estaba hacia afuera permanezca hacia afuera. (Considere marque el exterior o el interior de la máscara.)

Lave rutinariamente la tela que cubre la cara

- La cubierta debe lavarse antes del primer uso.
- Los reclusos deben enviar las cubiertas de tela a la lavanderia de la institución con su ropa.
- Lave las máscara con la configuración de agua más cáliente y seque completamente.

APPENDIX H. PPE DONNING SKILL TESTING SHEET

COVID-19 Personal Protective Equipment Donning

SKILLS TESTING SHEET

STUDENT NAME: _____ **DATE:** _____

Skill Step	Critical Performance Criteria	✓ if done correctly
	Following the protocol for PPE placement (donning) minimizes the risk for disease transmission: • The **DONNING PROCEDURE** can be used for both quarantine and isolation transmission-based precautions. • Exact **PPE** may differ based on availability, as well as type of room utilized (AIIR with anteroom, single room without anteroom, or dorm type space). • **EQUIPMENT:** Gloves, gown, N95 **OR** surgical mask, eye goggles**,** mask with shield or face shield (PPE availability), non-touch waste container close to door inside room and just outside door at entry.	
1.	• **Address personal hygiene issues, hydration, and importance of not touching face.** • **Remove unnecessary jewelry and equipment.** • **Kevlar vest/protective vest are worn per policy.**	
2.	• **Perform hand hygiene.**	
3.	• **Don gloves.**	
4.	• **Don gown.** • **Tie or secure in the back.**	
5.	**Depending on use of N95 respirator, surgical mask, or surgical mask with eye shield:** **a. Don N95 respirator:** • **Only fit-tested individuals may wear N95s; facial hair cannot interfere with mask seal. See NIOSH site for facial hair styles that can interfere with the respirator seal:** *https://www.cdc.gov/niosh/npptl/pdfs/FacialHairWmask11282017-508.pdf* • **Adjust to fit.** • **Conduct a user seal check: Exhale to check for air leakage; inhale and check for slight mask collapse.** **b. Don surgical mask or surgical mask with eye shield:** • **Adjust to fit.**	
6.	**Don safety glasses, goggles, or face shield:** • **Glasses,goggles or face shield sit on top or go over the mask** • **Adjust for vision and coverage**	

Donning PPE Skills (circle one): **PASS** **FAIL**

Instructor Signature: _____

Instructor Printed Name: _____

APPENDIX I. PPE DOFFING SKILLS TESTING SHEET

COVID-19 Personal Protective Equipment Doffing

SKILLS TESTING SHEET

STUDENT NAME: _____ **DATE:** _____

Skill Step	Critical Performance Criteria	✓ if done correctly
	Following the protocol for PPE removal (doffing) minimizes the risk for disease transmission: • The **DOFFING PROCEDURE** can be used for both quarantine and isolation transmission-based precautions. • Exact **PPE** may differ based on availability, as well as type of room utilized (AIIR with anteroom, single room without anteroom, or dorm type space). • Doffing has been modified to accommodate a lack of anteroom and the possibility of eye protection re-use. Facilities may create a doffing space or tape-off a designated doffing area immediately outside of room. • Hand hygiene can be performed between any step of the process. • **EQUIPMENT:** A non-touch waste container close to door inside room and just outside door at exit. Receptacle for contaminated eye protection/face shield.	
1.	• **If no anteroom is available, exit out of room to doff all PPE. If anteroom is available doff gloves and gown in room.** • **Ensure that the doffing area contains a non-touch waste bin, hand sanitizer, and a receptacle for contaminated eye protection and reusable face shields.**	
2.	• **Remove and discard gloves (pull off slowly and do not snap).** • **Dispose of gloves in waste bin next to door.**	
3.	**Remove Gown:** **a. Release the tie; then, grasp the gown at the hip area, and pull the gown down and away from the sides of your body.** **b. Once the gown is off your shoulders, pull one arm at a time from the sleeves of the gown so that the gown arms are bunched at your wrists.** **c. Remove gown from wrists.** **c. Roll the exposed side of the gown inward until it's a tight ball.** **d. Dispose of the gown in waste bin next to door.**	
5.	• **Immediately perform hand hygiene.**	
6.	**Based on type of eye protection:** **a. Remove safety glasses/goggles.** • **Carefully grasp edges only, without touching skin or eye.** • **Place in container designated for contaminated glasses or goggles to be cleaned and disinfected.** **b. Remove face shield.** • **Tilt your head forward slightly, grab the back strap with one hand, close eyes and pull it up and over head. (*Do not touch front of face shield.)*** • **Dispose of the face shield OR** • **Place in container designated for contaminated face shields to be cleaned and disinfected.**	
	PPE DOFFING SKILLS TESTING SHEET, Page 1 of 2	

7.	**Remove surgical mask or N95 respirator. (*Surgical mask may have eye shield.*)** ➔ *It is important that you not touch the front of the mask!* **a. Tilt your head forward slightly.** **b. Use two hands to grab the bottom strap; close eyes; pull out and over the head.** **c. Next, use both hands; grab the upper strap; close eyes; pull out and over the head.** **d. Keep tension on upper strap as you remove it, which will let the mask fall forward.** **e. Dispose of the mask or N-95, *OR* place it into labeled container (paper bag labeled with person's name) to be reused.**	
8.	**Perform hand hygiene at sink or use hand sanitizer.**	

Doffing PPE Skills (circle one): **PASS** **FAIL**

Instructor Signature: _____

Instructor Printed Name: _____

PPE DOFFING SKILLS TESTING SHEET, Page 2 of 2

APPENDIX J. ABBOTT ID NOW COMPETENCY AND PERFORMANCE ASSESSMENT

Abbott ID NOW™ Competency and Performance Assessment (PAGE 1)

SKILLS TESTING SHEET

STUDENT NAME: _____ **DATE:** _____

Skill Step	Critical Performance Criteria	✓ if done correctly
	Trainer should review all material listed below and verify that the trainee has read and understands the appropriate procedures or manufacturer instructions involved.	
1.	Trainee reads and understands procedure.	
2.	Trainer discusses principle of test procedure so that trainee understands scope and purpose of the test.	
3.	Trainer identifies the materials needed to perform test, and trainee knows location of these materials.	
4.	Trainee observes proper sample collection and handling.	
5.	Trainee observes test procedure being performed by trainer.	
6.	Trainee performs the procedure and should be able to: a. Identify proper sample type, use of the appropriate collection device, labeling, and handling of samples. b. Organize work area for testing. c. Perform quality control (QC) samples and training panel prior to performing patient samples. d. Set up timer and follow incubation times per the procedure. e. Interpret the results: • Positive • Negative • Invalid f. Decontaminate and clean work area, including proper disposal of hazardous waste and sharps.	
7.	Data entry/computer: a. Test order and accessioning. b. QC and interpretation of results. c. Report results and log QC data.	

Trainee Comments: _____

Trainee Signature: _____

Trainer Comments: _____

Trainer Signature: _____

Abbott ID NOW™ Competency and Performance Assessment (PAGE 2)

INSTRUCTIONS FOR TRAINER

PURPOSE:

The ability of each person to perform their duties should be assessed following training, and periodically thereafter. Retraining and reassessment of employee performance needs to be done when problems are identified with employee performance. The training and assessment program should be documented and specific for each job description. Activities requiring judgment or interpretive skills need to be included in the assessment.

INSTRUCTIONS FOR COMPLETING THE PERFORMANCE ASSESSMENT:

1. Record the facility name and location.
2. Record the employee's name and the procedure being observed.
3. Have the employee perform the procedure.
4. Record whether the steps completed were satisfactory or unsatisfactory, note any comments, and document any corrective action needed.
5. Sign and date the form.
6. Have the employee sign and date the form and provide comments.
7. Complete forms should be filed with the staff member's credentialing and training documents

Adapted from:
https://www.cdc.gov/labquality/docs/waived-tests/15_255581-test-or-not-test-booklet.pdf

APPENDIX K. ABBOTT ID NOW TRAINING LOG

Abbott ID NOW™ Certification of Training

Check all that apply: ☐ FLU A/B 2 ☐ Strep A 2 ☐ RSV ☐ COVID-19

The following personnel are responsible for running the ID NOW at _____ and have been thoroughly in-serviced on the test and test procedure.

Training has included:

- Review of the package insert.
- Demonstration of the product assay.
- Successful performance of the ID NOW assays and interpretation of results.
- Completion of **APPENDIX J.** Abbott ID Now Competency and Performance Assessment

Names of the personnel who have trained with the ID NOW and are responsible for reporting patient results are listed below:

Staff Person's Name (printed)	Staff Person's Signature	Date of Signature

Signature of Supervisor responsible for personnel and testing:

_____ _____

Signature *Date of Signature*

APPENDIX L. SAMPLE INCIDENT REPORT NARRATIVE FOR INMATES REFUSING COVID-19 TESTING

On _____(date), _____(inmate's name) , Reg. No. _____(number), refused a direct order to submit to testing for the COVID-19 virus as part of the testing initiative to prevent the transmission of a life-threatening disease to other staff and inmates. The Bureau tests an inmate for an infectious or communicable disease when the test is necessary to verify transmission following exposure to bloodborne pathogens or to infectious body fluid. An inmate who refuses diagnostic testing is subject to an incident report for refusing to obey an order (Program Statement 6190.04).

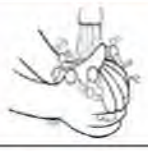
APPENDIX M. RESPIRATORY INFECTION MEDICAL ISOLATION ROOM SIGN

On the following page is a printable ***Respiratory Medical Isolation Precautions*** sign for posting on the doors of **MEDICAL ISOLATION UNITS**.

Respiratory/ Eye Medical Isolation Precautions

PRECAUCIONES de aislameiento médico

ANYONE ENTERING THIS ROOM SHOULD USE:
todas las peronas que entren e esta habitacion tienen que:

	**HAND HYGIENE** ***Hygiene De Las Manos***
	**N95 RESPIRATOR (fit-tested)** ***Respirador N95***
	**GOWN** ***Bata***
	**EYE PROTECTION** ***Protección para los ojos si contacto cercano***
	**GLOVES** ***Guantes***
	**PATIENT WEARS CLOTH FACE COVERING WHEN OTHERS ENTER ROOM AND DURING MOVEMENT.** ***Lleva cubierta de tela para la cara.***
	**KEEP DOOR CLOSED AT ALL TIMES!** ***Mantenga la puerta cerrada en todo momento***

APPENDIX N. QUARANTINE ROOM SIGN

On the following page is a ***Respiratory Infection Quarantine Precautions*** sign for posting on the doors of housing units being used for **QUARANTINE**.

Respiratory/ Eye Quarantine Precautions

PRECAUCIONES de Sala de Cuarentena

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infecciones,

todas las peronas que entren e esta habitacion tienen que:

HAND HYGIENE

Hygiene De Las Manos

SURGICAL MASK

PATIENT WEARS CLOTH FACE COVERING WHEN OTHERS ENTER ROOM AND DURING MOVEMENT.

Lleva cubierta de tela para la cara.

GLOVES

Guantes

GOWN FOR CLOSE CONTACT

Bata

EYE PROTECTION

Protección para los ojos

APPENDIX O. MEDICAL ISOLATION CHECKLIST

MEDICAL ISOLATION CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
MOVE TO MEDICAL ISOLATION:	• Have the inmate wear a **FACE COVERING** en route to the designated medical isolation area. Staff escorts will wear PPE to include gloves, gown, eye protection and N95. • Movement to medical isolation should be accomplished promptly for any inmate with confirmed or suspected COVID-19 infection.
TAKE TRANSMISSION-BASED PRECAUTIONS: • **STANDARD PRECAUTIONS**; use of PPE and hand hygiene for contact, eye protection, and droplets.	Use **(1) HAND HYGIENE** (before & after gloves) and **(2) PPE** (gloves, gown, eye protection, N-95) for entry into room, direct contact, escort, or open grid units or dorms. • **PRIOR TO ENTERING ROOM:** Perform hand hygiene. Don (put on) gloves, gown, fit-tested respirator (N95), and eye protection. (*See PPE donning checklist Appendix H .)* • **EXITING ROOM WITH AN ANTEROOM:** Stay ≥ 6 feet from patient, if possible; doff (remove) and dispose of gloves & gown, and then exit the room. In the anteroom, perform hand hygiene, doff eye protection, N-95 respirator, and repeat hand hygiene. • **IF NO ANTEROOM IS AVAILABLE:** Exit room to doff all PPE in a designated doffing area (taped off area) located immediately outside of the room. (*See PPE doffing checklist Appendix I.)*
PLACE SIGNAGE	Place ***Respiratory/Eye Medical Isolation Precautions*** *sign* on the door. (See *Appendix M*.)
INMATE EDUCATION	Advise and educate the inmate regarding possible COVID-19 illness: Reportable signs and symptoms, social distancing, and wearing of face covering. Provide education sheets.
COMMUNICATION	• Report COVID-19 case(s) to facility leadership, QIIPC, public health authority, and Regional QIIPC Consultants. • If the inmate's condition deteriorates (respiratory distress) and emergent transportation to local hospital is necessary, call ahead for guidance and direction before transfer.
DOCUMENTATION	• Place the inmate on **MEDICAL HOLD** in BEMR and Sentry for the duration of the isolation. • HP code as **U07.1 COVID confirmed (test positive)** or **U07.2 COVID suspect/probable** in BEMR. • Document inmate status **DAILY** in BEMR, including any test results and changes in condition.
STAFF INTERACTION	• Limit the number of staff interactions with ill inmate(s); dedicate certain personnel, if possible. • **DIRECT CONTACT PPE** includes N95, eye protection, gloves, and gown. Inmates should wear a face covering or mask when staff enters the room or when moving around the unit.
MEDICAL ISOLATION CHECKLIST, Page 1 of 2	

MEDICAL ISOLATION CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
MEDICAL EQUIPMENT & MEDICAL CARE	• Dedicate medical equipment to the area, if possible. • Provide supportive care, with frequent assessment for shortness of breath or O2 decompensation (pulse oximetry). • Have preparations in place for transfer to hospital, if needed.
FOOD SERVICE	Use regular or disposable dishware (dispose of in regular trash).
LAUNDRY	• Standard precautions; wear gown if contact with dirty laundry is expected. • Do not shake dirty laundry. • Double-bag when taking from isolation to laundry. Wash with normal laundry, in hot water and drying at high temperatures. • Disinfect dirty carts after use.
VISITS	In-person visits will be suspended until the end of medical isolation. Consult local leadership for exceptions.
TELEPHONE CALLS	Phone should be cleaned and disinfected with disposable towel and a product from *EPA List N*.
TRASH	• Double-bag in clear waste bags and dispose of as regular trash. • Ensure that trash is **NOT** processed by recycling.
CLEANING & DISINFECTION	• Provide supplies to clean/disinfect room. Utilize disinfectant from *EPA List N*. • Ideally, cleaning is performed by the inmate, or by staff at the time of inmate care to prevent additional entry into room.
RELEASE FROM MEDICAL ISOLATION FOR ASYMPTOMATIC INMATES	Utilize a **TIME-BASED** approach for releasing inmates with asymptomatic COVD-19 from medical isolation: • Asymptomatic inmates can be released from medical isolation 10 days after the date of their first positive PCR test.
RELEASE FROM MEDICAL ISOLATION FOR SYMPTOMATIC INMATES	Utilize a **SYMPTOM-BASED** approach for releasing inmates with symptomatic COVD-19 from medical isolation: • Inmates with **MILD OR MODERATE SYMPTOMS** can be released from medical isolation 10 days after symptom onset and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. • Inmates with **SEVERE SYMPTOMS** requiring hospitalization or **SEVERELY IMMUNOCOMPROMISED** inmates can be released from medical isolation 20 days after symptom onset. A **TEST-BASED APPROACH** may also be considered with Regional Medical Director consultation.
TERMINAL CLEANING	• If possible, the isolated inmate should clean the room before leaving. • After waiting 24 hours (if possible), the isolation area should be cleaned again with an EPA List N registered disinfectant—while wearing gloves, gown, and other PPE recommended by the disinfectant manufacturer **AND** based on the condition of the room (i.e., if splashes are anticipated, wear mask and eye protection).
MEDICAL ISOLATION CHECKLIST, Page 2 of 2	

APPENDIX P. QUARANTINE CHECKLIST

QUARANTINE CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
MOVE ASYMPTOMATIC INMATES TO QUARANTINE: • **EXPOSED CONTACTS OF COVID-19 CASES** • **NEW INTAKES** • **PRE-RELEASE/PRE-TRANSFER**	• Inmates should wear a **FACE COVERING** or surgical mask while being escorted to quarantine. PPE for escort staff is noted below. • They should preferably be designated to a single room with solid door. • **IF SINGLE HOUSING IS NOT AVAILABLE, THE INMATES MAY BE COHORTED WITH THEIR RESPECTIVE GROUP** – exposed contacts, intake, or pre-release/pre-transfer. Inmates in each category of quarantine should be housed separately from inmates in other categories. • **INMATES TEST IN/TEST OUT OF ALL THREE CATEGORIES OF QUARANTINE.** The Abbott (POC) or commercial (PCR) lab tests may be used for admission to quarantine.
TAKE TRANSMISSION-BASED PRECAUTIONS: • **STANDARD PRECAUTIONS**; use of PPE and hand hygiene for contact, eye protection, and droplets.	• **HAND HYGIENE** (before and after wearing gloves). • **PPE** (gloves, eye protection, surgical mask, and gown) for staff having direct contact (including medical care, escort, or transport) or opening food trap or entering inmate room. • For **"EXPOSED" QUARANTINE** in open units, open doors, or open bars, consider use of N95 respirator. • **IF NOT ENTERING ROOM AND ≥ 6 FEET AWAY**, a gown may not be necessary. • **PRIOR TO ENTERING ROOM OR INMATE CONTACT:** Perform hand hygiene. Don (put on) gloves, gown, surgical mask, and eye protection. (*See PPE donning checklist Appendix H for specifics.)* • **EXITING ROOM WITH AN ANTEROOM:** Have inmate(s) move back to a social distance ≥ 6 feet; doff (remove) gloves & gown, and then exit the room. In the anteroom, perform hand hygiene, doff eye protection and mask, and repeat hand hygiene. • **IF NO ANTEROOM IS AVAILABLE:** Exit out of room to doff all PPE in a designated doffing area (taped off area) located immediately outside of room. **(***See doffing checklist Appendix I for specifics.)* • Used PPE is disposed of in regular trash, with a receptacle in the doffing area, as well as place for any items to be recycled.
PLACE SIGNAGE	Place an ***Respiratory/Eye Infection Quarantine Precautions*** sign on the door. (See *Appendix N*.)
INMATE EDUCATION	Advise and educate inmates to report symptoms of COVID-19 illness. Educate them to maintain social distance and wear face coverings. Provide education sheets.
COMMUNICATION AND DOCUMENTATION	• Notify facility leadership, QIIPC, HSA, psychology, and Regional QIIPC consultants of quarantine situation. • Place a **MEDICAL HOLD** in BEMR and Sentry for the duration of the quarantine. Code inmate(s) as **Z0489-Q**. • Enter testing, entry, and exit (beginning and end of quarantine) symptoms, signs, and temperature screening in BEMR. • For "exposure" quarantine, conduct symptom/temp screens at least once **DAILY** (due to the probability that some will become ill). Daily screens can be conducted by non-healthcare staff after training completion. Any **POSITIVE SYMPTOMS** are reported to healthcare staff for assessment testing and isolation.
QUARANTINE CHECKLIST, Page 1 of 2	

QUARANTINE CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
STAFF INTERACTION	• Staff assessments not requiring direct contact will be conducted with social distancing of ≥ 6 feet away. • Limit the number of staff interactions with inmates and take measures to reduce the number of staff interacting with quarantined inmates. Dedicate personnel to the unit, if possible.
MEDICAL EQUIPMENT	• Dedicate medical equipment to the unit, if possible. • Clean and disinfect after/between use.
MEDICAL CARE IF INMATES BECOME SYMPTOMATIC	• **MEDICALLY ISOLATE INMATES PROMPTLY** if they become symptomatic (cough, SOB, HA, dizziness, fatigue, loss of taste or smell, sore throat, N&V, chest pain) and/or an oral temperature ≥ 100.4 F (equivalent temps are 101°F for tympanic/ear and 100°F for forehead/non-contact). • Positive symptoms require assessment, clinical encounter, testing, and move to isolation. Limit close or direct contact. Provide necessary medical care as needed.
FOOD SERVICE	• Use regular trays or disposable dishware.
LAUNDRY	• Wear gloves. • Regular central laundry processes are acceptable. • Do not shake dirty laundry. • Disinfect dirty carts after use.
VISITS	In-person visits will be suspended until the end of quarantine. Consult local leadership for exceptions.
TELEPHONE CALLS	Phone is cleaned and disinfected after each use with registered disinfectant from *EPA List N*.
TRASH	• Wear **GLOVES** and **DOUBLE-BAG** in clear waste bags; • Ensure that trash is **NOT** processed by recycling.
CLEANING/DISINFECTION	• Provide supplies to inmate to clean and disinfect the room. • Use disinfectant from *EPA List N*.
DISCONTINUATION OF QUARANTINE	• Duration of quarantine is 14 days. • If at all possible, **DO NOT ADD INDIVIDUALS TO AN EXISTING QUARANTINE** after the 14-day quarantine clock has started. If new inmates are added into a quarantine cohort or anyone in the cohort becomes positive, the clock starts back at zero. • **PRIOR TO RELEASE FROM QUARANTINE, ASYMPTOMATIC INMATES SHOULD UNDERGO COVID-19 TESTING AND TEST NEGATIVE.** • A commercial **PCR** test should be performed for inmates releasing to the general population and for releases or transfers. • Abbott **POC** tests may be used for immediate releases and for transfers to other BOP facilities when commercial lab turnaround times are more than 7 days.
TERMINAL CLEANING	• Inmates should clean the area at end of quarantine, if possible. • If inmates in quarantine became **SYMPTOMATIC**, wait 24 hours (if possible), and then clean and disinfect with an *EPA List N* registered disinfectant with PPE recommended by the disinfectant manufacturer (i.e., gloves, gown, and if splashes are anticipated, wear mask and eye protection).
QUARANTINE CHECKLIST, Page 2 of 2	

APPENDIX Q. COVID-19 CODING CLINICAL REFERENCE GUIDE

CURRENT CODE	DESCRIPTION	WHEN TO USE
J1282	Pneumonia due to coronavirus disease 2019	For a patient with pneumonia confirmed as due to COVID-19. Also add U071 to the health problem list.
J208	Acute bronchitis due to other specified organisms	For a patient with acute bronchitis confirmed as due to COVID-19. Also add U071 to the health problem list.
J22	Unspecified acute lower respiratory infection	For a patient with lower respiratory infection not otherwise specified or an acute respiratory infection associated with COVID-19. Also add U071 to the health problem list.
J40	Bronchitis, not specified as acute or chronic	For a patient with bronchitis not otherwise specified due to COVID-19. Also add U071 to the health problem list.
J80	Acute respiratory distress syndrome	For a patient with acute respiratory distress syndrome (ARDS) due to COVID-19. Also add U071 to the health problem list.
J960	Acute respiratory failure	For a patient with acute respiratory failure due to COVID-19. Also add U071 to the health problem list.
J988	Other specified respiratory disorders	For a patient with a respiratory infection not otherwise specified associated with COVID-19. Also add U071 to the health problem list.
M3581	Multisystem inflammatory syndrome	For individuals with multisystem inflammatory syndrome (MIS) and COVID-19. Also add U071 to the health problem list.
M3589	Other specified systemic involvement of connective tissue	For individuals with other specified systemic involvement of connective tissue and COVID-19. Also add U071 to the health problem list.
R05	Cough	For patients presenting with a cough and suspected COVID-19 but a definitive COVID-19 diagnosis was not been established. Also add Z20822 to the health problem list.
R0602	Shortness of breath	For patients presenting with shortness of breath and suspected COVID-19 but a definitive COVID-19 diagnosis was not established. Also add Z20822 to the health problem list.
R509	Fever	For patients presenting with fever and suspected COVID-19 but a definitive COVID-19 diagnosis was not established. Also add Z20822 to the health problem list.
Page 1 of 2		

CURRENT CODE	DESCRIPTION	WHEN TO USE
U07.1	COVID-19	Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID- 19 test result. Do not use U071 for suspected, possible, probable, or inconclusive COVID-19 (see Z0489-c19).
Z03818-c19	Coronavirus COVID-19 Test Negative/ Virus Ruled Out	Negative test on file.
Z0489-q	Quarantine - Asymptomatic person in Quarantine	Use when placing new intakes into Quarantine Utilize for contacts of confirmed COVID-19 cases.
Z20822	Contact with and (suspected) exposure to COVID-19	For asymptomatic individuals with actual or suspected exposure to COVID-19. See also Z03818-c19.
Z8616	Personal history of COVID-19	For patients with a history of COVID-19.
(Page 2 of 2)		

Note: BOP Quality Improvement/Infection Prevention & Control Coordinators have the rights to enter, update or entry error erroneous BEMR ICD10 codes.

APPENDIX R. PRIORITIZATION OF HEALTH CARE SERVICES DURING DISRUPTIONS

NORMAL CONDITIONS	SCOPE OF SERVICES
Normal resources and demands	No change in scope of services
MILD DISRUPTION	**NEAR-NORMAL SCOPE OF SERVICES**
Disruptions: • Slightly reduced health care staffing. • Some inmates ill; few severely ill. • Community hospitalization available. • Rearranged health care staffing/roles.	**Possible adjustments include:** • Alter site of care for patients with COVID-like symptoms. • Reduce preventive health care services (continue TB screening, influenza and pneumococcal vaccination). • Maintain a chronic care clinic. Identify and monitor inmates defined by the CDC as being at risk for serious illness if infected with COVID-19. • Provide care for minor ailments, as feasible.
MODERATE DISRUPTION	**REVISED MEDICAL CARE SCOPE OF SERVICES**
Disruptions: • Health care staffing somewhat reduced. • Some shortages of supplies/medication. • Limited laboratory capability. • Many inmates ill; some severely ill.	**Possible adjustments include:** • Prioritize delivery of chronic care. • Minimize patients on directly observed therapy consistent with guidance from the medical director. • Postpone most preventive health care except TB screening and vaccinations for influenza and pneumonia. • Focus on key life-saving care. • Send severely ill to the hospital. • Postpone care for low priority health problems.
SEVERE DISRUPTION	**TOTAL SYSTEM / SCOPE OF SERVICES ALTERATION**
Disruptions: • Health care staffing significantly reduced. • Significant shortages of supplies/medications. • No laboratory capability; no chest radiography. • Numerous inmates ill; many severely ill. • No community hospitalization available.	**Possible adjustments include:** • Focus on key live-saving care. • Cohort sickest inmates; provide palliative care. • Deliver care in accordance with priorities established by the BOP Medical Director and in consultation with the Regional Medical Director.

APPENDIX S. TRIAGE OF MEDICAL AND MENTAL HEALTH CONDITIONS DURING DISRUPTIONS

TABLE 1. Examples of Conditions to be Seen for Same-Day Emergency/Urgent Care Visit

MEDICAL

- Acute chest pain
- Acute abdomen: Severe, rebound tenderness, absent bowel sounds, or localized to RLQ
- Unstable diabetes (BS<60, or >350 and symptomatic)
- Asthma/significant dyspnea
- Acute ophthalmology disturbance (foreign body sensation, a sudden change in vision)
- Hemoptysis or night sweats
- Seizure/syncope
- Stroke/TIA symptoms
- 2nd/3rd-degree burns
- High temp (>101), sepsis
- Acute musculoskeletal injuries (limb immobility, open fracture; any injury requiring completion of an injury assessment form)
- Severe acute headache
- Hematemesis
- Melena or hematochezia (acute of unknown origin)
- Severe hypertension (SBP >170, DBP>110, or symptomatic)
- Intractable nausea/vomiting/diarrhea.
- Development of gangrene/open diabetic ulcer/ significant cellulitis, and open draining wounds
- Eye injuries: Foreign object (penetrating and non-penetrating), corneal abrasion, blurred vision, pain
- Testicular pain (r/o torsion)
- Acute uterine bleeding (Hct drops 6% within 4 hrs.)
- New onset peripheral edema or orthopnea
- Male inmates with UTIs
- Rash: Any intensely pruritic or vesicular rash; a rash consistent with scabies, varicella, small pox, herpes zoster, or otherwise unexplained
- New onset of incapacitating pain
- Altered mental status
- HIV+ inmate with fever, headache, mental status and/or changes of loss of vision

MENTAL HEALTH

- Thoughts of self-harm
- Thoughts of harm towards others
- New onset hallucinations
- New onset delusions
- New onset anxiety attacks
- Manic symptoms
- Severe depression
- Drug or alcohol withdrawal
- New onset severe medication side effects

TABLE 2. Examples of Conditions to be Seen Within 24–48 Hours	
MEDICAL	
• Asthma, no acute distress • Acute infections w/symptoms (fever, cough) • Earache, suspected infection	• Medication renewals for chronic conditions such as angina, diabetes, HTN, TB, psychotropics
MENTAL HEALTH	
• Moderate depression • Hypomania • Recurrence of anxiety symptoms/attacks	• Chronic psychotic symptoms • New, mild-to-moderate medication side effects

TABLE 3. Conditions Requiring Evaluation Within 72 Hours	
MEDICAL	
• Cough • Sore throat/URI without temp • Constipation (unrelieved by OTC meds)	• Headache – Chronic • Skin rash with s/s of itch, pain, spreading
MENTAL HEALTH	
• Mild depression • Chronic anxiety under treatment	

TABLE 4. Conditions Requiring Evaluation Within One Week	
MEDICAL	
• Tuberculosis prophylaxis/evaluation/clearance • Chronic rash, blisters, calluses, corns, jock itch, athlete's foot • Hemorrhoids • Gastritis (without nausea/vomiting/diarrhea)	• Eye problems other than described in above tables • All other medication refills • Convalescence and or Duty Status inquiries
MENTAL HEALTH	
• Chronic medication side effects	

TABLE 5. Conditions Requiring Evaluation Within Two Weeks
MEDICAL
• Musculoskeletal pain, chronic, no recent injury • Back pain, chronic • Allergies, chronic

(TRIAGE OF MEDICAL AND MENTAL HEALTH CONDITIONS DURING DISRUPTIONS, page 2 of 2)

APPENDIX T. CPAP or BiPAP in USE Signage

On the next page is a printable sign to be placed on the door of a room where a CPAP or BiPAP is in use.

Respiratory Precautions

Airborne/Contact/Eye Protection

CPAP or BiPAP IN USE

PRECAUCIONES de Sala de Cuarentena

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infección, cualquiera que entre e esta habitación debe utilizar:

	**HAND HYGIENE** ***Hygiene De Las Manos***
	**N-95 RESPIRATOR (Fit-Tested)** ***Respirador N-95***
	**GOWN** ***Bata***
	**Eye Protection** ***Protección para los ojos si contacto cercano***
	**Gloves** ***Guantes***
	**Door to this room remains closed <u>when CPAP or BiPAP is in use</u>.** ***La puerta de esta habitación permanence cerrada <u>cuando se usa CPAP o BiPAP</u>.***

APPENDIX U. SWITCHING TO A NON-VENTED FULL-FACE MASK FOR CPAP OR BIPAP

In patients with severe sleep apnea with co-morbidities such as morbid obesity, pulmonary hypertension, cardiomyopathy, etc., even the temporary discontinuation of BiPAP or CPAP may constitute a higher risk. When the decision is made to allow the patient to continue using CPAP/BiPAP, the machine must be set up and used with a full-face, non-vented CPAP mask with an in-line viral filter attached to the intake and exhalation ports. The viral filters should be changed daily. See the diagram on the next page for setup.

→ *See MODULE 7 for more information about aerosol generating procedures (AGPs).*

SWITCHING TO A NON-VENTED FULL-FACE MASK FOR CPAP AND BIPAP

(ResMed Non-vented full-face mask – Small #61739, Med #61740, Lge #61741)

Covers mouth & nose. Has no holes in the mask or elbow attachment on the mask:

1. From the elbow on the mask, attach a **SWIVEL CONNECTOR** (Respironics #7041):

2. From there, attach a **VIRAL FILTER** (Airlife #001851):

3. From the viral filter, attach an **EXHALATION PORT** (Respironics #312149):

4. The remainder of the CPAP is unchanged!

APPENDIX V. COVID-19 SCREENING TOOL FOR STAFF, CONTRACTORS, AND VISITORS

CORONAVIRUS DISEASE 2019 (COVID-19) ENHANCED SCREENING TOOL STAFF/CONTRACTORS/VISITORS

DATE: _____

1. TEMPERATURE: _____ °F **METHOD:** ☐ MOUTH ☐ EAR ☐ FOREHEAD	
☐ **If temperature is: (mouth) ≥ 100.4°F OR (ear) ≥101°F OR (forehead) ≥ 100°F** **Then deny access, place on Leave (NOT Safety and Weather leave) for 1 day.** ***Proceed to Section 3 below.***	
2A. OTHER SYMPTOMS (completed by employee, contractor or visitor)	
☐ Yes ☐ No	**New-Onset Cough** # of days: ____
☐ Yes ☐ No	**New-Onset Trouble Speaking/Difficulty Breathing**
☐ Yes ☐ No	**Fatigue**
☐ Yes ☐ No	**Muscle or Body Aches**
☐ Yes ☐ No	**Sore Throat**
☐ Yes ☐ No	**New Loss of Taste or Smell**
☐ Yes ☐ No	**Stuffy/Runny Nose**
☐ Yes ☐ No	**Nausea or Vomiting**
☐ Yes ☐ No	**Diarrhea**
2B. COVID-19 VACCINE (completed by employee, contractor or visitor)	
☐ Yes ☐ No	**Received COVID-19 Vaccine in the past 72 hours**
☐ Contact the Medical Officer on call for the institution to provide disposition: Disposition by Medical Officer after assessing symptoms: ☐ Leave ☐ Work If staff is being sent home, give them a copy of this document and a copy of *Memo for the Local Health Department/Personal Healthcare Provider* for them to take to the local health department or their personal healthcare provider for COVID-19 testing.	
3. NOTIFICATION OF LOCAL HUMAN RESOURCES DEPARTMENT	
☐ If Individual is placed on leave for Section 1 or 2, share document with HR Office for T&A purpose. ☐ **HR OFFICE:** Please have HSD place this document in the Employee's Medical Folder (Blue Folder) if leave is indicated.	
Staff Name (Last, First): _____ **Year of Birth:** _____ **Institution:** _____ **State:** _____	

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APPENDIX W. CRITICAL INFRASTRUCTURE MEMO TO LOCAL DOH FOR EMPLOYEE TESTING

U.S. Department of Justice

Federal Bureau of Prisons

Washington, D.C. 20534

DATE: _____

MEMORANDUM FOR HEALTH DEPARTMENT

FROM: (b)(6); (b)(7)(C) MD, MPH, FACOEM
Chief Occupational Safety & Health Branch
Health Services Division

SUBJECT: Staff identified as close contact of COVID-19 positive individual

Please note that _____ is an employee of the Federal Bureau of Prisons and as such works in a Critical Infrastructure Industry as defined by the Department of Homeland Security. Our employees have a special responsibility to maintain a normal work schedule as they are critical in maintaining safety within the Federal Bureau of Prisons and the community, and are unable to quarantine for 14 days.

This individual may have close contact with a confirmed or suspected COVID-19 case, as defined by the Center for Disease Control and Prevention (CDC)* and will require testing.

This necessary priority testing is critical in preventing further transmission within the prison and also in the community.

Therefore, we appreciate your cooperation with this request in considering this employee for **priority COVID-19 testing**.

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

APPENDIX X. COVID-19 MEDICAL CONDITIONS SELF-REPORTING TOOL

COVID-19 Medical Condition Self-Reporting Tool

Last Name: _____ **First Name:** _____

BOP ID#: BOP_____

Job Title: _____

___ Civil Service

___ PHS Officer

Department: _____

Dept. Contact Phone #: _____

Institution: _____

Human Resources Manager Name: _____

Diagnosis/Diagnoses (Please list all that should be considered):

_____

_____

I certify that this information is true and complete to the best of my knowledge.

Print Name: _____ Signature: _____

Date: _____

Staff who are self-reporting as high risk, and requesting modification to their work during the COVID-19 pandemic, must complete and submit this ***COVID-19 Medical Condition Self-Reporting Tool*** to their designated HR POC or send it directly to the Employee Health mailbox at BOP-HSD-EmployeeHealth-S@bop.gov. The subject line of the email should be "High risk staff declaration form- [Last name, First name]"

APPENDIX Y. COVID-19 MEDICAL ISOLATION INFIRMARY GUIDANCE

Under certain circumstances, establishment of an onsite infirmary at an institution may be necessary. Considerations include the number of symptomatic patients, institution resources and local healthcare resources. The decision to stand up an infirmary should be made in consultation between the institution and regional and central office leadership.

1. GENERAL GUIDELINES FOR INFIRMARY SET-UP

- **PATIENT CRITERIA FOR ADMISSION TO THE MEDICAL ISOLATION INFIRMARY**
  - Criteria for admission to and discharge from the infirmary should be reviewed in consultation with the Clinical Director.
  - Admission to and discharge from the infirmary will occur only on the order of a physician or designated authorized health professional.
  - Follow guidance in **MODULE 4** for medical isolation guidance.
  - Eligible patients include the following:
    - COVID-19 patients (positive, probable, or suspected) with mild to moderate symptoms.
    - COVID-19 patients who are hemodynamically stable with mild to moderate symptoms and requiring 2–3 liters of oxygen per nasal cannula to maintain O2 saturation above 90%.
    - COVID-19 patients post-hospitalization who are still being treated as positive and are hemodynamically stable, requiring continued medical observations or treatment (e.g., IV antibiotics, oxygen, etc.).
      - *Patients returning from the hospital who have completed treatment for COVID-19 infection, and have met CDC criteria for release from isolation, should* ***NOT*** *be placed in the isolation infirmary.*

- **STAFFING PATTERN**
  - The team may consist of six members, including one Medical Officer, one Advanced Practice Provider (APP), and four Registered Nurses (RN) per 5–10 bed infirmary—based on the patients' medical acuity. Infirmary bed estimates generally range from 0.5 to 1 percent of the population (i.e., 5 to 10 medical infirmary beds per 1,000 inmates).
  - A Medical Officer should be on call 24 hours per day for the infirmary.
  - A Medical Officer should evaluate patients daily, as required by the severity of their illnesses.
  - At least two RNs should be on each shift. This allows for continuous coverage of the unit in case one RN has to step off the unit for any reason, as well as allowing the RNs to watch out for breaks in each other's PPE.
  - There should be health care personnel on duty 24 hours per day, seven days per week, who make rounds a minimum of once per shift—and more often, as required by patients' needs and physicians' orders. A health care provider is to remain in the infirmary at all times.
  - Patients should always be within sight or hearing of a health care staff member (e.g., call lights, buzzer system).

- **LOCATION OF THE MEDICAL ISOLATION INFIRMARY**
  - Each institution varies, and coordination with the local executive staff will be necessary to determine a suitable location.
  - The location of the medical isolation infirmary unit can be co-located within the medical isolation unit.
  - The institutional pandemic plan, in consultation with facility's personnel, will identify a location. In addition to structures in place at the institution, the institution may also consider utilizing large temporary structures like tents.
    - Consider utilizing a location large enough to house the patients and their necessary belongings. Approximately 72 square feet (12' L x 6' W) should be allowed for each patient, to ensure that there is at least six feet between patients' beds, and safe walkways of at least three feet between the head and foot of the bed.
    - Ensure that there is at least a six-foot wide egress aisle for safe evacuation of the unit if necessary.
  - Housing Units can be utilized for Infirmary Medical Isolation in order of precedence, as determined by the CDC guidance provided in **MODULE 4**.
  - Ideally, the location will have a sink with running water, soap, and paper towels. If this is not feasible, ensure adequate alcohol-based hand sanitizer is available.
  - Ideally, the locations should have separate entrance and exit locations.
    - The entrance/exit locations require space for donning and doffing of PPE, as well as a means of performing hand hygiene.
    - Proper donning of appropriate PPE will be completed prior to entering the unit.
    - Proper doffing of PPE will be completed upon exiting the unit.
    - Refer to **MODULE 2** for additional guidance on PPE.
  - Access to toilets and shower facilities for patients, and toileting facilities for staff.
  - If space is utilized that does not have emergency lighting, portable emergency lighting will be needed.

- **NECESSARY SUPPLIES**
  - *The list below is in addition to the Suggested Infirmary Supply and Equipment List identified* below
  - Signage as recommended in the various **MODULES**.
  - In accordance with fire and safety codes, a mechanism to separate patients in the absence of walls when privacy is necessary: Foldable panels, privacy screens, a sheet draped between the beds, etc.
  - Stocked hand hygiene station(s): Running water, soap, paper towels, and/or alcohol-based hand sanitizer, as outlined in **MODULE 1**.
  - PPE: Sufficient supply of gowns, gloves, N95 masks, goggles, and face shields in multiple sizes, as outlined in **MODULE 2**.
  - Dedicated computer terminal(s) for health care providers to document and review information on the patients.

- Telephone:
  - If secure: A regular phone with dial-out access to outside of the institution should be utilized.
  - If unable to make secure: The telephone will ring directly to Control, like the suicide watch phone. This phone would be available for staff working in the unit to receive phone calls, while still preventing inmates from using the phone to make outside calls.
- Cleaning supplies as outlined in **MODULE 1**.
- Mechanisms to properly secure the following items on the unit:
  - Needles, sharps, syringes – behind two locks.
  - Medication – behind at least one lock (excludes controlled substances).
- Dedicated non-critical medical equipment: Vital signs machine, stethoscope, non-touch and oral thermometers, pulse oximetry device, blood glucose meter, etc. These will need to be disinfected appropriately between patients, following the manufacturer's recommendations, if supplies do not allow for one device per patient.

- Cleaning and disinfecting of the unit completed in accordance with the guidance in **MODULES 1 AND 4**.

2. DOCUMENTATION

- Documentation should occur in BEMR.
  - Health Services should work with the local computer services and facilities to provide additional computer terminals where needed.
  - Cleaning and disinfection of computer equipment located in a medical isolation infirmary should be accomplished frequently in accordance with the manufacturer's recommendations.
  - Paper documentation has the following drawbacks:
    - Creates gaps in the patient record and prohibits the capture of data needed for the COVID-19 reporting requirements.
    - Leads to potential medical/medication errors.
    - Creates a vehicle for transmission of the COVID-19 virus (minimal paper should be used because it cannot be easily disinfected).
- In addition to documentation required for Medical Isolation (refer to **MODULE 4**), documentation in BEMR should include infirmary admission and discharge notes, along with daily clinical encounter notes

3. PHARMACY:

- Stock of individually bottled over-the-counter items to treat symptoms. A provider with prescribing authority will need to document an order for the patient to receive these items; nurses and paramedics may utilize approved protocols.
  - Examples include, but are not limited to:
    - Acetaminophen
    - Ibuprofen
    - Cough medicine
  - The Clinical Director can modify this list to meet the needs of the patient population.

4. Suggested Infirmary Supply and Equipment List

Intravenous Delivery			
Item	**Need**	**Item**	**Need**
IV starter kits		IV poles	10
Transparent dressings (i.e., Tegaderm, Opsite)		IV fluids (NS, 1/2NS, LR, 1/2NS, or NS with 5% Dextrose)	
Clear and paper tape		IV tubing sets and extension	
IV catheters (16, 18, and 20 gauge)		Alcohol wipes	
3 cc syringes			
Oxygen Delivery			
Item	**Need**	**Item**	**Need**
O2 tanks with roller stand holder		Bag valve mask	
Oxygen concentrator Christmas trees		Non-rebreather mask	
Oxygen cylinder key		Nasal cannula	
O2 concentrators		Simple face mask	
Portable suction machine		Albuterol multi-dose inhalers (nebulizers are not recommended)	
Yankauer suction set – tubing & canister			
Miscellaneous			
Item	**Need**	**Item**	**Need**
PPE (gowns, gloves, eye protection, masks)		Vital signs monitors	10
Cots, pillows, and blankets		Thermometers (oral and touch free)	
Tall large trash cans	5	Probe covers for oral thermometer	
Influenza testing supplies or kits		Portable Pulse Ox machines	
COVID-19 testing supplies or kits		Patient scale	1
EPA registered disinfectant wipes		Glucometer w/ testing supplies	
EPA registered disinfectant solution		Stethoscopes	
Hand wash stations		Oral fluid supplement (ORS, Gatorade)	
Hand sanitizer		Bed wedges	
Automated external defibrillator (AED)	1	Stretcher, backboard, and wheel chair	
Portable cart for nurse to provide care at bedside or cell to cell		Refrigerator or cooler (to hold potential samples)	

(COVID-19 Medical Isolation Infirmary Guidance, page 4 of 4)

APPENDIX Z. COVID-19 TIPS FOR OFFICIAL TRAVEL USING COMMERCIAL VENDORS

To reduce the risk of infection among the traveling workforce, limit close contact with others by maintaining a distance of at least 6 feet while at work and in public, when possible.

- **Don't** come to work if you are sick. Please notify your supervisor and stay home, except to get medical care. Discuss your work situation with supervisor before returning to work.

- Afterhours: Stay in your hotel room to the extent possible. Eat in your hotel room with either room service or delivery service. If in-room food delivery options is not available, get take-out from the hotel restaurant or another restaurant nearby.
    - Limit activities in public to essential errands, such as getting food.

- Wash your hands often with soap and water for at least 20 seconds. Use hand sanitizer with at least 60% alcohol if soap and water aren't available.

  Key times to wash your hands include:
    - Before preparing and serving food and beverages
    - Before eating food
    - Before and after work breaks and shifts
    - After touching frequently touched surfaces
    - After removing gloves or other personal protective equipment (PPE)

- Avoid touching your eyes, nose, and mouth with unwashed hands.

- Cover your mouth and nose with a tissue when you cough or sneeze, or use the inside of your elbow. Throw used tissues in the trash and immediately wash hands with soap and water for at least 20 seconds or use hand sanitizer containing at least 60% alcohol.

- You must wear a face covering while around other people, especially in situations where you cannot maintain proper social distancing (6ft.) from others.

Monitor your health and practice social distancing outside of work. Further COVID-19 Guidance for all staff can be located on the Agency's COVID-19 Sallyport Page.

If you get sick with fever, cough, or trouble breathing during travel, stop working immediately, put on a mask, notify your supervisor, and separate yourself from others to the extent possible while you seek medical attention as appropriate.

These recommendations are derived from the Centers for Disease Control guidance document at the following link: *https://www.cdc.gov/coronavirus/2019-ncov/travelers/airline-toolkit.html*

APPENDIX AA. STAFF AND INMATE COVID-19 CONTACT INVESTIGATION AND TRACING WORKSHEET

Definitions:

- **Common COVID-19 symptoms:** Fever, cough, shortness of breath, headache, sore throat, general feeling of being unwell (myalgia or fatigue), diarrhea or nausea, and acute onset loss of taste or smell.
- **Infectious period:** Person is contagious at onset of symptoms and possibly two days prior to symptom onset (e.g., if symptoms began on Sunday, ask about activities starting on Friday).
- **Asymptomatic infection:** When a person may be contagious but has no symptoms.
- **Incubation period:** The time from exposure to illness onset. The average incubation period may be 3-5 days (range 2-14 days).
- **Treatment:** There is no specific treatment for COVID-19 at this time.
- **Exposed to SARS-CoV-2:** In general, a person needs to be in close contact with a sick person to get infected. Close contact includes:
  - Living in the same household or room and sharing close space (bathroom) with a person with COVID-19
  - Caring for a sick person with COVID-19
  - Being within 6 feet (about two arms-length) of a person with COVID-19 for about 15 minutes, OR
  - Being in direct contact with secretions from a sick person with COVID-19 (e.g., being coughed on, sharing cups or utensils, sharing personal items, kissing, etc.)

Points to Consider:

- This tool, which can be used for staff or inmates, assists to guide contact tracing at the institution level. The goal of interviewing the index case and contacts of the index case is to establish the infectious period and identify other potentially exposed persons.
- It is critically important that time be spent establishing trust with persons before conducting an interview and making sure that the person understands the purpose of the contact investigation. For languages other than English, utilize an interpreter, if needed.
- The questions below should be used to guide the contact investigation interview. Depending on the person's responses, additional questions may be asked as follow-up on their answers. If a question is not applicable, note N/A.
  - Inmates: If inmate is unavailable for an interview (i.e., they are in the hospital), information can be obtained from cellmates, job supervisors, unit officers or teams, etc.
  - Staff: If staff is unavailable for an interview, information can be obtained from human resources, department heads or Admin LT, etc.

    DO NOT file interview documentation in the inmate's medical record or staff record.

→ *Refer to **Module 5. Surveillance** for additional information related to contract tracing and the CDC https://www.cdc.gov/coronavirus/2019-ncov/php/principles-contact-tracing.html for additional information regarding contact tracing*

Contact Tracing Worksheet

Inmate Name:_____ **Registration #:**_____ **Facility Intake Date:**_____

Staff Name: _____**DEPT:**_____**FACILITY:**_____

Interviewer Name: _____ **Interview Date:** _____

1. Review the COVID-19 diagnosis with the person:

☐ Assess the person's knowledge of the condition

☐ Describe COVID-19, how it is diagnosed and treated, and the treatment plan

☐ Describe how COVID-19 is transmitted (droplet)

☐ Discuss the need to identify potentially exposed contacts

☐ Describe how a close contact is defined

2. Obtain COVID-19 vaccination history

3. Have you received a COVID-19 vaccine? ☐ YES ☐ NO

If YES, when and what manufacturer?

_____

4. Obtain infection history:

a. Have you had any close contact with a person with a confirmed or probable diagnosis of COVID-19 in the last 2 weeks? ☐ YES ☐ NO

If YES, where and when?

_____

b. Have you had a positive COVID-19 test result? ☐ YES ☐ NO

If YES, where and when?

_____

c. Have you been diagnosed with COVID-19? ☐ YES ☐ NO

If YES, where and when?

_____

(continued on next page)

5. Ask about medical history *(INMATES only).* What other medical conditions do you have?

6. Ask about a history of COVID-19 symptoms.

YES	NO	Have you had any of the following symptoms in the **last two weeks**?	If YES, how long have you had them? When did they start?
		Cough	
		Fever or subjective fever (felt feverish)	
		Shortness of breath	
		Chills	
		Muscle aches	
		Lethargy or fatigue	
		Headache	
		Nasal congestion	
		Chest pain or tightness	
		Sore throat	
		Loss of taste or smell	
		Nausea	
		Vomiting	
		Diarrhea (>3 loose stools in 24 hours)	
		Abdominal pain	
Date of symptom onset:			

7. Ask about the risk factors.

YES	NO	Please answer the following questions	When and Where?
		Are you living/quarantined with someone diagnosed with COVID-19 in the last two weeks?	
		Have you had contact with someone diagnosed with COVID-19 (i.e., > 15 minutes cumulative time over 24 hours and within < 6 feet)?	
		Are you part of a carpool to work or use public transit?	

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8. If symptoms began prior to arrival at the facility *(INMATES only)*:

a. Where were you living?

_____

b. Who were you living with?

_____

c. How were you transferred to this facility and when (e.g., plane, bus, van)? Were you sitting at least six feet from others?

_____

d. Did you come from a non-BOP facility or were you intermingled with non-BOP inmates in transit?

_____

9. Please describe your previous day-to-day activities at your facility:

Time of Day	Daily Activities (lunch, education, training, meetings, breaks, free time)
Morning	
Mid-Day	
Afternoon	
Evening	

10. Has the above activity been your pattern during the period since___/___/___(2 days before symptom onset) or has the way you spend your time changed in any way? If changed, how and when did your pattern change? _____

_____

11. Did you spend time with any staff outside of your assigned duty post (i.e. lunch, visits, socializing, and institution gym) in the 2 days prior to illness? (*STAFF only)* ☐ YES ☐ NO

_____

(continued on next page)

12. Please tell me if you have been involved in any of the following activities, in the last two days (*INMATES only*).

YES	NO	Activity	Where?	When?	With whom?
		Watching TV?			
		Playing cards or games?			
		Religious services?			
		Recreation or sports?			
		Work?			
		Education?			
		Library?			
		Using common phones?			
		Using common computer?			
		Sharing food or drink?			
		Wear a facial covering?		How often?	
		Other:			

13. In the two days prior to symptom onset (or if asymptomatic, in the two days prior to testing), who have you sat or stood near for more than 15 minutes (this may be cumulative contact time)? (Prompt for potential activities in question 5-9) (**For STAFF:** Only close contacts who work at the institution)

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14. Are there any staff members with whom you have had close contact with? ☐ YES ☐ NO

Name of Staff	When?	Where?	Were you wearing a mask or face covering?

15. Is there any other information that might help identify anyone else you have been in contact with? Is there anyone else who you're concerned could have become infected with COVID-19 by being near you?

_____
_____
_____
_____
_____

16. Do you have any questions about COVID-19?

_____
_____
_____
_____
_____

APPENDIX AB. STAFF POSITIVE CASE FORM

Per **PS6701.01,** all employees are required to report a COVID-19 positive test through their institution human resources department to (b)(6); (b)(7)(C) In addition to completion of this form, a copy/screenshot of the laboratory results or healthcare provide statement indicating the results should also be included. The subject line for the email should include: "**COVID-19 Staff + Results – Name of Institution**"

Employee Name	
Institution	
Employee Department	
Unit(s)/Facility worked 48 hours prior to symptoms or positive test	
TDY date and institution (f applicable)	
Last day of work	
First date of symptoms (list symptoms if available)	
Test date	
Test confirmation date	
Test report date	
Was staff member vaccinated?	
Did COVID-19+ staff spend an accumulated time of more than 15 min with anyone (lunch, breaks)? If yes, provide # of staff contacts.	
Provide # of known staff positive contacts. Were staff contacts notified?	
Number of known inmate contacts	
Are any inmates quarantined and being tested as result of exposure? If yes, provide # of inmates and unit(s)	

APPENDIX AC. STANDARD EMAIL FOR NOTIFICATION OF STAFF CONTACTS

Dear _____,

If you are a **Blind Copy "BC" recipient** of this email, I am contacting you to let you know that you may be a contact to a recent COVID-19 staff case on or about [*month/date/20XX - month/date/20XX]*.

Unless you have symptoms of COVID-19, you can continue to come to work after you have completed the enhanced screening tool. Monitor your symptoms daily and take your temperature at home in addition to the screening at work entry. You may receive a call from the health department regarding a contact investigation. Please wear a mask or facial covering at work when in close contact with others for a 14-day period and as directed by current guidance (e.g., eat alone, frequent hand washing and cleaning/disinfection of personal area).

Review the attached Interim Guidance for Implementing Safety Practices for Critical Infrastructure Workers who may have had exposure to a person with suspected or confirmed COVID-19.

Refer to the CDC Guidance for Household Information and Considerations for the Family.

If my institution has confirmed cases of the virus, what can I do to prevent bringing the virus home?

Working around staff or inmates that may be infected may cause anxiety and concern and the dedication of thousands of BOP staff to continue performing their necessary duties is admirable. There are several things you can do to protect yourself and loved ones:

- Get a COVID-19 vaccine.
- Wash your hands or use hand sanitizer frequently during your shift, immediately prior to leaving work and again immediately when you return home.
- Coronaviruses are generally thought to be spread most often by respiratory droplets.
- Take the same precautions you do at work at home – cover your coughs and sneezes, wash hands and clean high touch surfaces frequently, and avoid touching your face.
- Staff should also clean high touch areas of routinely used items such as duty belts and other equipment.

What can I do to manage stress?

- The outbreak of coronavirus disease 2019 (COVID-19) may be stressful for people. Fear and anxiety about a disease can be overwhelming and cause strong emotions in adults and children. Tools for coping with stress will help you, the people you care about, and your community stronger. "Resources for Staying Well During COVID-19" can be found here: *http://sallyport.bop.gov/co/hsd/infectious_disease/docs/Coronavirus/covid19_resources_all_bop_staff_v1_20200327.pdf*.
- Please don't forget that the Employee Assistance Program (EAP) for the Bureau of Prisons is available. There is someone to talk to all day, all week, all year at (800) 327-2251.
- The BOP has also activated a *Staff Support Line* to assist during this crisis.

The latest BOP guidance and information concerning COVID-19 can be found here: *https://sallyport.bop.gov/co/hsd/infectious_disease/covid19/index.jsp*.