In response to the four areas identified in the Administrative Order NO. 2020-14, we respectfully respond as follows:

1. Protocols for screening and testing detainees, staff, and others entering or leaving each facility

   In an effort to be proactive and prepared for the potential spread of Coronavirus Disease 2019 (COVID-19) in our facilities, The GEO Group, Inc. (GEO) initiated a multidisciplinary approach from our headquarters to all of our facilities to create and sustain the highest level of vigilance and readiness. We embarked on a robust and ongoing educational campaign to bring awareness to our staff and our detainees. This campaign was conducted in multiple languages to ensure ready comprehension.

   On February 26, 2020, educational materials from the Centers for Disease Control and Prevention (CDC) were provided to all facilities which are continuously updated. Our local leadership was tasked to discuss the CDC's "what you need to know about COVID-19," "Stop the Spread of Germs" and "Cover your Cough". The information was posted in vital areas of our facilities, such as the front entrance, visiting areas, health services unit, housing units, Restrictive Housing Unit and staff break rooms. Our facilities are ensuring that detainees are informed via townhall meetings and staff are informed by using the following venues to emphasize the important role of prevention: shift briefings, meetings with staff and department heads.

   As of today, all transfers from the facility are suspended to reduce the risk of exposure except for outside treatments clinically determined to be medically necessary and/or emergent.

   As of March 13, 2020, the suspension of visitation and professional/legal visits were in effect in order to mitigate the potential transmission of COVID-19. In situations where a professional/legal visitor is denied access to the facility the Facility Administrator will attempt to facilitate an alternative method of communication (telephone, video conferencing, etc.) whenever possible. A Visitor Screening-COVID-19 Questionnaire was deployed to prevent the contact with visitors presenting high risk of exposure to staff and detainees.

   As of March 13, 2020, we implemented employee wellness checks, including temperature screenings upon arrival at the facility, for all shifts. Also, as of April 3, 2020, all employees receiving personal protective equipment including N-80 masks and surgical gloves for their use while on duty.

2. The number of detainees tested and the number of positive tests;

   Number of detainees tested: **4**[1]
   Number of detainees positive: **1**

3. The number of staff and/or other testing positive;

   Number of staff testing positive: **3**

4. All efforts undertaken to mitigate the spread of COVID-19 both generally, and in response to any symptomatic inmate(s) and/or positive test(s);

   On February 28, 2020, the Corporate Chief Medical Officer, provided to our facility the Technical Direction TD-2020-1, Coronavirus COVID-19. The TD provided a comprehensive approach in the management to COVID-19, based on the latest information provided by the CDC. The Coronavirus (COVID-19) Management Policy 531, was updated and deployed along with the GEO Health Services Interim Reference Sheet (following guidance from the CDC, ICE Health Services Corp and the Federal Bureau of Prisons guidelines). The interim guideline, as recommended by the CDC, implemented temperature checks as well as the COVID-19 Patient Screening Tool (HS-168) for all new arrivals. The "pre-intake" temperature check is part our front-line assessment to identify and immediately place under medical isolation symptomatic and/or high-risk patients for COVID-19.

   The GEO Health Services Interim Reference Sheet was expanded to identify possible cases during regular sick call, health assessments and other medical encounters in which a patient presents with signs or symptoms of a respiratory illness. Our facility is equipped with COVID-19 diagnostic kits to be used when appropriate clinical cases are identified.

   On March 6, 2020, GEO as part of GEO's Emergency Preparedness Program, our facility fashioned a local multidisciplinary team and framed a workable tactical plan (COVID-19 Emergency Plan) to be deployed in the event of a confirmed case of COVID-19. **Our emergency plan is intended to provide the guiding principles addressing our operational preparedness, prevention and management of COVID-19.**

   Our team continually assesses facility inventories of food, medicines, cleaning supplies, personal protective equipment (PPE), and facility operational practices to assure the safety, security, health, and well-being of detainees are met. We are conducting tactical tabletop exercises and

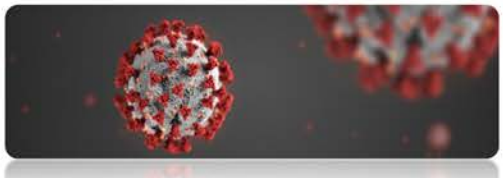
[1] On April 3, 2020, the New York City Department of Health (DOH) indicated that the testing for a person experiencing flu-like symptoms at the Queens Private Detention Facility for COVID-19 was no longer necessary. The DOH stated that the person should be confined and his or her symptoms should be treated. He or she can be released from confinement when the person has no fever without

updating our COVID-19 emergency plans to ensure compliance with the American Correctional Association and the CDC guidelines based on what on currently known about the transmission and management of the illness.

We are placing high emphasis on good hygiene practices, intensifying cleaning, and disinfection of the facility. Furthermore, we implemented strong internal controls screening new detainees, staff and visitors when applicable. We have championed the importance of social distancing in our correctional environment as critical, continuously educating and communicating with our detainees and staff the importance of this risk exposure mitigation strategy to prevent COVID-19 exposure and infection. We implemented delivered modification to our common areas, recreation activities, group activities, and when feasible, housing arrangements.

We are diligent working in the prevention and management of suspect or confirm COVID-19 cases inside our facility. We have sound practices embracing the CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. Our multilevel approach includes medical isolation and clinical management of anyone with confirmed or suspected COVID-19 cases. The Clinical Director is working with our security teams and they are capable of implement the necessary internal control to quarantine close contact, restrict movement, implement infection control practices and maintain our highest level of cleaning and disinfecting all areas. Our detainees will continue to have frequent opportunities for informal contact with facility managerial and supervisory staff depending their status during this public health emergency.

As a part of our compressive prevention practice, staff are directed to stay home if they are sick. We are ensuring that staff are aware that they will not be able to enter the facility if they are presenting symptoms of COVID-19 (fever cough, shortness of breath, etc.). We are conducting daily checks of their temperatures and they required to complete a questionnaire to identify symptoms and history of high-risk exposure before authorizing entrance to the facility. Given the public health emergency, staff who refuse the enhanced health screening will be denied entry to the facility. If staff register an oral temperature of greater than or equal to 100.4 degrees (Fahrenheit), and present a risk of exposure based on the questionnaire they are denied entry to the facility.



STOP COVID-19

S - System of Control T - Tactical Plan Review O - Operational effectiveness P - Priorities

Version -1.0

3-30-2020

- Social Distancing -

Ensure that social distancing is part of the daily practice in every area of the facility. Our strategies are being tailored to the individual space in our facilities and the needs of the population and staff. Not all strategies will be feasible in our facilities.

Example strategies with varying levels of intensity include:

Common areas:

Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)

Recreation:

- Choose recreation spaces where individuals can spread out
- Stagger time in recreation spaces
- Restrict recreation space usage to a single housing unit per space (where feasible)

Food Services & Meals:

- Stagger meals
- Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
- Provide meals inside housing units or cells

Group activities:

- Limit the size of group activities
- Increase space between individuals during group activities
- Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
- Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out

Housing:

- If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
- Arrange bunks so that individuals sleep head to foot to increase the distance between them
- Rearrange scheduled movements to minimize mixing of individuals from different housing areas

GEO 2019 Novel Coronavirus (COVID-19) Patient Screening Tool

1. Assess the Risk of Exposure	
☐ Yes ☐ No	Have you traveled from, or through, any of the locations identified by the CDC as increasing epidemiologic risk within the last 14 days? Link to CDC Criteria Last date of travel (mm/dd/yyyy):
☐ Yes ☐ No	Had close contact with anyone diagnosed (laboratory-confirmed) with COVID-19 illness within the last 14 days? Last date of contact (mm/dd/yyyy):

If the answer to ALL the above risk of exposure questions is NO, then STOP here and proceed with normal intake.
If the answer to ANY of the above risk of exposure questions is YES, then immediately assess symptoms.

2. Assess Symptoms		Date of Onset:
☐ Yes ☐ No	**Fever** (*Fever may not be present in some patients, such as elderly, immunosuppressed, or taking certain medications. Fever may be subjective or objective).*	
☐ Yes ☐ No	**Cough**	
☐ Yes ☐ No	**Shortness of Breath (SOB)**	
☐ Yes ☐ No	**Chills**	
☐ Yes ☐ No	**Headache**	
☐ Yes ☐ No	**Muscle Aches**	
☐ Yes ☐ No	**Sore Throat**	
☐ Yes ☐ No	**Vomiting or diarrhea**	
☐ Yes ☐ No	**Abdominal discomfort**	

3. Implement Infection Prevention Control Measures

3a. The Symptomatic Patient

If the patient has any symptoms implement Standard, Contact, and Airborne Precautions (including eye protection).

- ☐ Place a surgical mask on the patient and minimize proximity to staff and inmates
- ☐ All staff escorting, evaluating, or otherwise in close contact with the patient should use appropriate PPE and respiratory protection with current fit testing.
- ☐ House patient in a certified Airborne Infection Isolation (AII) room. If no AII room is available, transport to a designated referral healthcare facility in coordination with the local public health authority.
- ☐ Report case to local health dept., Clinical Director, Regional & Corporate Leadership and client representative.
- ☐ Place patient on a Medical Hold.

3b. The Asymptomatic Patient

If the patient has no symptoms house in a single cell and observe.

- ☐ House patient in a single room, preferably within Health Services. If unable to house patient in a single room, contact client representative or designee.
- ☐ At minimum document a daily symptom assessment and vital signs.
- ☐ Report case to local health dept., Clinical Director, Regional & Corporate Leadership and client representative.
- ☐ If at any time the patient becomes symptomatic implement the steps in 3a – The Symptomatic Patient.
- ☐ Continue modified housing and observation procedures until 14 days after the last possible exposure date.
- ☐ Place patient on a Medical Hold.

Name (Last, First): _____ **Patient #** _____
Institution: _____
Provider Name/Signature: _____ **Date:** _____

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities

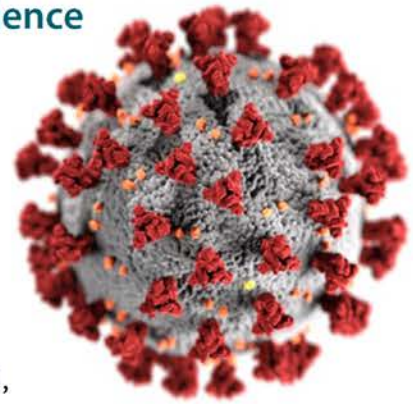
This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the following CDC website periodically for updated interim guidance: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

This document provides interim guidance specific for correctional facilities and detention centers during the outbreak of COVID-19, to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors. Recommendations may need to be revised as more information becomes available.

In this guidance

Who is the intended audience for this guidance?



This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities (including but not limited to federal and state prisons, local jails, and detention centers), law enforcement agencies that have custodial authority for detained populations (i.e., US Immigration and Customs Enforcement and US Marshals Service), and their respective health departments, to assist in preparing for potential introduction, spread, and mitigation of COVID-19 in their facilities. In general, the document uses terminology referring to correctional environments but can also be applied to civil and pre-trial detention settings.

This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes. **The guidance may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions.** Facilities should contact CDC or their state, local, territorial, and/or tribal public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.

Why is this guidance being issued?

Correctional and detention facilities can include custody, housing, education, recreation, healthcare, food service, and workplace components in a single physical setting. The integration of these components presents unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors. Consistent application of specific preparation, prevention, and management measures can help reduce the risk of transmission and severe disease from COVID-19.

- Incarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced.
- In most cases, incarcerated/detained persons are not permitted to leave the facility.
- There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including daily staff ingress and egress; transfer of incarcerated/detained persons between facilities and systems, to court appearances, and to outside medical visits; and visits from family, legal representatives, and other community members. Some settings, particularly jails and detention centers, have high turnover, admitting new entrants daily who may have been exposed to COVID-19 in the surrounding community or other regions.
- Persons incarcerated/detained in a particular facility often come from a variety of locations, increasing the potential to introduce COVID-19 from different geographic areas.
- Options for medical isolation of COVID-19 cases are limited and vary depending on the type and size of facility, as well as the current level of available capacity, which is partly based on medical isolation needs for other conditions.
- Adequate levels of custody and healthcare staffing must be maintained to ensure safe operation of the facility, and options to practice social distancing through work alternatives such as working from home or reduced/alternate schedules are limited for many staff roles.
- Correctional and detention facilities can be complex, multi-employer settings that include government and private employers. Each is organizationally distinct and responsible for its own operational, personnel, and occupational health protocols and may be prohibited from issuing guidance or providing services to other employers or their staff within the same setting. Similarly, correctional and detention facilities may house individuals from multiple law enforcement agencies or jurisdictions subject to different policies and procedures.
- Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19.
- Because limited outside information is available to many incarcerated/detained persons, unease and misinformation regarding the potential for COVID-19 spread may be high, potentially creating security and morale challenges.
- The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and is determined by the supplies provided in the facility and by security considerations. Many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants.
- Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

CDC has issued separate COVID-19 guidance addressing healthcare infection control and clinical care of COVID-19 cases as well as close contacts of cases in community-based settings. Where relevant, community-focused guidance documents are referenced in this document and should be monitored regularly for updates, but they may require adaptation for correctional and detention settings.

This guidance document provides additional recommended best practices specifically for correctional and detention facilities. **At this time, different facility types (e.g., prison vs. jail) and sizes are not differentiated. Administrators and agencies should adapt these guiding principles to the specific needs of their facility.**

What topics does this guidance include?

The guidance below includes detailed recommendations on the following topics related to COVID-19 in correctional and detention settings:

- √ Operational and communications preparations for COVID-19
- √ Enhanced cleaning/disinfecting and hygiene practices
- √ Social distancing strategies to increase space between individuals in the facility
- √ How to limit transmission from visitors
- √ Infection control, including recommended personal protective equipment (PPE) and potential alternatives during PPE shortages
- √ Verbal screening and temperature check protocols for incoming incarcerated/detained individuals, staff, and visitors
- √ Medical isolation of confirmed and suspected cases and quarantine of contacts, including considerations for cohorting when individual spaces are limited
- √ Healthcare evaluation for suspected cases, including testing for COVID-19
- √ Clinical care for confirmed and suspected cases
- √ Considerations for persons at higher risk of severe disease from COVID-19

Definitions of Commonly Used Terms

Close contact of a COVID-19 case—In the context of COVID-19, an individual is considered a close contact if they a) have been within approximately 6 feet of a COVID-19 case for a prolonged period of time or b) have had direct contact with infectious secretions from a COVID-19 case (e.g., have been coughed on). Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

Cohorting—Cohorting refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group, or quarantining close contacts of a particular case together as a group. Ideally, cases should be isolated individually, and close contacts should be quarantined individually. However, some correctional facilities and detention centers do not have enough individual cells to do so and must consider cohorting as an alternative. See Quarantine and Medical Isolation sections below for specific details about ways to implement cohorting to minimize the risk of disease spread and adverse health outcomes.

Community transmission of COVID-19—Community transmission of COVID-19 occurs when individuals acquire the disease through contact with someone in their local community, rather than through travel to an affected location. Once community transmission is identified in a particular area, correctional facilities and detention centers are more likely to start seeing cases inside their walls. Facilities should consult with local public health departments if assistance is needed in determining how to define "local community" in the context of COVID-19 spread. However, because all states have reported cases, all facilities should be vigilant for introduction into their populations.

Confirmed vs. Suspected COVID-19 case—A confirmed case has received a positive result from a COVID-19 laboratory test, with or without symptoms. A suspected case shows symptoms of COVID-19 but either has not been tested or is awaiting test results. If test results are positive, a suspected case becomes a confirmed case.

Incarcerated/detained persons—For the purpose of this document, "incarcerated/detained persons" refers to persons held in a prison, jail, detention center, or other custodial setting where these guidelines are generally applicable. The term includes those who have been sentenced (i.e., in prisons) as well as those held for pre-trial (i.e., jails) or civil purposes (i.e, detention centers). Although this guidance does not specifically reference individuals in every type of custodial setting (e.g., juvenile facilities, community confinement facilities), facility administrators can adapt this guidance to apply to their specific circumstances as needed.

Medical Isolation—Medical isolation refers to confining a confirmed or suspected COVID-19 case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established clinical and/or testing criteria for release from isolation, in consultation with clinical providers and public health officials (detailed in guidance below). In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term "medical isolation" to avoid confusion.

Quarantine—Quarantine refers to the practice of confining individuals who have had close contact with a COVID-19 case to determine whether they develop symptoms of the disease. Quarantine for COVID-19 should last for a period of 14 days. Ideally, each quarantined individual would be quarantined in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, the individual should be placed under medical isolation and evaluated for COVID-19. If symptoms do not develop, movement restrictions can be lifted, and the individual can return to their previous residency status within the facility.

Social Distancing—Social distancing is the practice of increasing the space between individuals and decreasing the frequency of contact to reduce the risk of spreading a disease (ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic). Social distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals will be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them). Although social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this CDC publication.

Staff—In this document, "staff" refers to all public sector employees as well as those working for a private contractor within a correctional facility (e.g., private healthcare or food service). Except where noted, "staff" does not distinguish between healthcare, custody, and other types of staff including private facility operators.

Symptoms—Symptoms of COVID-19 include fever, cough, and shortness of breath. Like other respiratory infections, COVID-19 can vary in severity from mild to severe. When severe, pneumonia, respiratory failure, and death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations most at risk for disease and complications are not yet fully understood. Monitor the CDC website for updates on these topics.

Facilities with Limited Onsite Healthcare Services

Although many large facilities such as prisons and some jails usually employ onsite healthcare staff and have the capacity to evaluate incarcerated/detained persons for potential illness within a dedicated healthcare space, many smaller facilities do not. Some of these facilities have access to on-call healthcare staff or providers who visit the facility every few days. Others have neither onsite healthcare capacity nor onsite medical isolation/quarantine space and must transfer ill patients to other correctional or detention facilities or local hospitals for evaluation and care.

The majority of the guidance below is designed to be applied to any correctional or detention facility, either as written or with modifications based on a facility's individual structure and resources. However, topics related to healthcare evaluation and clinical care of confirmed and suspected COVID-19 cases and their close contacts may not apply directly to facilities with limited or no onsite healthcare services. It will be especially important for these types of facilities to coordinate closely with their state, local, tribal, and/or territorial health department when they encounter confirmed or suspected cases among incarcerated/detained persons or staff, in order to ensure effective medical isolation and quarantine, necessary medical evaluation and care, and medical transfer if needed. The guidance makes note of strategies tailored to facilities without onsite healthcare where possible.

Note that all staff in any sized facility, regardless of the presence of onsite healthcare services, should observe guidance on recommended PPE in order to ensure their own safety when interacting with confirmed and suspected COVID-19 cases. Facilities should make contingency plans for the likely event of PPE shortages during the COVID-19 pandemic.

COVID-19 Guidance for Correctional Facilities

Guidance for correctional and detention facilities is organized into 3 sections: Operational Preparedness, Prevention, and Management of COVID-19. Recommendations across these sections can be applied simultaneously based on the progress of the outbreak in a particular facility and the surrounding community.

- **Operational Preparedness**. This guidance is intended to help facilities prepare for potential COVID-19 transmission in the facility. Strategies focus on operational and communications planning and personnel practices.
- **Prevention.** This guidance is intended to help facilities prevent spread of COVID-19 from outside the facility to inside. Strategies focus on reinforcing hygiene practices, intensifying cleaning and disinfection of the facility, screening (new intakes, visitors, and staff), continued communication with incarcerated/detained persons and staff, and social distancing measures (increasing distance between individuals).
- **Management.** This guidance is intended to help facilities clinically manage confirmed and suspected COVID-19 cases inside the facility and prevent further transmission. Strategies include medical isolation and care of incarcerated/detained persons with symptoms (including considerations for cohorting), quarantine of cases' close contacts, restricting movement in and out of the facility, infection control practices for individuals interacting with cases and quarantined contacts or contaminated items, intensified social distancing, and cleaning and disinfecting areas visited by cases.

Operational Preparedness

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and incarcerated/detained persons about these preparations and how they may temporarily alter daily life.

Communication & Coordination

√ **Develop information-sharing systems with partners.**

- Identify points of contact in relevant state, local, tribal, and/or territorial public health departments before cases develop. Actively engage with the health department to understand in advance which entity has jurisdiction to implement public health control measures for COVID-19 in a particular correctional or detention facility.
- Create and test communications plans to disseminate critical information to incarcerated/detained persons, staff, contractors, vendors, and visitors as the pandemic progresses.

- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- Where possible, put plans in place with other jurisdictions to prevent confirmed and suspected COVID-19 cases and their close contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
- Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.

√ **Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.**

- Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting.
- Facilities without onsite healthcare capacity should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.
- Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.
- Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.

√ **Coordinate with local law enforcement and court officials.**

- Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission.
- Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.

√ **Post signage throughout the facility communicating the following:**

- **For all:** symptoms of COVID-19 and hand hygiene instructions
- **For incarcerated/detained persons:** report symptoms to staff
- **For staff:** stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor.
- Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

√ **Review the sick leave policies of each employer that operates in the facility.**

- Review policies to ensure that they actively encourage staff to stay home when sick.
- If these policies do not encourage staff to stay home when sick, discuss with the contract company.
- Determine which officials will have the authority to send symptomatic staff home.

- √ **Identify staff whose duties would allow them to work from home. Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of COVID-19 transmission.**
  - o Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.
  - o Put systems in place to implement work from home programs (e.g., time tracking, etc.).
- √ **Plan for staff absences.** Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.
  - o Allow staff to work from home when possible, within the scope of their duties.
  - o Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
  - o Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
  - o Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.
- √ **Consider offering revised duties to staff who are at** higher risk of severe illness with COVID-19**.** Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
  - o Facility administrators should consult with their occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to COVID-19.
- √ **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of COVID-19 are similar to those of influenza. Preventing influenza cases in a facility can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.
- √ **Reference the Occupational Safety and Health Administration website for recommendations regarding worker health.**
- √ **Review** CDC's guidance for businesses and employers to identify any additional strategies the facility can use within its role as an employer.

Operations & Supplies

- √ **Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.**
  - o Standard medical supplies for daily clinic needs
  - o Tissues
  - o Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
  - o Hand drying supplies
  - o Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
  - o Cleaning supplies, including EPA-registered disinfectants effective against the virus that causes COVID-19

- Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See PPE section and Table 1 for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s.
- Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated

√ **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**

- See CDC guidance optimizing PPE supplies.

√ **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.

√ **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See Hygiene section below for additional detail regarding recommended frequency and protocol for hand washing.)

- Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.

√ **If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**

√ **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

Cases of COVID-19 have been documented in all 50 US states. Correctional and detention facilities can prevent introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission.

Operations

√ **Stay in communication with partners about your facility's current situation.**

- State, local, territorial, and/or tribal health departments
- Other correctional facilities

√ **Communicate with the public about any changes to facility operations, including visitation programs.**

- √ **Restrict transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.**
  - o Strongly consider postponing non-urgent outside medical visits.
  - o If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to properly isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.
- √ **Implement lawful alternatives to in-person court appearances where permissible.**
- √ **Where relevant, consider suspending co-pays for incarcerated/detained persons seeking medical evaluation for respiratory symptoms.**
- √ **Limit the number of operational entrances and exits to the facility.**

Cleaning and Disinfecting Practices

- √ **Even if COVID-19 cases have not yet been identified inside the facility or in the surrounding community, begin implementing intensified cleaning and disinfecting procedures according to the recommendations below. These measures may prevent spread of COVID-19 if introduced.**
- √ **Adhere to** CDC recommendations for cleaning and disinfection during the COVID-19 response. Monitor these recommendations for updates.
  - o Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones).
  - o Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
  - o Use household cleaners and EPA-registered disinfectants effective against the virus that causes COVID-19 as appropriate for the surface, following label instructions. This may require lifting restrictions on undiluted disinfectants.
  - o Labels contain instructions for safe and effective use of the cleaning product, including precautions that should be taken when applying the product, such as wearing gloves and making sure there is good ventilation during use.
- √ **Consider increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of these areas throughout the day.**
- √ **Ensure adequate supplies to support intensified cleaning and disinfection practices, and have a plan in place to restock rapidly if needed.**

Hygiene

√ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**

√ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis.** Sample signage and other communications materials **are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

- **Practice good cough etiquette:** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
- **Practice good** hand hygiene**:** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
- **Avoid sharing eating utensils, dishes, and cups.**
- **Avoid non-essential physical contact.**

√ **Provide incarcerated/detained persons and staff no-cost access to:**

- **Soap—**Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
- **Running water, and hand drying machines or disposable paper towels for hand washing**
- **Tissues** and no-touch trash receptacles for disposal

√ **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.

√ **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

√ **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process,** in order to identify and immediately place individuals with symptoms under medical isolation. See Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below).

- **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
  - Require the individual to wear a face mask.
  - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
  - Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
  - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.

- **If an individual is a close contact of a known COVID-19 case (but has no COVID-19 symptoms):**
  - Quarantine the individual and monitor for symptoms two times per day for 14 days. (See Quarantine section below.)
  - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.

√ **Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms).** Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:

- **Common areas:**
  - Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)
- **Recreation:**
  - Choose recreation spaces where individuals can spread out
  - Stagger time in recreation spaces
  - Restrict recreation space usage to a single housing unit per space (where feasible)
- **Meals:**
  - Stagger meals
  - Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
  - Provide meals inside housing units or cells
- **Group activities:**
  - Limit the size of group activities
  - Increase space between individuals during group activities
  - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
  - Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out
- **Housing:**
  - If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
  - Arrange bunks so that individuals sleep head to foot to increase the distance between them
  - Rearrange scheduled movements to minimize mixing of individuals from different housing areas
- **Medical:**
  - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
  - Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.

- √ **Communicate clearly and frequently with incarcerated/detained persons about changes to their daily routine and how they can contribute to risk reduction.**
- √ **Note that if group activities are discontinued, it will be important to identify alternative forms of activity to support the mental health of incarcerated/detained persons.**
- √ **Consider suspending work release programs and other programs that involve movement of incarcerated/detained individuals in and out of the facility.**
- √ **Provide** up-to-date information about COVID-19 **to incarcerated/detained persons on a regular basis, including:**
  - o Symptoms of COVID-19 and its health risks
  - o Reminders to report COVID-19 symptoms to staff at the first sign of illness
- √ **Consider having healthcare staff perform rounds on a regular basis to answer questions about COVID-19.**

Prevention Practices for Staff

- √ **Remind staff to stay at home if they are sick.** Ensure that staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.
- √ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all staff daily on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - o In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
  - o Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- √ **Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including:**
  - o Symptoms of COVID-19 and its health risks
  - o Employers' sick leave policy
  - o **If staff develop a fever, cough, or shortness of breath while at work:** immediately put on a face mask, inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
  - o **If staff test positive for COVID-19:** inform workplace and personal contacts immediately, and do not return to work until a decision to discontinue home medical isolation precautions is made. Monitor CDC guidance on discontinuing home isolation regularly as circumstances evolve rapidly.
  - o **If a staff member is identified as a close contact of a COVID-19 case (either within the facility or in the community):** self-quarantine at home for 14 days and return to work if symptoms do not develop. If symptoms do develop, follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- √ **If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff about their possible exposure to COVID-19 in the workplace, but should maintain confidentiality as required by the Americans with Disabilities Act.**
  - o Employees who are close contacts of the case should then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).

√ **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with respiratory symptoms while interviewing, escorting, or interacting in other ways.**

√ **Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.**

Prevention Practices for Visitors

√ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**

√ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.

- Staff performing temperature checks should wear recommended PPE.
- Exclude visitors and volunteers who do not clear the screening process or who decline screening.

√ **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**

√ **Provide visitors and volunteers with information to prepare them for screening.**

- Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
- If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.
- Display signage outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.

√ **Promote non-contact visits:**

- Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
- Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
- Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.

√ **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**

- If moving to virtual visitation, clean electronic surfaces regularly. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
- Inform potential visitors of changes to, or suspension of, visitation programs.
- Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
- If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

NOTE: Suspending visitation would be done in the interest of incarcerated/detained persons' physical health and the health of the general public. However, visitation is important to maintain mental health.

If visitation is suspended, facilities should explore alternative ways for incarcerated/detained persons to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them. See above suggestions for promoting non-contact visits.

√ **Restrict non-essential vendors, volunteers, and tours from entering the facility.**

Management

If there has been a suspected COVID-19 case inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

Operations

√ **Implement alternate work arrangements deemed feasible in the** Operational Preparedness **section.**

√ **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.**

- If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.

√ **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.

√ **When possible, arrange lawful alternatives to in-person court appearances.**

√ **Incorporate screening for COVID-19 symptoms and a temperature check into release planning.**

- Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.)
  - If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
  - If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
  - Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.

√ **Coordinate with state, local, tribal, and/or territorial health departments.**

- When a COVID-19 case is suspected, work with public health to determine action. See Medical Isolation section below.
- When a COVID-19 case is suspected or confirmed, work with public health to identify close contacts who should be placed under quarantine. See Quarantine section below.
- Facilities with limited onsite medical isolation, quarantine, and/or healthcare services should coordinate closely with state, local, tribal, and/or territorial health departments when they encounter a confirmed or suspected case, in order to ensure effective medical isolation or quarantine, necessary medical evaluation and care, and medical transfer if needed. See Facilities with Limited Onsite Healthcare Services section.

Hygiene

√ **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See above.)

√ **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See above.)

Cleaning and Disinfecting Practices

√ **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See above.)

√ **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).**

Medical Isolation of Confirmed or Suspected COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities with Limited Onsite Healthcare Services, or without sufficient space to implement effective medical isolation, should coordinate with local public health officials to ensure that COVID-19 cases will be appropriately isolated, evaluated, tested (if indicated), and given care.

√ **As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.**

√ **Keep the individual's movement outside the medical isolation space to an absolute minimum.**

- Provide medical care to cases inside the medical isolation space. See Infection Control and Clinical Care sections for additional details.
- Serve meals to cases inside the medical isolation space.
- Exclude the individual from all group activities.
- Assign the isolated individual a dedicated bathroom when possible.

√ **Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters.** Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.

√ **Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom where possible.** Cohorting should only be practiced if there are no other available options.

- If cohorting is necessary:
  - **Only individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.**
  - Unless no other options exist, do not house COVID-19 cases with individuals who have an undiagnosed respiratory infection.
  - Ensure that cohorted cases wear face masks at all times.

√ **In order of preference, individuals under medical isolation should be housed:**

- Separately, in single cells with solid walls (i.e., not bars) 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 and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
- As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
- Safely transfer individual(s) to another facility with available medical isolation capacity in one of the above arrangements
  (NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

If the ideal choice does not exist in a facility, use the next best alternative.

√ **If the number of confirmed cases exceeds the number of individual medical isolation spaces available in the facility, be especially mindful of cases who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other infected individuals. If cohorting is unavoidable, make all possible accommodations to prevent transmission of other infectious diseases to the higher-risk individual. (For example, allocate more space for a higher-risk individual within a shared medical isolation space.)

- Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
- Note that incarcerated/detained populations have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages.

√ **Custody staff should be designated to monitor these individuals exclusively where possible.** These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see PPE section below) and should limit their own movement between different parts of the facility to the extent possible.

√ **Minimize transfer of COVID-19 cases between spaces within the healthcare unit.**

√ **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** Instruct them to:

- o **Cover** their mouth and nose with a tissue when they cough or sneeze
- o **Dispose** of used tissues immediately in the lined trash receptacle
- o **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.

√ **Maintain medical isolation until all the following criteria have been met. Monitor the CDC website for updates to these criteria.**

For individuals who will be tested to determine if they are still contagious:

- The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
- The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
- The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart

For individuals who will NOT be tested to determine if they are still contagious:

- The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
- The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
- At least 7 days have passed since the first symptoms appeared

For individuals who had a confirmed positive COVID-19 test but never showed symptoms:

- o At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND**
- o The individual has had no subsequent illness

√ **Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.**

- o If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.

Cleaning Spaces where COVID-19 Cases Spent Time

Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note—these protocols apply to suspected cases as well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19. Refer to the Definitions section for the distinction between confirmed and suspected cases.

- o Close off areas used by the infected individual. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions), before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
- o Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).

√ **Hard (non-porous) surface cleaning and disinfection**

- o If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- o For disinfection, most common EPA-registered household disinfectants should be effective. Choose cleaning products based on security requirements within the facility.
  - Consult a list of products that are EPA-approved for use against the virus that causes COVID-19. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
  - Diluted household bleach solutions can be used if appropriate for the surface. Follow the manufacturer's instructions for application and proper ventilation, and check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted. Prepare a bleach solution by mixing:
    - 5 tablespoons (1/3rd cup) bleach per gallon of water or
    - 4 teaspoons bleach per quart of water

√ **Soft (porous) surface cleaning and disinfection**

- o For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
  - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
  - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and are suitable for porous surfaces.

√ **Electronics cleaning and disinfection**

- o 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.
  - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Additional information on cleaning and disinfection of communal facilities such can be found on CDC's website.

√ **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See PPE section below.)

√ **Food service items.** Cases under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.

√ Laundry from a COVID-19 cases **can be washed with other individuals' laundry.**

- o Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
- o Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- o Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.

- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

√ **Consult** cleaning recommendations above **to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity, or without sufficient space to implement effective quarantine, should coordinate with local public health officials to ensure that close contacts of COVID-19 cases will be effectively quarantined and medically monitored.

√ **Incarcerated/detained persons who are close contacts of a** confirmed or suspected COVID-19 case **(whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**

- If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.

√ **In the context of COVID-19, an individual (incarcerated/detained person or staff) is considered a close contact if they:**

- Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time OR
- Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on)

Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

√ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**

- Provide medical evaluation and care inside or near the quarantine space when possible.
- Serve meals inside the quarantine space.
- Exclude the quarantined individual from all group activities.
- Assign the quarantined individual a dedicated bathroom when possible.

√ **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually.** Cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.

- If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under medical isolation immediately.
- If an entire housing unit is under 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.
- Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine.

- If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.

√ **If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of those who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.)

√ **In order of preference, multiple quarantined individuals should be housed:**

- Separately, in single cells with solid walls (i.e., not bars) 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 (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.
- As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
- Safely transfer to another facility with capacity to quarantine in one of the above arrangements

(NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

√ **Quarantined individuals should wear face masks if feasible based on local supply, as source control, under the following circumstances** (see PPE section and Table 1):

- If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
- If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
- All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
- Asymptomatic individuals under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear face masks.

√ **Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties** (see PPE section and Table 1).

- Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear PPE.

- √ **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
  - o If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See Medical Isolation section above.)
  - o See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- √ **If an individual who is part of a quarantined cohort becomes symptomatic:**
  - o **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
  - o **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
  - o **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- √ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**
- √ **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- √ **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- √ **Laundry from quarantined individuals can be washed with other individuals' laundry.**
  - o Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
  - o Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - o Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - o Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity or without sufficient space for medical isolation should coordinate with local public health officials to ensure that suspected COVID-19 cases will be effectively isolated, evaluated, tested (if indicated), and given care.

- √ **If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.**
- √ **Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and should be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing. See Medical Isolation section above.**

- √ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.
- √ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
  - o If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
  - o If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

Management Strategies for Incarcerated/Detained Persons without COVID-19 Symptoms

- √ **Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**
  - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
  - o Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
- √ **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.** See Screening section for a procedure to safely perform a temperature check.
- √ **Consider additional options to intensify** social distancing within the facility.

Management Strategies for Staff

- √ **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**
  - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.
- √ **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**
  - o See above for definition of a close contact.
  - o Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

Infection control guidance below is applicable to all types of correctional facilities. Individual facilities should assess their unique needs based on the types of exposure staff and incarcerated/detained persons may have with confirmed or suspected COVID-19 cases.

- √ **All individuals who have the potential for direct or indirect exposure to COVID-19 cases or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Monitor these guidelines regularly for updates.**

- Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
- Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).

√ **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see PPE section).

√ **Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

√ **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**

- If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital.
- The initial medical evaluation should determine whether a symptomatic individual is at higher risk for severe illness from COVID-19. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.

√ **Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and monitor the guidance website regularly for updates to these recommendations.**

√ **Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the suspected case is wearing a face mask.**

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.

√ **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).**

√ **The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.**

√ **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.**

Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons

√ **Ensure that all staff (healthcare and non-healthcare) and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with confirmed and suspected COVID-19 cases.**

- Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program.
- For PPE training materials and posters, please visit the CDC website on Protecting Healthcare Personnel.

√ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**

√ **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (**see Table 1). **Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.**

√ **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**

√ **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with COVID-19 cases and their contacts (see Table 1). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**

- **N95 respirator**

See below for guidance on when face masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case.

- **Face mask**
- **Eye protection**—goggles or disposable face shield that fully covers the front and sides of the face
- **A single pair of disposable patient examination gloves**

Gloves should be changed if they become torn or heavily contaminated.

- **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**
  - If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
  - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, 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.

√ **Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website:**

- **Guidance in the event of a shortage of N95 respirators**
  - Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand.** During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.
- **Guidance in the event of a shortage of face masks**
- **Guidance in the event of a shortage of eye protection**
- **Guidance in the event of a shortage of gowns/coveralls**

Table 1. Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional Facility during the COVID-19 Response

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case*)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	–	✓	–	–	–
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case* (but not performing temperature checks or providing medical care)	–	Face mask, eye protection, and gloves as local supply and scope of duties allow.			–
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons	–	✓	✓	✓	✓
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	✓**		✓	✓	✓
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	✓	–	✓	✓	✓
Staff handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓

* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.

** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

The guidance above recommends verbal screening and temperature checks for incarcerated/detained persons, staff, volunteers, and visitors who enter correctional and detention facilities, as well as incarcerated/detained persons who are transferred to another facility or released from custody. Below, verbal screening questions for COVID-19 symptoms and contact with known cases, and a safe temperature check procedure are detailed.

- √ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**
  - o *Today or in the past 24 hours, have you had any of the following symptoms?*
    - *Fever, felt feverish, or had chills?*
    - *Cough?*
    - *Difficulty breathing?*
  - o *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*
- √ **The following is a protocol to safely check an individual's temperature:**
  - o Perform hand hygiene
  - o Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
  - o Check individual's temperature
  - o **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
  - o Remove and discard PPE
  - o Perform hand hygiene

MEMORANDUM

GEO Secure Services™
4955 Technology Way
Boca Raton, Florida 33431

Tel: 561 893 0101
866 301 4436
Fax: 561 999 7635
www.geogroup.com

Date: March 20, 2020

To: Facility Clinical Directors

CC: Health Service Administrators
Health Service Directors, Health Service Managers,
Regional DOs
Executive Vice President, Continuum of Care and Reentry
Regional VP's,
Facility Administrators

From: John E. Christakis, M.D.
Chief Medical Officer

RE: OUTSIDE CONSULTATIONS – CLINICAL DIRECTORS REVIEW

Due to COVID-19 and risk for viral exposure, Clinical Directors, effective immediately, will be advised to determine the necessity of off-site non-emergent consultations and procedures until further notification from corporate Health Services. Our Clinical Directors at the facility will inform the FA regarding any off-site consultations in managing this new directive. If the treatment requested is determined to be medically necessary and/or emergent, the patient will be sent to the appropriate off-site provider for further health care.

If the approved treatment is determined to be non-emergent, the treatment by an off-site provider should be rescheduled as well as a follow-up by the facility's provider at their discretion. All rescheduled appointments must be documented as an order in the patient's medical file.

If you have any questions or concerns, please contact me.

Attached: GEO Policy #214 Referral, Outside Medical Care

Secure Services™

MEMORANDUM

GEO Secure Services™
4955 Technology Way
Boca Raton, Florida 33431

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866 301 4436
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Date: March 13, 2020

To: All Facility Administrators, Regional VP's, DO's, HSA's HSD's, HSM's

From: J. David Donahue, Senior Vice President, President, GEO Secure Services

RE: SUSPENSION OF VISITATION AND PROFESSIONAL/LEGAL VISITS – EXECUTIVE ORDER

At this time, all social visitation will be suspended in all, Bureau of Prisons (BOP), Immigration Custom Processing and US Marshal Facilities until further notice. In addition to suspending social visits, the BOP has also directed the suspension of legal visits for 30 days. There are several other jurisdictions who have already suspended social visitation and I anticipate others to follow.

To facilitate professional/legal visits that will continue if required by the client, Facility Administrators must follow the protocols directed by the client. Additionally, I'm issuing this order requiring all of these visitors to be screened using the attached visitor screening form Number EOCV19 and titled "***Visitor Screening- COVID-19 Questionnaire***".

This form is to be completed by the visitor, at the security checkpoint prior to entry into the facility. Any "Yes" responses on the form will result in a denial of the visit. In locations where qualitative temperature readings are taken, a visitor with a fever, temperature of >100.4 degrees F, will also be denied access to the facility.

Post orders must be modified to accommodate these interim measures and all forms are to remain a part of the post documentation.

In situations where a professional/legal visitor is denied access to the facility the Facility Administrator will attempt to facilitate an alternative method of communication (telephone, video conferencing, etc.) whenever possible.

If you have any questions regarding these directives please do not hesitate to contact me.

FORM EOCV19 03/13/20

The GEO Group, Inc.®

Visitor Screening - COVID-19 Questionnaire

Name:	**Mobile/Home Phone:**
Visitor Purpose:	**Inmate/Detainee/Department:**
Facility Name:	**Date/ Time of Visit:**

1.	**In the past 14 days, have you experienced flu-like symptoms such as fever (>100.4 degrees F/38 degrees C), coughing, respiratory illness such as shortness of breath?** **YES / NO If YES, when? _____**
2.	**In the past 14 days, have you traveled outside of the U.S?** **YES / NO If YES, where? _____**
3.	**In the past 14 days have you traveled to China or an area affected by Coronavirus (Specifically, Iran, Italy, South Korea, Europe)?** **YES / NO If YES, where? _____**
4.	**In the past 14 days, have you had close contact with a person with confirmed COVID-19 infection while they were ill, or under investigation for infection to COVID-19?** **YES / NO If Yes, when?_____**
5.	**In the last 14 days have you been in contact with someone who has traveled outside of the U.S.?** **YES / NO If YES, where? _____**

Visitor Qualitative Temperature Reading:_____

Visitor Signature: _____ Date: _____

Access to Facility (Circle One)	**Approved**	**Denied**

If you are permitted access to visit, you are required to adhere to the following:

- **Proper hand hygiene- Wash your hands prior to entering**
- **Do not shake hands or make any physical contact**
- **Do not share pens or pencils or other items**
- **Cover your mouth and nose when you cough or sneeze**

Failure to complete the questionnaire may result in refusal for you to access the facility.

GEO Health Services

Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19) [V3.0]

Information captured from the ICE Health Service Corps (IHSC) - Version 7.0, March 11, 2020

What's new in this version from CDC

- Recommendations to reduce the risk of transmission
- Centers for Disease Control and Prevention (CDC) guidance including but not limited to the following:
  - Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings
  - Strategies for Optimizing the Supply of N95 Respirators
  - Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings
  - Transmission-Based Precautions
- Information added to convey that revised CDC guidance expands testing to a wider group of symptomatic patients. Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- Information added to convey that testing is now available through LabCorp and other commercial laboratories.
- Added Patient Education Material
- Added Nursing Assessment Protocol - Upper Respiratory: Rule Out COVID-19
- Dental Guidance Memorandum
- Added guidance from CDC Interim Guidance on Management COVID-19 - Read for guidance on PPE use.

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple. For the most current information, check the CDC information for frequent updates at: https://www.cdc.gov/coronavirus/2019-ncov/index.html .

CDC interim guidance for health care professionals, including clinical criteria, is available at https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html

Health Service Corps Recommendations

Note: recommendations will be updated if and as necessary to address the evolving public health situation.

1. ***During intake medical screening:***
   a. **Ask all patients if they have had close contact[1] with a person with laboratory-confirmed COVID-19 in the past 14 days**
   b. **Ask all patients if they have traveled from or through mainland China and/or through, any of the geographic area(s) with widespread or sustained community transmission in the past 14 days. Check CDC website for listing at https://www.cdc.gov/coronavirus/2019- ncov/hcp/clinical-criteria.html.**
   c.
      i. If the patient responded yes to 1a and/or 1b, assess for fever and symptoms of respiratory illness.
         a. If patient has a fever or symptoms of respiratory illness, refer to #4 below
         b. If the patient does not have fever or respiratory illness, refer to # 2 below.
         c. Add a Medical Alert/Hold in the health record that states, *"Contact with laboratory-confirmed COVID-19.*

   d. If the patient has fever and/or symptoms or respiratory illness and has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact1 with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see #3 ENCOUNTER below).

   e. Educate all patients to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.

2. **MONITORING of patients with exposure risk who do not present with fever or symptoms:**
   a. See also *Interim Recommendations for Risk Assessment of Persons* with *Potential 2019 Novel Coronavirus (COVID-19) Exposure in Travel-, Community-, or Custody Settings*
   b. For patients with travel history from or through geographic area(s) with sustained community transmission* in the past 14 days and/or detainees who have had close contact[1] with a person with laboratory-confirmed COVID-19 in the past 14 days who do not present with fever or symptoms of respiratory illness → monitor for 14 days and observe daily for fever and/or symptoms of respiratory illness.
      i. ***Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html.**
   c. House in a single cell room if available. If a single cell room is not available, house

patients as a cohort for 14 days after arrival.

d. Refer also to appendix A, Intake Screening Questions and Appendix B, Intake Screening Algorithm
e. Medical staff should notify their assigned IHSC Field Medical Coordinator or client representative.
f. Request a medical alert in following usual protocols stating that "the patient is under observation through mm/dd/yyyy due to recent travel from or through mainland China and/or through, any of the locations identified by the CDC as increasing epidemiologic risk in the past 14 days." Release the medical alert at the completion of the 14-day observation period.
g. During the 14-day observation period, if an asymptomatic patient under observation days must be released in the U.S., notify the local health department including the intended address and telephone number of the patient's intended destination.
h. Document any asymptomatic patients under monitoring on the Lower Respiratory Illness Tracking Tool (ICE Facilities), GEO HS-241 Influenza/H1N1/COVID-19 Tracking Log, or other client required forms. Document all medical encounters on the appropriate progress note and problem list, as necessary.
i. For monitoring of asymptomatic patients, it is not necessary to contact the local health department.

3. ***ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a patient presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:***
   a. Ask all patients what countries they have traveled from or through in the past two weeks.
      i. Check whether these countries include international area(s) with sustained transmission.* Document the encounter on the Nursing Assessment Protocol (NAP) Upper Respiratory: Rule out COVID-19.
      ii. *Please see CDC website listing of international area(s) with sustained transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html. See attached ONESource form for reference.
   b. If the patient has traveled from or through area(s) with sustained community transmission*in the past 14 days, or if they have had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days
      i. → refer to #4 ISOLATION below.
   c. If the patient has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact[1] with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days then
      i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
      ii. See CDC Interim Guidance on Management COVID-19
      iii. See #5 SPECIMEN COLLECTION AND LABORATORY TESTING below.

d. Educate patients to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.

4. ***ISOLATION and management of patients with fever and/or symptoms of respiratory illness and who have traveled from or through* geographic area(s) with widespread or sustained community transmission at *in the past 14 days or have had close contact*[1] *with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days:***
   a. See also *Interim Recommendations for Risk Assessment of Persons with Potential 2019-Novel Coronavirus (COVID-19) Exposure in Travel-, Community-, or Custody Settings*
   b. See CDC Interim Guidance on Management COVID-19
   c. Place a tight-fitting surgical mask on the patient.
   d. Promptly consult the Clinical Director or designee.
   e. Place the patient in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill patient separately from the general patient population.
   f. **Implement standard, airborne and contact precautions, including use of eye protection**
   g. Call the local and/or state health department for notification and to request guidance on medical evaluation and procedures for specimen collection and testing for COVID-19
   h. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
      i. See #5 SPECIMEN COLLECTION AND LABORTORY TESTING below.
   i. If the patient has underlying illness or is acutely ill, or symptoms do not resolve, arrange transportation to local hospital via EMS and have your Clinical Director to consult with the Corporate Chief Medical Officer (CMO).
   j. If the patient is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how to manage the patient safely.
   k. Promptly notify the facility's staff responsible for infection prevention and control.
   l. Medical staffing follow local reporting procedures as delineated in their local emergency plan and ensure the HSA is notified as soon as possible.
   m. Patients in isolation for respiratory illness and who and who have epidemiologic risk for COVID-19 exposure will wear a tight-fitting surgical mask when outside of the room under airborne and contact precautions
   n. Document any ill patient who is suspected of having COVID-19 on the Lower Respiratory Illness Tracking Tool (ICE Facilities), GEO HS-241 Influenza/H1N1/COVID-19 Tracking Log, or other client required forms. Document all medical encounters on the appropriate progress note and problem list,,as necessary.
   o. The contagious period for COVID-19 is still undetermined if:
      i. the patient tests positive for COVID-19 and fever and symptoms have resolved, consult with the Corporate CMO and/or local health department

regarding appropriate release from isolation.

ii. the patient tests negative for COVID-19, had high or medium exposure risk and symptoms have resolved, release from isolation after completion of the 14-day monitoring period after arrival.

iii. the patient tests negative for COVID-19 and fever and/or symptoms persist, consult with the Corporate CMO.

p. Educate patients to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.

5. ***SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19***

a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.

b. See **Specimen Collection instructions on the Labcorp COVID-19 Website.** **https://www.labcorp.com/information-labcorp-about-coronavirus-disease-2019-covid-19**

i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

6. ***Infectious disease public health actions:***

a. Educate patients to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill. See also https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html

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

c. **Known exposure to a person with confirmed COVID-19 action to be taken will be:**

i. Implement cohorting with restricted movement for patients housed with the ill patient or who have been in close contact[1] with the ill patient for the duration of the most recent incubation period (14 days after most recent exposure to an ill patient).

ii. Monitor cohorted patients daily to observe for fever and symptoms of respiratory illness.

iii. Refer exposed patients with new onset fever and/or respiratory illness to a medical provider for evaluation.

iv. Discontinue cohorting when 14-day incubation period completes with no new cases.

d. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19 action to be taken will be:**

i. Implement cohorting with restricted movement for patients housed with the ill patient or who have been in close contact[1] with the ill patient for the duration of the most recent incubation period.

ii. Monitor cohorted patients daily to observe for fever and symptoms of respiratory illness.
iii. Refer exposed patients with new onset fever and/or respiratory illness to a medical provider for evaluation.
iv. If the index patient is subsequently confirmed to have COVID-19, see section 5.b above.
v. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
vi. Any of the cohorted patients with exposure risk will complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).

e. Report cohorting through routine IHSC cohort reporting protocols (ICE facilities).
f. Document any asymptomatic and afebrile patients under monitoring for COVID-19 on the Lower Respiratory Illness Tracking Tool (ICE Facilities), GEO HS-241 Influenza/ H1N1/COVID-19 Tracking Log, or other client required forms. Document all medical encounters on the appropriate progress note and problem list, as necessary.
g. Recommend to Field Office Director (ICE facilities), other client representative or designee that patients cohorted due to high or medium exposure risk or known exposure to an ill person not be transferred or transported.
h. If a cohorted patient must be released in the U.S., notify the local health department including the intended address and telephone numbers of the patient's intended destination.

[1]Per CDC COVID-19 guidance https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html, a close contact is currently defined as:

a) being within approximately 6 feet (2 meters), or within the room or care area, of a novel coronavirus case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a novel coronavirus case.– *or* –
b) having direct contact with infectious secretions of a novel coronavirus case (e.g., being coughed on) while not wearing recommended personal protective equipment.

See CDC's Interim Healthcare Infection Prevention and Control Recommendations for Patients Under Investigation for 2019 Novel Coronavirus. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with novel coronavirus (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

Resources and references

- Novel Coronavirus 2019, Wuhan, China | CDC
- Infection Control: Novel Coronavirus 2019 (COVID-19) | CDC
- 2019 Novel Coronavirus (2019-nCoV) | TDSHS
- nCOV2019 | CDPH
- Novel Coronavirus Outbreak 2020 | Washington State Department of Health
- Coronavirus | NYC Health
- 2019 Novel (New) Coronavirus | NYDOH
- 2019 Novel Coronavirus (2019-nCoV) | Florida Department of Health
- 2019 Novel Coronavirus (2019 nCoV) | Frequently Asked Questions | IDPH

Points of contact for questions

- GEO Corporate Chief of Nursing
- ICE Facility Medical Staffing: Assigned Field Medical Coordinators

GEO 2019 Novel Coronavirus (COVID-19) Patient Screening Tool

1. Assess the Risk of Exposure	
☐ Yes ☐ No	Have you traveled from, or through, any of the locations identified by the CDC as increasing epidemiologic risk within the last 14 days? Link to CDC Criteria Last date of travel (mm/dd/yyyy):
☐ Yes ☐ No	Had close contact with anyone diagnosed (laboratory-confirmed) with COVID-19 illness within the last 14 days? Last date of contact (mm/dd/yyyy):

If the answer to ALL the above risk of exposure questions is NO, then STOP here and proceed with normal intake.
If the answer to ANY of the above risk of exposure questions is YES, then immediately assess symptoms.

2. Assess Symptoms		Date of Onset:
☐ Yes ☐ No	**Fever** (*Fever may not be present in some patients, such as elderly, immunosuppressed, or taking certain medications. Fever may be subjective or objective).*	
☐ Yes ☐ No	**Cough**	
☐ Yes ☐ No	**Shortness of Breath (SOB)**	
☐ Yes ☐ No	**Chills**	
☐ Yes ☐ No	**Headache**	
☐ Yes ☐ No	**Muscle Aches**	
☐ Yes ☐ No	**Sore Throat**	
☐ Yes ☐ No	**Vomiting or diarrhea**	
☐ Yes ☐ No	**Abdominal discomfort**	

3. Implement Infection Prevention Control Measures

3a. The Symptomatic Patient

If the patient has any symptoms implement Standard, Contact, and Airborne Precautions (including eye protection).

- ☐ Place a surgical mask on the patient and minimize proximity to staff and inmates
- ☐ All staff escorting, evaluating, or otherwise in close contact with the patient should use appropriate PPE and respiratory protection with current fit testing.
- ☐ House patient in a certified Airborne Infection Isolation (AII) room. If no AII room is available, transport to a designated referral healthcare facility in coordination with the local public health authority.
- ☐ Report case to local health dept., Clinical Director, Regional & Corporate Leadership and client representative.
- ☐ Place patient on a Medical Hold.

3b. The Asymptomatic Patient

If the patient has no symptoms house in a single cell and observe.

- ☐ House patient in a single room, preferably within Health Services. If unable to house patient in a single room, contact client representative or designee.
- ☐ At minimum document a daily symptom assessment and vital signs.
- ☐ Report case to local health dept., Clinical Director, Regional & Corporate Leadership and client representative.
- ☐ If at any time the patient becomes symptomatic implement the steps in 3a – The Symptomatic Patient.
- ☐ Continue modified housing and observation procedures until 14 days after the last possible exposure date.
- ☐ Place patient on a Medical Hold.

Name (Last, First): _____ **Patient #** _____
Institution: _____
Provider Name/Signature: _____ **Date:** _____

Health Service Interim Recommendations for Screening and Early Management for 2019 Novel Coronavirus (COVID-19) Updated March 21, 2020

EDUCATE all patients on hygiene, including handwashing, covering coughs, and requesting sick call if ill

Intake medical screening
See CDC Interim Guidance on Management COVID-19

Travel from or through geographic area(s) with widespread or sustained community transmission **in the past 14 days**‡

AND/OR

Close contact* with a person with laboratory-confirmed coronavirus or their respiratory secretions **in the past 14 days**

No travel from or through from or through geographic area(s) with sustained (ongoing) community transmission in the past 14 days‡

AND

No close contact* with a person with laboratory-confirmed coronavirus or their respiratory secretions in the past 14 days

AND

No fever or symptoms of respiratory illness

STOP

Fever and/or respiratory illness in the past 14 days

No fever or respiratory illness in the past 14 days

Fever and/or respiratory illness with in the past 14 days without known epidemiologic risk

Refer to a provider for clinical evaluation (see Assessment and Early Management algorithm)

ISOLATION
See CDC Interim Guidance on Management COVID-19
Isolate and refer to a medical provider
Document in the GEO/ Client Tracking Tool

MONITORING:

- See CDC Interim Guidance on Management COVID-19
- House in a single room if available, or as a cohort
- Observe for 14 days
- Add Medical Alert in the health record
- Document in the GEO/Client Tracking Tool

‡**Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html**

***Close contact is defined as—**

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

Health Services Interim Recommendations
For 2019 Novel Coronavirus (COVID-19) Risk | Assessment and Early Management
Updated March 21, 2020

Fever and/or respiratory illness in the past 14 days See CDC Interim Guidance on Management COVID-19

Test for other causes of respiratory illnesses including infections such as influenza

Travel from or through geographic area(s) with sustained (ongoing) community transmission **in the past 14 days‡OR**
Close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days
‡Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Medical providers consider the need to test for COVID-19 in the context of other test results and epidemiologic risk information

ISOLATION | MEDICAL HOUSING UNIT (MHU)

- See CDC Interim Guidance on Management COVID-19
- Airborne infection isolation room, if available (prioritize for high and medium risk)
- Implement standard, airborne and contact precautions including eye protection
- Isolate and refer to a medical provider
- Add Medical Hold
- Document in the GEO/Client Tracking Tool

Testing for COVID-19 indicated

Testing for COVID-19 not indicated

ASSESS CLIICAL STATUS | EXAM
Is fever present?
Subjective?
Measured? _____°C/F
Is respiratory illness present?
Cough?
Shortness of breath?

Routine management

Contact health department to report at-risk patients and their clinical status
Assess need to collect specimens to test for COVID-19
Decide disposition
Update GEO/Client Tracking Tool

EDUCATE all patients on hygiene, including handwashing, covering coughs, and requesting sick call if ill

- Coordinate specimen collection and testing through LabCorp or the local health department
- See LabCorp specimen collection and testing information

- See CDC Recommendations for specimen collection and testing: https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html
- Update GEO/Client Tracking Tool with test results if testing was performed

Interim Recommendations for Risk Assessment of Persons with Potential 2019-Novel Coronavirus (COVID-19) Exposure in Travel-, Community-, or Custody Settings[1]

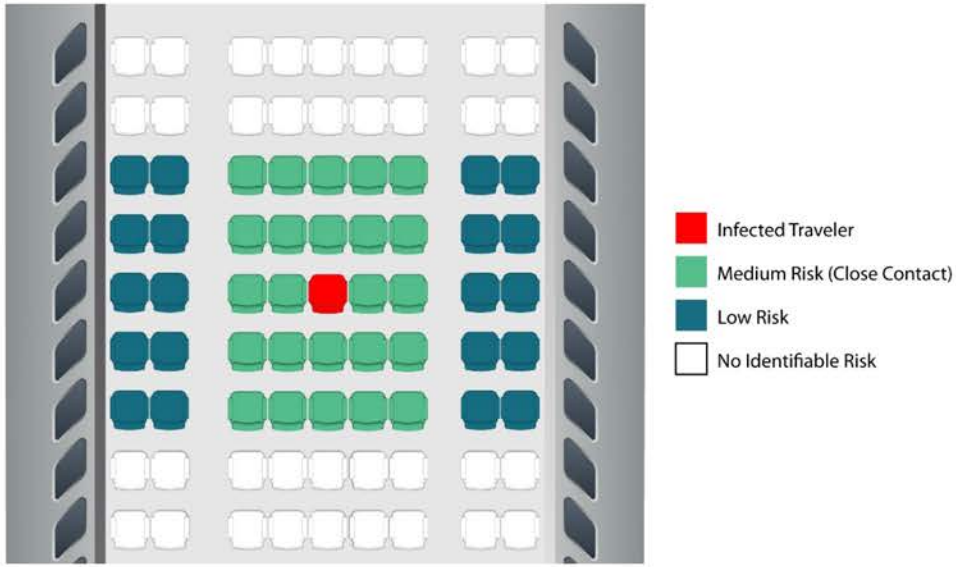
Updated March 21, 2020

Exposure Risk Category	Centers for Disease Control and Prevention (CDC) Definition (as of March 7, 2020)	Correctional Setting Definition
High risk	• Travel from Hubei Province, China or Iran	• Travel from or through Hubei Province, China or Iran
	• Living in the same household as, being an intimate partner of, or providing care in a nonhealthcare setting (such as a home) for a person with symptomatic laboratory-confirmed COVID-19 infection ***without using recommended precautions*** for home care and home isolation	• Housing in the same 2–4-person cell or sleeping with head position within 6 feet of a person with symptomatic laboratory-confirmed COVID-19
Medium risk (assumes not having any exposures in the high-risk category)	• Travel from a country with widespread sustained transmission, other than Hubei Province, China or Iran • Travel from a country with sustained community transmission	• Travel from or through international area(s) with sustained community transmission* in the past 14 days other than Hubei Province, China or Iran *Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Exposure Risk Category	Centers for Disease Control and Prevention (CDC) Definition (as of March 7, 2020)	Correctional Setting Definition
	• Close contact with a person with symptomatic laboratory-confirmed COVID-19 • On an aircraft, being seated within 6 feet (two meters) of a traveler with symptomatic laboratory-confirmed COVID-19 infection; this distance correlates approximately with 2 seats in each direction • Living in the same household as, an intimate partner of, or caring for a person in a nonhealthcare setting (such as a home) to a person with symptomatic laboratory-confirmed COVID-19 infection ***while consistently using recommended precautions*** for home care and home isolation	• Close contact[2] with a person with symptomatic laboratory-confirmed COVID-19) • On an aircraft, bus, or van, being seated within 6 feet (two meters) of a traveler with symptomatic laboratory-confirmed COVID-19; this distance correlates approximately with 2 rows or 2 seats in each direction • Housing in the same unit as a person with symptomatic laboratory-confirmed COVID-19 but not in the same 2–4- person cell and not sleeping with head position within 6 feet of a person with symptomatic laboratory-confirmed COVID-19
Low risk (assumes not having any exposures in the high- or medium risk categories)	• Travel from or through any other country	• Travel from or through any other country
	• Being in the same indoor environment (e.g., a classroom, a hospital waiting room) as a person with symptomatic laboratory-confirmed COVID-19 for a prolonged period of time but not meeting the definition of close contact	• Being in the same indoor environment (e.g., general detention population, dining hall, recreation, work duty, library, or religious services) as a person with symptomatic laboratory-confirmed COVID-19 for a prolonged period of time but not meeting the definition of close contact[2]
	• On an aircraft, being seated within two rows of a traveler with symptomatic laboratory-confirmed 2019-nCoV infection but not within 6 feet (2 meters) (refer to graphic) AND not having any exposures that meet a medium- or a high-risk definition (refer to graphic)	• On an aircraft, bus, or van being seated within two rows of a traveler with symptomatic laboratory-confirmed COVID-19 but not within 6 feet (2 meters) (refer to graphic)

Exposure Risk Category	Centers for Disease Control and Prevention (CDC) Definition (as of March 7, 2020)	Correctional Setting Definition
	N/A	Direct close contact[2] with a person under investigation for COVID-19 that is pending laboratory confirmation
No identifiable risk	Interactions with a person with symptomatic laboratory-confirmed COVID-19 infection that do not meet any of the high-, medium- or low-risk conditions above, such as walking by the person or being briefly in the same room.	Interactions with a person with symptomatic laboratory-confirmed COVID-19 or a person under investigation for COVID-19 that do not meet any of the high-, medium- or low-risk conditions above, such as walking by the person or being briefly in the same room.
No risk	N/A	Exposure to an asymptomatic person who was exposed to another person with high-, medium, low-, or no identifiable risk of exposure to COVID-19

Graphic



Sample seating chart for a COVID-19 aircraft contact investigation showing risk levels based on distance from the infected traveler.[1]

[1]Source and adapted from CDC | Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Cases

[2]**Close contact** is defined as:

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

Interim Recommended Actions Based on Risk Assessment of Persons with Potential 2019 Novel Coronavirus (COVID-19) Exposure in Travel-, Community-, or Custody Settings[1]

Updated March 21, 2020

Exposure Risk Category	CDC Recommended Management (as of March 7, 2020)	Correctional Setting Selected Recommended Actions (used in conjunction with Reference Sheet)
SYMPTOMATIC		
High risk	• Immediate isolation with consideration of public health orders • Public health assessment to determine the need for medical evaluation; if medical evaluation warranted, diagnostic testing should be guided by CDC's PUI definition • If medical evaluation is needed, it should occur with pre-notification to the receiving HCF and EMS, if EMS transport indicated, and with all recommended infection control precautions in place • Controlled travel: Air travel only via air medical transport. Local travel is only allowed by medical transport (e.g., ambulance) or private vehicle while symptomatic person is wearing a face mask.	• ISOLATION • Promptly place a surgical mask over the patient's face and nose • Refer to a provider • Promptly place in an airborne infection isolation room (AII); priority for AII room use • Consult with the local health department for guidance on testing for COVID-19 • Consult with Corporate Chief MedicallOfficer • Implement administrative and environmental controls • Implement strict hand hygiene • Implement standard precautions • Implement transmission-based precautions; see CDC Interim Guidance on Management COVID-19 • Request medical hold • Recommend no transfer or transport • Document in GEO/Client Tracking Tool
Medium risk	• Self-isolation • Public health assessment to determine the need for medical evaluation; if medical evaluation warranted, diagnostic testing should be guided by CDC's PUI definition	• ISOLATION • Promptly place a surgical mask over the patient's face and nose • Refer to a provider

Exposure Risk Category	CDC Recommended Management (as of March 7, 2020)	Correctional Setting Selected Recommended Actions (used in conjunction with Reference Sheet)
	• If medical evaluation is needed, it should ideally occur with pre-notification to the receiving HCF and EMS, if EMS transport indicated, and with all recommended infection control precautions in place. • Controlled travel: Air travel only via air medical transport. Local travel is only allowed by medical transport (e.g., ambulance) or private vehicle while symptomatic person is wearing a face mask.	• Promptly place in an AII room; priority for AII room use • Consult with the local health department for guidance on testing for COVID-19 • Consult with Corporate Chief Medical Officer • Implement administrative and environmental controls • Implement strict hand hygiene • Implement standard precautions • Implement transmission-based precautions; see CDC Interim Guidance on Management COVID-19 • Request medical hold • Recommend no transfer or transport • Document in GEO/Client Tracking Tool
Low risk	• Self-isolation, social distancing • Person should seek health advice to determine if medical evaluation is needed. • If sought, medical evaluation and care should be guided by clinical presentation; diagnostic testing for COVID-19 should be guided by CDC's PUI definition. • Travel on commercial conveyances should be postponed until no longer symptomatic.	• ISOLATION • Promptly place in an AII room if available, or other single room • Use discretion to prioritize AII room needs, including high- and medium- risk and symptoms consistent with COVID-19, tuberculosis (TB), influenza, varicella, etc. • Refer to a provider • Consult with the local health department for guidance on testing for COVID-19 • Consult with Corporate Chief Medical Officer • Implement administrative and environmental controls • Implement strict hand hygiene • Implement standard precautions

Exposure Risk Category	CDC Recommended Management (as of March 7, 2020)	Correctional Setting Selected Recommended Actions (used in conjunction with Reference Sheet)
		• Implement transmission-based precautions; see CDC Interim Guidance on Management COVID-19 • Request medical hold • Recommend no transfer or transport
No Identifiable Risk[2]	• Self-isolation, social distancing • Person should seek health advice to determine if medical evaluation is needed. • If sought, medical evaluation and care should be guided by clinical presentation; diagnostic testing for COVID-19 should be guided by CDC's PUI definition. • Travel on commercial conveyances should be postponed until no longer symptomatic.	• ISOLATION • Promptly place in an AII room if available, or other single room • Use discretion to prioritize AII room needs, including high- and medium- risk and symptoms consistent with COVID-19, tuberculosis (TB), influenza, varicella, etc. • Refer to a provider • Consult with the local health department for guidance on testing for COVID-19 • Consult with Corporate Chief Medical Officer • Implement administrative and environmental controls • Implement strict hand hygiene • Implement standard precautions • Implement transmission-based precautions; see CDC Interim Guidance on Management COVID-19
No risk	N/A	No restriction

ASYMPTOMATIC		
High risk	• Quarantine (voluntary or under public health orders) in a location to be determined by public health authorities. • No public activities. • Daily active monitoring, if possible based on local priorities • Controlled travel	• MONITORING • Cohort alone or as a group with other asymptomatic persons under monitoring for 14 days • Prioritize medical housing unit needs based on acuity and suspected or known contagiousness • Implement administrative and environmental controls • Implement strict hand hygiene • Implement standard precautions • See CDC Interim Guidance on Management COVID-19 • Monitor daily for fever and symptoms • Add medical alert • Recommend no transfer or transport during monitoring period • Document in GEO/Client Tracking Tool
Medium risk	**Close contacts in this category:** • Recommendation to remain at home or in a comparable setting • Practice social distancing • Active monitoring as determined by local priorities • Recommendation to postpone long-distance travel on commercial conveyances **Travelers from mainland China (outside Hubei Province) or Iran** • Recommendation to remain at home or in a comparable setting • Practice social distancing	• MONITORING • Cohort alone or as a group with other asymptomatic persons under monitoring for 14 days • Prioritize medical housing unit needs based on acuity and suspected or known contagiousness • Implement administrative and environmental controls • Implement strict hand hygiene • Implement standard precautions • See CDC Interim Guidance on Management COVID-19 • Monitor daily for fever and symptoms • Add medical alert • Recommend no transfer or transport during monitoring period

	• Self-monitoring with public health supervision as determined by local priorities • Recommendation to postpone additional long-distance travel on commercial conveyances after they reach their final destination **Travelers from other countrv with widespread transmission** • Recommendation to remain at home or in a comparable setting, • Practice social distancing • Self-monitoring • Recommendation to postpone additional long-distance travel on commercial conveyances after they reach their final destination **Travelers from country with sustained community transmission** • Practice social distancing • Self-observation	• Document in/GEO/Client Tracking Tool

Low risk	• No restriction on movement • Self-observation	• MONITORING • Cohort alone or as a group with other asymptomatic persons under monitoring for 14 days • Prioritize medical housing unit needs based on acuity and suspected or known contagiousness • Implement administrative and environmental controls • Implement strict hand hygiene • Implement standard precautions • See CDC Interim Guidance on Management COVID-19 • Monitor daily for fever and symptoms • Document in GEO/Client Tracking Tool
No identifiable risk	None	No restriction
No risk	N/A	No restriction

[1]Source and adapted from CDC | Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Case

The ONESource

Quick Reference Page

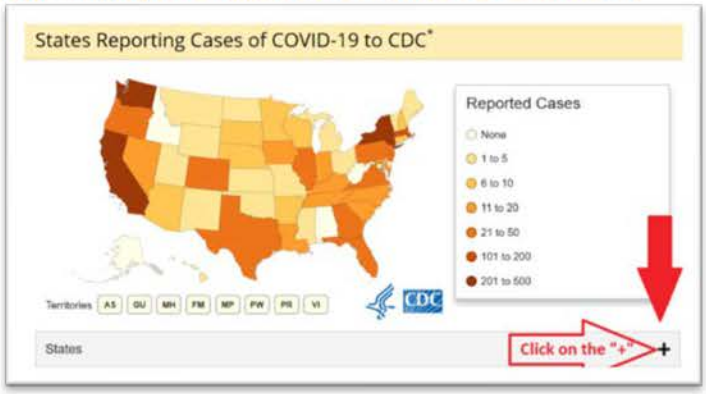
Sustained Community Transmission

"Sustained community transmission" is determined by the CDC and will be indicated on the map on this resource page: https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html where state community transmission indicates "Yes".

If you are located in an area indicated "**YES**" by the CDC, "such screening includes self-reporting and temperature checks for the next 30 days, at which time the process will be reevaluated."

Please check this daily as it will change based on daily reporting.

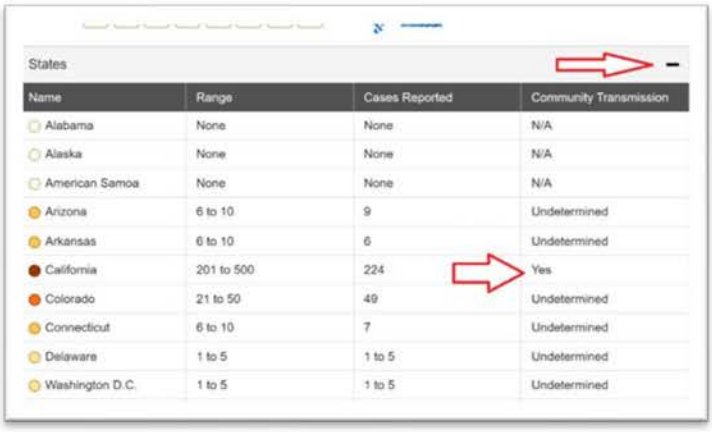
https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html



Scroll down until you see the map

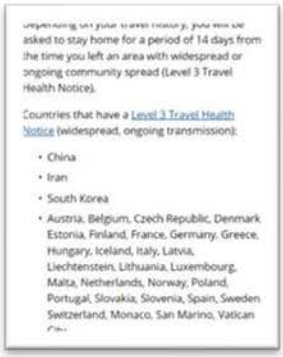
Click on the "+"

You will see the Community Transmission



Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the USA

https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html



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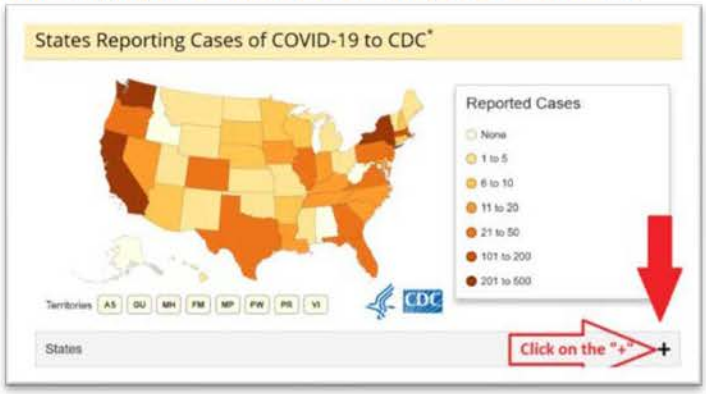

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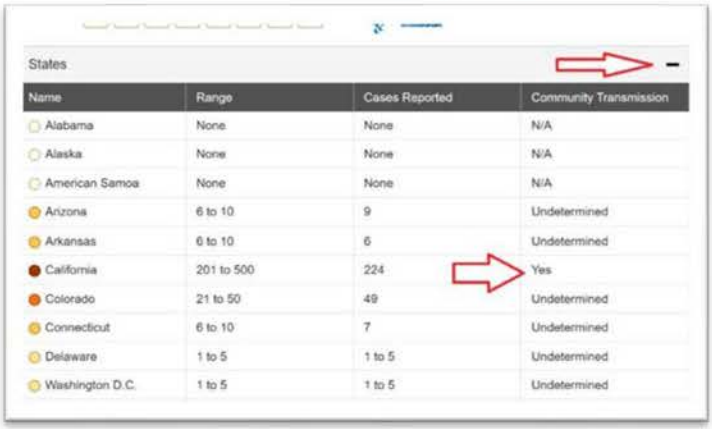
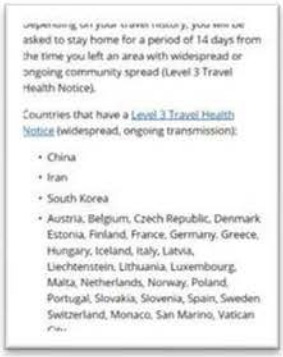


Name	Range	Cases Reported	Community Transmission
Alabama	None	None	N/A
Alaska	None	None	N/A
American Samoa	None	None	N/A
Arizona	6 to 10	9	Undetermined
Arkansas	6 to 10	6	Undetermined
California	201 to 500	224	Yes
Colorado	21 to 50	49	Undetermined
Connecticut	6 to 10	7	Undetermined
Delaware	1 to 5	1 to 5	Undetermined
Washington D.C.	1 to 5	1 to 5	Undetermined

Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the USA

https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html



COVID 19 CORONAVIRUS DISEASE

Share Facts About COVID-19

Know the facts about coronavirus disease 2019 (COVID-19) and help stop the spread of rumors.

FACT 1 Diseases can make anyone sick regardless of their race or ethnicity.

People of Asian descent, including Chinese Americans, are not more likely to get COVID-19 than any other American. Help stop fear by letting people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.

FACT 2 Some people are at increased risk of getting COVID-19.

People who have been in close contact with a person known to have COVID-19 or people who live in or have recently been in an area with ongoing spread are at an increased risk of exposure.

FACT 3 Someone who has completed quarantine or has been released from isolation does not pose a risk of infection to other people.

For up-to-date information, visit CDC's coronavirus disease 2019 web page.

FACT 4 You can help stop COVID-19 by knowing the signs and symptoms:

- Fever
- Cough
- Shortness of breath

Seek medical advice if you

- Develop symptoms

AND

- Have been in close contact with a person known to have COVID-19 or if you live in or have recently been in an area with ongoing spread of COVID-19.

FACT 5 There are simple things you can do to help keep yourself and others healthy.

- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

For more information: **www.cdc.gov/COVID19**

CS 315446-A 03/06/2020

COMPARTA LA INFORMACIÓN SOBRE EL COVID-19

Infórmese sobre la enfermedad del coronavirus 2019 (COVID-19) y ayude a detener los rumores.

DATO 1

Las enfermedades pueden afectar a cualquier persona, sin importar su raza o grupo étnico.

El miedo y la ansiedad relacionados con el COVID-19 pueden provocar que la gente evite o rechace a otras personas aun cuando no estén en riesgo de propagar el virus.

DATO 2

Para la mayoría de las personas, se piensa que el riesgo inmediato de enfermarse gravemente por el virus que causa el COVID-19 es bajo.

Los adultos mayores y las personas de cualquier edad que tengan afecciones graves subyacentes podrían tener un mayor riesgo de presentar complicaciones más graves a causa del COVID-19.

DATO 3

Alguien que haya completado el periodo de cuarentena o que ya salió del aislamiento no presenta un riesgo de infección para las demás personas.

Para obtener información actualizada, visite la página web de los CDC sobre la enfermedad del coronavirus 2019.

DATO 4

Hay cosas simples que puede hacer para ayudar a que usted y los demás se mantengan sanos.

- Lávese las manos frecuentemente con agua y jabón por al menos 20 segundos, especialmente después de sonarse la nariz, toser o estornudar; después de ir al baño; y antes de comer o preparar la comida.
- Evite tocarse los ojos, la nariz y la boca con las manos sin lavar.
- Quédese en casa si está enfermo.
- Cúbrase la nariz y la boca con un pañuelo desechable al toser o estornudar y luego bótelo a la basura.

DATO 5

Usted puede ayudar a detener el COVID-19 conociendo los signos y los síntomas:

- Fiebre
- Tos
- Dificultad para respirar

Consulte a un médico si le ocurre lo siguiente:

- Tiene síntomas

Y

- Ha estado en contacto cercano con una persona que se sepa que tiene el COVID-19, o si usted vive o ha estado recientemente en un área con propagación en curso del COVID-19.

cdc.gov/COVID-19-es

CS 315446-B 03/18/2020

分享有关 COVID-19 的事实

了解冠状病毒疾病 2019 (COVID-19) 有关的事实，帮助遏制谣言的传播。

事实 1

无论是何种族或族群，任何人均有可能感染。

对 COVID-19 的恐惧和焦虑会让人们逃避或排斥他人，即使他们并没有传播病毒的风险。

事实 2

对于大多数人来说，诱发 COVID-19 的病毒引起重症的直接风险被认为很低。

老年人和患有严重基础疾病的任何年龄的人，可能会因 COVID-19 导致更严重并发症的风险更高。

事实 3

完成隔离或从隔离中解除的人不会对其他人构成感染风险。

有关最新信息，请访问美国疾病控制和预防中心（CDC）的冠状病毒疾病 2019 网页。

事实 4

您可以通过做一些简单的事情来帮助自己和他人保持健康。

- 用肥皂和水洗手至少 20 秒，特别是在擤鼻涕、咳嗽或打喷嚏后；去洗手间；以及吃饭或做饭前。
- 避免用未清洗过的手触碰眼睛、鼻子和嘴巴。
- 生病时待在家里。
- 咳嗽或打喷嚏时用纸巾遮住，然后将纸巾丢进垃圾里。

事实 5

了解下列体征和症状有助于遏制 COVID-19：

- 发热
- 咳嗽
- 呼吸困难

如果您符合以下描述，请就医，

- 出现症状

并且

- 与确诊 COVID-19 的人密切接触或如果您居住在或最近曾到过 COVID-19 正在传播的地区。

cdc.gov/COVID19-ch

CS 315446-C 03/16/2020

The GEO Group, Inc.

NURSING ASSESSMENT PROTOCOLS

UPPER RESPIRATORY: RULE OUT CORONAVIRUS

Inmate/Detainee/Resident:	DOB:	ID Number:	Facility Name:

SUBJECTIVE: Chief Complaint:

Sick Call ____Routine_____ Urgent ____Walk-In ____Self-Declared Emergency ____True Emergency

Date/Time/Activity at onset:

Allergies:

Precipitating factors: Date I/D/R admitted to facility:

Has I/D/R been out of the country or in any High-Risk states (Where, when)?

Has I/D/R had any outside visitors (when)?

Has I/D/R been off-site recently (when, where):

Has I/D/R had any diarrhea(when)?

Has I/D/R been exposed to Coronavirus or Flu? (Who, What, When):

Current medications (OTC and Rx):

History of HTN: Heart disease: Diabetes:

Other chronic illness: Recent respiratory infection:

OBJECTIVE BP:_____P:_____R:_____**T:_____(> than 100.4 refer to provider)** Weight:_____O2 Sat: _____

Weakness: **Fatigue:**

Cough: ____Yes ____No Productive: ____Yes ____No

Respiratory rhythm:_____even ____**uneven** ____unlabored ____**labored**_____shallow_____normal_____deep

Shortness of Breath: Retractions/Accessory muscle use:

Right Lung Sounds (describe severity): ____Clear ____Wheezes ____Ronchi ____Rales ____Diminished

Left Lung Sounds (describe severity) : ____Clear ____Wheezes ____Ronchi ____Rales ____Diminished

Skin: ___Normal (warm/pink/dry) ___Pale_____Flushed ___Cyanotic____Mottled ___Diaphoretic ___Cool ___Dusky

Swollen glands (describe): Severity (Scale 1-10):

ASSESSMENT:

PLAN: ***Notify On call MD/PA/ NP if Temperature > 100.4, dry cough, respiratory distress, severe symptoms or signs of infection.***

1. **Promptly place a surgical mask over the patient's face and nose**
2. Test for Influenza A and B. If Positive, notify Provider and refer to URI: Colds/Flu/Sore Throat/Sinusitis Protocol
3. ***Notify provider immediately if Influenza test Negative***
4. Place in a single cell or negative pressure room
5. Report to HSA for potential dorm cohort
6. If need to be transported to ER – call in advance the EMS and hospital and notify of possible COVID-19

EDUCATION:

___ Instructed to cough or sneeze into their elbow or sleeve or cover coughs or sneezes with a tissue and throw the tissue directly into the trash

___Instructed in proper hand washing for a minimum of 20-seconds with soap and water.

___Instructed not to touch face, eyes, mouth

___Instructed notify medical staff if symptoms persist or worsen.

___Instructed to maintain social distancing- 6 feet from those with symptoms

NOTE: Reaffirm - Wash hands frequently especially after eating, coughing, sneezing, using the toilet.

Patient verbalized understanding of above instructions.

Interpreter Line Number, if required: _____

Nursing Signature:_____ Date: _____

Print/Stamp:_____ Time: _____

MEMORANDUM

GEO Secure Services™
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Boca Raton, Florida 33431

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866 301 4436
Fax: 561 999 7635
www.geogroup.com

Date: March 23, 2020

To: Facility Dental Providers

CC: Health Services Administrators
Health Services Directors, Health Services Managers,
Regional DOs
Executive Vice President, Continuum of Care and Reentry
Regional VPs
Facility Administrators
John Cucurus, DDS, GEO Consultant Dentist

From: John E. Christakis, M.D., Chief Medical Officer MD.

RE: CORONAVIRUS COVID-19 DENTAL GUIDANCE

To Our Dental Providers,

Due to the COVID-19 outbreak and the risk of viral exposure, effective immediately, our Dental providers are advised to determine the necessity of off-site non-emergent consultations and procedures until further notice from corporate Health Services. Our dental directors will notify the facility FA regarding any off-site consultations in managing this new directive. As providers we must take the lead in limiting the risk of spreading the virus, and elective procedures such as crowns and/or fixed prosthodontics may need to be postponed at this time.

If the treatment requested is deemed to be medically necessary and/or emergent, the patient will be sent to the appropriate off-site consultant for further dental or oral surgical care.

If the approved treatment is determined to be non-emergent, the treatment by an off-site provider will be rescheduled. A follow-up patient visit by the facility's dental provider will be scheduled per his discretion. All re-scheduled appointments must be documented in the patient's medical record as a written or digitalized order. Examples of visits which may be re-scheduled are, a) all hygiene appointments, b) comprehensive exams, c) periodic exams and all elective procedures. Please use your professional judgement in determining which patients need to be re-scheduled.

Until follow-up guidance from the ADA and the CDC is provided, the onsite dental program will be focusing on emergency dental care only.

Coronavirus Disease 2019 (COVID-19)

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities

This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of the date of posting, March 23, 2020.

The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the CDC website periodically for updated interim guidance.

This document provides interim guidance specific for correctional facilities and detention centers during the outbreak of COVID-19, to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors. Recommendations may need to be revised as more information becomes available.

Who is the intended audience for this guidance?

This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities (including but not limited to federal and state prisons, local jails, and detention centers), law enforcement agencies that have custodial authority for detained populations (i.e., US Immigration and Customs Enforcement and US Marshals Service), and their respective health departments, to assist in preparing for potential introduction, spread, and mitigation of COVID-19 in their facilities. In general, the document uses terminology referring to correctional environments but can also be applied to civil and pre-trial detention settings.

This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes. **The guidance may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions.** Facilities should contact CDC or their state, local, territorial, and/or tribal public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.

Why is this guidance being issued?

Correctional and detention facilities can include custody, housing, education, recreation, healthcare, food service, and workplace components in a single physical setting. The integration of these components presents unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors. Consistent application of specific preparation, prevention, and management measures can help reduce the risk of transmission and severe disease from COVID-19.

- Incarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced.
- In most cases, incarcerated/detained persons are not permitted to leave the facility.
- There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including daily staff ingress and egress; transfer of incarcerated/detained persons between facilities and systems, to court appearances, and to outside medical visits; and visits from family, legal representatives, and other community members. Some settings, particularly jails and detention centers, have high turnover, admitting new entrants daily who may have been exposed to COVID-19 in the surrounding community or other regions.
- Persons incarcerated/detained in a particular facility often come from a variety of locations, increasing the potential to introduce COVID-19 from different geographic areas.
- Options for medical isolation of COVID-19 cases are limited and vary depending on the type and size of facility, as well as the current level of available capacity, which is partly based on medical isolation needs for other conditions.
- Adequate levels of custody and healthcare staffing must be maintained to ensure safe operation of the facility, and options to practice social distancing through work alternatives such as working from home or reduced/alternate schedules are limited for many staff roles.
- Correctional and detention facilities can be complex, multi-employer settings that include government and private employers. Each is organizationally distinct and responsible for its own operational, personnel, and occupational health protocols and may be prohibited from issuing guidance or providing services to other employers or their staff within the same setting. Similarly, correctional and detention facilities may house individuals from multiple law enforcement agencies or jurisdictions subject to different policies and procedures.
- Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19.
- Because limited outside information is available to many incarcerated/detained persons, unease and misinformation regarding the potential for COVID-19 spread may be high, potentially creating security and morale challenges.
- The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and is determined by the supplies provided in the facility and by security considerations. Many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants.
- Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

CDC has issued separate COVID-19 guidance addressing healthcare infection control and clinical care of COVID-19 cases as well as close contacts of cases in community-based settings. Where relevant, community-focused guidance documents are referenced in this document and should be monitored regularly for updates, but they may require adaptation for correctional and detention settings.

This guidance document provides additional recommended best practices specifically for correctional and detention facilities. **At this time, different facility types (e.g., prison vs. jail) and sizes are not differentiated. Administrators and agencies should adapt these guiding principles to the specific needs of their facility.**

What topics does this guidance include?

The guidance below includes detailed recommendations on the following topics related to COVID-19 in correctional and detention settings:

- Operational and communications preparations for COVID-19
- Enhanced cleaning/disinfecting and hygiene practices
- Social distancing strategies to increase space between individuals in the facility
- How to limit transmission from visitors
- Infection control, including recommended personal protective equipment (PPE) and potential alternatives during PPE shortages
- Verbal screening and temperature check protocols for incoming incarcerated/detained individuals, staff, and visitors
- Medical isolation of confirmed and suspected cases and quarantine of contacts, including considerations for cohorting when individual spaces are limited
- Healthcare evaluation for suspected cases, including testing for COVID-19
- Clinical care for confirmed and suspected cases
- Considerations for persons at higher risk of severe disease from COVID-19

Definitions of Commonly Used Terms

Close contact of a COVID-19 case – In the context of COVID-19, an individual is considered a close contact if they a) have been within approximately 6 feet of a COVID-19 case for a prolonged period of time or b) have had direct contact with infectious secretions from a COVID-19 case (e.g., have been coughed on). Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

Cohorting – Cohorting refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group, or quarantining close contacts of a particular case together as a group. Ideally, cases should be isolated individually, and close contacts should be quarantined individually. However, some correctional facilities and detention centers do not have enough individual cells to do so and must consider cohorting as an alternative. See Quarantine and Medical Isolation sections below for specific details about ways to implement cohorting to minimize the risk of disease spread and adverse health outcomes.

Community transmission of COVID-19 – Community transmission of COVID-19 occurs when individuals acquire the disease through contact with someone in their local community, rather than through travel to an affected location. Once community transmission is identified in a particular area, correctional facilities and detention centers are more likely to start seeing cases inside their walls. Facilities should consult with local public health departments if assistance is needed in determining how to define "local community" in the context of COVID-19 spread. However, because all states have reported cases, all facilities should be vigilant for introduction into their populations.

Confirmed vs. Suspected COVID-19 case – A **confirmed case** has received a positive result from a COVID-19 laboratory test, with or without symptoms. A **suspected case** shows symptoms of COVID-19 but either has not been tested or is awaiting test results. If test results are positive, a suspected case becomes a confirmed case.

Incarcerated/detained persons – For the purpose of this document, "incarcerated/detained persons" refers to persons held in a prison, jail, detention center, or other custodial setting where these guidelines are generally applicable. The term includes those who have been sentenced (i.e., in prisons) as well as those held for pre-trial (i.e., jails) or civil purposes (i.e,

detention centers). Although this guidance does not specifically reference individuals in every type of custodial setting (e.g., juvenile facilities, community confinement facilities), facility administrators can adapt this guidance to apply to their specific circumstances as needed.

Medical Isolation – Medical isolation refers to confining a confirmed or suspected COVID-19 case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established clinical and/or testing criteria for release from isolation, in consultation with clinical providers and public health officials (detailed in guidance below). In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term "medical isolation" to avoid confusion.

Quarantine – Quarantine refers to the practice of confining individuals who have had close contact with a COVID-19 case to determine whether they develop symptoms of the disease. Quarantine for COVID-19 should last for a period of 14 days. Ideally, each quarantined individual would be quarantined in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, the individual should be placed under medical isolation and evaluated for COVID-19. If symptoms do not develop, movement restrictions can be lifted, and the individual can return to their previous residency status within the facility.

Social Distancing – Social distancing is the practice of increasing the space between individuals and decreasing the frequency of contact to reduce the risk of spreading a disease (ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic). Social distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals will be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them). Although social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this CDC publication .

Staff – In this document, "staff" refers to all public sector employees as well as those working for a private contractor within a correctional facility (e.g., private healthcare or food service). Except where noted, "staff" does not distinguish between healthcare, custody, and other types of staff including private facility operators.

Symptoms – Symptoms of COVID-19 include fever, cough, and shortness of breath. Like other respiratory infections, COVID-19 can vary in severity from mild to severe. When severe, pneumonia, respiratory failure, and death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations most at risk for disease and complications are not yet fully understood. Monitor the CDC website for updates on these topics.

Facilities with Limited Onsite Healthcare Services

Although many large facilities such as prisons and some jails usually employ onsite healthcare staff and have the capacity to evaluate incarcerated/detained persons for potential illness within a dedicated healthcare space, many smaller facilities do not. Some of these facilities have access to on-call healthcare staff or providers who visit the facility every few days. Others have neither onsite healthcare capacity nor onsite medical isolation/quarantine space and must transfer ill patients to other correctional or detention facilities or local hospitals for evaluation and care.

The majority of the guidance below is designed to be applied to any correctional or detention facility, either as written or with modifications based on a facility's individual structure and resources. However, topics related to healthcare evaluation and clinical care of confirmed and suspected COVID-19 cases and their close contacts may not apply directly to facilities with limited or no onsite healthcare services. It will be especially important for these types of facilities to coordinate closely with their state, local, tribal, and/or territorial health department when they encounter confirmed or suspected cases among incarcerated/detained persons or staff, in order to ensure effective medical isolation and quarantine, necessary medical evaluation and care, and medical transfer if needed. The guidance makes note of strategies tailored to facilities without onsite healthcare where possible.

Note that all staff in any sized facility, regardless of the presence of onsite healthcare services, should observe guidance on recommended PPE in order to ensure their own safety when interacting with confirmed and suspected COVID-19 cases. Facilities should make contingency plans for the likely event of PPE shortages during the COVID-19 pandemic.

COVID-19 Guidance for Correctional Facilities

Guidance for correctional and detention facilities is organized into 3 sections: Operational Preparedness, Prevention, and Management of COVID-19. Recommendations across these sections can be applied simultaneously based on the progress of the outbreak in a particular facility and the surrounding community.

- **Operational Preparedness.** This guidance is intended to help facilities prepare for potential COVID-19 transmission in the facility. Strategies focus on operational and communications planning and personnel practices.
- **Prevention**. This guidance is intended to help facilities prevent spread of COVID-19 from outside the facility to inside. Strategies focus on reinforcing hygiene practices, intensifying cleaning and disinfection of the facility, screening (new intakes, visitors, and staff), continued communication with incarcerated/detained persons and staff, and social distancing measures (increasing distance between individuals).
- **Management.** This guidance is intended to help facilities clinically manage confirmed and suspected COVID-19 cases inside the facility and prevent further transmission. Strategies include medical isolation and care of incarcerated/detained persons with symptoms (including considerations for cohorting), quarantine of cases' close contacts, restricting movement in and out of the facility, infection control practices for individuals interacting with cases and quarantined contacts or contaminated items, intensified social distancing, and cleaning and disinfecting areas visited by cases.

Operational Preparedness

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and incarcerated/detained persons about these preparations and how they may temporarily alter daily life.

Communication & Coordination

- **Develop information-sharing systems with partners.**
  - Identify points of contact in relevant state, local, tribal, and/or territorial public health departments before cases develop. Actively engage with the health department to understand in advance which entity has jurisdiction to implement public health control measures for COVID-19 in a particular correctional or detention

facility.

- Create and test communications plans to disseminate critical information to incarcerated/detained persons, staff, contractors, vendors, and visitors as the pandemic progresses.
- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- Where possible, put plans in place with other jurisdictions to prevent confirmed and suspected COVID-19 cases and their close contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
- Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.

- **Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.**
  - Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting.
  - Facilities without onsite healthcare capacity should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.
  - Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.
  - Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.

- **Coordinate with local law enforcement and court officials.**
  - Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission.
  - Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.
- **Post signage throughout the facility communicating the following:**
  - **For all:** symptoms of COVID-19 and hand hygiene instructions
  - **For incarcerated/detained persons**: report symptoms to staff
  - **For staff**: stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor.
  - Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

- **Review the sick leave policies of each employer that operates in the facility.**

- Review policies to ensure that they actively encourage staff to stay home when sick.
- If these policies do not encourage staff to stay home when sick, discuss with the contract company.
- Determine which officials will have the authority to send symptomatic staff home.

- **Identify staff whose duties would allow them to work from home.** Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of COVID-19 transmission.
  - Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.
  - Put systems in place to implement work from home programs (e.g., time tracking, etc.).

- **Plan for staff absences.** Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.
  - Allow staff to work from home when possible, within the scope of their duties.
  - Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
  - Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
  - Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.

- **Consider offering revised duties to staff who are at higher risk of severe illness with COVID-19.** Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
  - Facility administrators should consult with their occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to COVID-19.
- **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of COVID-19 are similar to those of influenza. Preventing influenza cases in a facility can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.

- **Reference the Occupational Safety and Health Administration website for recommendations regarding worker health.**

- **Review CDC's guidance for businesses and employers** to identify any additional strategies the facility can use within its role as an employer.

Operations & Supplies

- **Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.**
  - Standard medical supplies for daily clinic needs
  - Tissues
  - Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby

discourage frequent hand washing.
    - Hand drying supplies
    - Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
    - Cleaning supplies, including EPA-registered disinfectants effective against the virus that causes COVID-19
    - Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See PPE section and Table 1 for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s. Visit CDC's website for a calculator to help determine rate of PPE usage.
    - Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated

- **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**
    - See CDC guidance optimizing PPE supplies.

- **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.
- **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See Hygiene section below for additional detail regarding recommended frequency and protocol for hand washing.)
    - Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.

- **If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**
- **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

Cases of COVID-19 have been documented in all 50 US states. Correctional and detention facilities can prevent introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission.

Operations

- **Stay in communication with partners about your facility's current situation.**
  - State, local, territorial, and/or tribal health departments
  - Other correctional facilities
- **Communicate with the public about any changes to facility operations, including visitation programs.**
- **Restrict transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.**
  - Strongly consider postponing non-urgent outside medical visits.
  - If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case – including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to properly isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.
- **Implement lawful alternatives to in-person court appearances where permissible.**
- **Where relevant, consider suspending co-pays for incarcerated/detained persons seeking medical evaluation for respiratory symptoms.**
- **Limit the number of operational entrances and exits to the facility.**

Cleaning and Disinfecting Practices

- **Even if COVID-19 cases have not yet been identified inside the facility or in the surrounding community, begin implementing intensified cleaning and disinfecting procedures according to the recommendations below. These measures may prevent spread of COVID-19 if introduced.**
- **Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.** Monitor these recommendations for updates.
  - Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones).
  - Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
  - Use household cleaners and EPA-registered disinfectants effective against the virus that causes COVID-19 as appropriate for the surface, following label instructions. This may require lifting restrictions on undiluted disinfectants.
  - Labels contain instructions for safe and effective use of the cleaning product, including precautions that should be taken when applying the product, such as wearing gloves and making sure there is good ventilation during use.
- **Consider increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of these areas throughout the day.**
- **Ensure adequate supplies to support intensified cleaning and disinfection practices, and have a plan in place to restock rapidly if needed.**

Hygiene

- **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**
- **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis. Sample signage and other communications materials are available on the CDC website.** Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
  - **Practice good cough etiquette:** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
  - **Practice good hand hygiene:** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
  - **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
  - **Avoid sharing eating utensils, dishes, and cups.**
  - **Avoid non-essential physical contact.**

- **Provide incarcerated/detained persons and staff no-cost access to:**
  - **Soap** – Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
  - **Running water, and hand drying machines or disposable paper towels** for hand washing
  - **Tissues** and no-touch trash receptacles for disposal
- **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.
- **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

- **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process**, in order to identify and immediately place individuals with symptoms under medical isolation. See Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below).
  - **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath)**:**
    - Require the individual to wear a face mask.
    - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
    - Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
    - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health

department to coordinate effective medical isolation and necessary medical care.

- **If an individual is a close contact of a known COVID-19 case (but has no COVID-19 symptoms):**
  - Quarantine the individual and monitor for symptoms two times per day for 14 days. (See Quarantine section below.)
  - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.

- **Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms).** Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:
  - **Common areas:**
    - Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)
  - **Recreation:**
    - Choose recreation spaces where individuals can spread out
    - Stagger time in recreation spaces
    - Restrict recreation space usage to a single housing unit per space (where feasible)
  - **Meals:**
    - Stagger meals
    - Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
    - Provide meals inside housing units or cells
  - **Group activities:**
    - Limit the size of group activities
    - Increase space between individuals during group activities
    - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
    - Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out
  - **Housing:**
    - If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
    - Arrange bunks so that individuals sleep head to foot to increase the distance between them
    - Rearrange scheduled movements to minimize mixing of individuals from different housing areas
  - **Medical:**
    - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
    - Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.

- **Communicate clearly and frequently with incarcerated/detained persons about changes to their daily routine and how they can contribute to risk reduction.**

- **Note that if group activities are discontinued, it will be important to identify alternative forms of activity to support the mental health of incarcerated/detained persons.**

- **Consider suspending work release programs and other programs that involve movement of incarcerated/detained individuals in and out of the facility.**
- **Provide up-to-date information about COVID-19 to incarcerated/detained persons on a regular basis, including:**
  - Symptoms of COVID-19 and its health risks
  - Reminders to report COVID-19 symptoms to staff at the first sign of illness
- **Consider having healthcare staff perform rounds on a regular basis to answer questions about COVID-19.**

Prevention Practices for Staff

- **Remind staff to stay at home if they are sick.** Ensure that staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.
- **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all staff daily on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
  - Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.

- **Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including:**
  - Symptoms of COVID-19 and its health risks
  - Employers' sick leave policy
  - **If staff develop a fever, cough, or shortness of breath while at work**: immediately put on a face mask, inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
  - **If staff test positive for COVID-19:** inform workplace and personal contacts immediately, and do not return to work until a decision to discontinue home medical isolation precautions is made. Monitor CDC guidance on discontinuing home isolation regularly as circumstances evolve rapidly.
  - **If a staff member is identified as a close contact of a COVID-19 case (either within the facility or in the community):** self-quarantine at home for 14 days and return to work if symptoms do not develop. If symptoms do develop, follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- **If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff about their possible exposure to COVID-19 in the workplace, but should maintain confidentiality as required by the Americans with Disabilities Act.**
  - Employees who are close contacts of the case should then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).
- **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with respiratory symptoms while interviewing, escorting, or interacting in**

other ways.

- **Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.**

Prevention Practices for Visitors

- **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**
- **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
  - Staff performing temperature checks should wear recommended PPE.
  - Exclude visitors and volunteers who do not clear the screening process or who decline screening.
- **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**
- **Provide visitors and volunteers with information to prepare them for screening.**
  - Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
  - If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.
  - Display signage outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.
- **Promote non-contact visits:**
  - Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
  - Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
  - Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.
- **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**
  - If moving to virtual visitation, clean electronic surfaces regularly. (See Cleaning guidance below for instructions on cleaning electronic surfaces.)
  - Inform potential visitors of changes to, or suspension of, visitation programs.
  - Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
  - If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

NOTE: Suspending visitation would be done in the interest of incarcerated/detained persons' physical health and the health of the general public. However, visitation is important to maintain mental health. If visitation is suspended, facilities should explore alternative ways for incarcerated/detained persons to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them. See above suggestions for promoting non-contact visits.

- **Restrict non-essential vendors, volunteers, and tours from entering the facility.**

Management

If there has been a suspected COVID-19 case inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

Operations

- **Implement alternate work arrangements deemed feasible in the Operational Preparedness**
- **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.**
    - If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case – including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.
- **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.
- **When possible, arrange lawful alternatives to in-person court appearances.**
- **Incorporate screening for COVID-19 symptoms and a temperature check into release planning.**
    - Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.)
        - If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case – including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
        - If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
        - Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.
- Coordinate with state, local, tribal, and/or territorial health departments.
    - When a COVID-19 case is suspected, work with public health to determine action. See Medical Isolation section below.
    - When a COVID-19 case is suspected or confirmed, work with public health to identify close contacts who should be placed under quarantine. See Quarantine section below.

- Facilities with limited onsite medical isolation, quarantine, and/or healthcare services should coordinate closely with state, local, tribal, and/or territorial health departments when they encounter a confirmed or suspected case, in order to ensure effective medical isolation or quarantine, necessary medical evaluation and care, and medical transfer if needed. See Facilities with Limited Onsite Healthcare Services section.

Hygiene

- **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See above.)
- **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See above.)

Cleaning and Disinfecting Practices

- **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See above.)
- **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).**

Medical Isolation of Confirmed or Suspected COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity, or without sufficient space to implement effective medical isolation, should coordinate with local public health officials to ensure that COVID-19 cases will be appropriately isolated, evaluated, tested (if indicated), and given care.

- **As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.**
- **Keep the individual's movement outside the medical isolation space to an absolute minimum.**
  - Provide medical care to cases inside the medical isolation space. See Infection Control and Clinical Care sections for additional details.
  - Serve meals to cases inside the medical isolation space.
  - Exclude the individual from all group activities.
  - Assign the isolated individual a dedicated bathroom when possible.
- **Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters.** Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.
- **Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom where possible.** Cohorting should only be practiced if there are no other available options.
  - If cohorting is necessary:
    - **Only individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.**
    - Unless no other options exist, do not house COVID-19 cases with individuals who have an undiagnosed respiratory infection.

        - Ensure that cohorted cases wear face masks at all times.
    - **In order of preference, individuals under medical isolation should be housed:**
        - Separately, in single cells with solid walls (i.e., not bars) 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 and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
        - As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
        - As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
        - As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
        - Safely transfer individual(s) to another facility with available medical isolation capacity in one of the above arrangements
          (NOTE – Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

If the ideal choice does not exist in a facility, use the next best alternative.

- **If the number of confirmed cases exceeds the number of individual medical isolation spaces available in the facility, be especially mindful of cases who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other infected individuals. If cohorting is unavoidable, make all possible accommodations to prevent transmission of other infectious diseases to the higher-risk individual. (For example, allocate more space for a higher-risk individual within a shared medical isolation space.)
    - Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
    - Note that incarcerated/detained populations have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages.
- **Custody staff should be designated to monitor these individuals exclusively where possible.** These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see PPE section below) and should limit their own movement between different parts of the facility to the extent possible.
- **Minimize transfer of COVID-19 cases between spaces within the healthcare unit.**
- **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** 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. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.
- **Maintain medical isolation until all the following criteria have been met. Monitor the CDC website for**

updates to these criteria.

- **For individuals who will be tested to determine if they are still contagious:**
  - The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
  - The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
  - The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart
- **For individuals who will NOT be tested to determine if they are still contagious:**
  - The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
  - The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
  - At least 7 days have passed since the first symptoms appeared
- **For individuals who had a confirmed positive COVID-19 test but never showed symptoms:**
  - At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND**
  - The individual has had no subsequent illness

- **Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.**
  - If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.

Cleaning Spaces where COVID-19 Cases Spent Time

- **Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note – these protocols apply to suspected cases as well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19. Refer to the Definitions section for the distinction between confirmed and suspected cases.**
  - Close off areas used by the infected individual. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions), before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
  - Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).
- **Hard (non-porous) surface cleaning and disinfection**
  - If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
  - For disinfection, most common EPA-registered household disinfectants should be effective. Choose cleaning products based on security requirements within the facility.
    - Consult a list of products that are EPA-approved for use against the virus that causes COVID-19 . Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
    - Diluted household bleach solutions can be used if appropriate for the surface. Follow the manufacturer's instructions for application and proper ventilation, and check to ensure the product is not past its

expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted. Prepare a bleach solution by mixing:
    - 5 tablespoons (1/3rd cup) bleach per gallon of water or
    - 4 teaspoons bleach per quart of water
- **Soft (porous) surface cleaning and disinfection**
    - For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
        - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
        - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and are suitable for porous surfaces.
- **Electronics cleaning and disinfection**
    - 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.
        - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Additional information on cleaning and disinfection of communal facilities such can be found on CDC's website.

- **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See PPE section below.)
- **Food service items.** Cases under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- **Laundry from a COVID-19 cases can be washed with other individuals' laundry.**
    - Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
    - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
    - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
    - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.
- **Consult cleaning recommendations above to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity, or without sufficient space to implement effective quarantine, should coordinate with local public health officials to ensure that close contacts of COVID-19 cases will be effectively quarantined and medically monitored.

- **Incarcerated/detained persons who are close contacts of a confirmed or suspected COVID-19 case (whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**
    - If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.
- **In the context of COVID-19, an individual (incarcerated/detained person or staff) is considered a close contact if they:**
    - Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time **OR**
    - Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on)

Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).

- **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**
    - Provide medical evaluation and care inside or near the quarantine space when possible.
    - Serve meals inside the quarantine space.
    - Exclude the quarantined individual from all group activities.
    - Assign the quarantined individual a dedicated bathroom when possible.
- **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually.** Cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.
    - If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under medical isolation
    - If an entire housing unit is under 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.
    - Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine.
    - If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.
- **If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of those who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.)
- **In order of preference, multiple quarantined individuals should be housed:**
    - Separately, in single cells with solid walls (i.e., not bars) 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 (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.
- As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
- Safely transfer to another facility with capacity to quarantine in one of the above arrangements (NOTE – Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

- **Quarantined individuals should wear face masks if feasible based on local supply, as source control, under the following circumstances** (see PPE section and Table 1)**:**
  - If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
  - If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
  - All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
  - Asymptomatic individuals under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear face masks.
- **Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties** (see PPE section and Table 1).
  - Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear PPE.
- **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
  - If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See Medical Isolation section above.)
  - See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- **If an individual who is part of a quarantined cohort becomes symptomatic:**
  - **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
  - **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
  - **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**

- **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- **Laundry from quarantined individuals can be washed with other individuals' laundry.**
  - Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
  - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
  - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
  - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity or without sufficient space for medical isolation should coordinate with local public health officials to ensure that suspected COVID-19 cases will be effectively isolated, evaluated, tested (if indicated), and given care.

- **If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.**
- **Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and should be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing. See Medical Isolation section above.**
- **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.
- **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
  - If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.)
  - If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

Management Strategies for Incarcerated/Detained Persons without COVID-19 Symptoms

- **Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**

- Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
- Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

- **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.**See Screening section for a procedure to safely perform a temperature check.
- **Consider additional options to intensify social distancing** within the facility.

Management Strategies for Staff

- **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**
  - Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.
- **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**
  - See above for definition of a close contact.
  - Refer to CDC guidelines for further recommendations regarding home quarantine for staff.

Infection Control

Infection control guidance below is applicable to all types of correctional facilities. Individual facilities should assess their unique needs based on the types of exposure staff and incarcerated/detained persons may have with confirmed or suspected COVID-19 cases.

- **All individuals who have the potential for direct or indirect exposure to COVID-19 cases or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Monitor these guidelines regularly for updates.**
  - Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
  - Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).
- **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see PPE section).
- **Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

- **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**
  - If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital.
  - The initial medical evaluation should determine whether a symptomatic individual is at higher risk for severe illness from COVID-19. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
- **Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and monitor the guidance website regularly for updates to these recommendations.**
- **Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the suspected case is wearing a face mask.**
  - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.
- **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).**
- **The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.**
- **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.**

Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons

- **Ensure that all staff (healthcare and non-healthcare) and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with confirmed and suspected COVID-19 cases.**
  - Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program.
  - For PPE training materials and posters, please visit the CDC website on Protecting Healthcare Personnel.
- **Ensure that all staff are trained to perform hand hygiene after removing PPE.**
- **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (see Table 1). Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.**
- **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**
- **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with COVID-19 cases and their contacts (see Table 1). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**

- **N95 respirator**
  See below for guidance on when face masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case.
- **Face mask**
- **Eye protection** – goggles or disposable face shield that fully covers the front and sides of the face
- **A single pair of disposable patient examination gloves**
  Gloves should be changed if they become torn or heavily contaminated.
- **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**
  - If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
  - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, 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.

- **Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website:**
  - **Guidance in the event of a shortage of N95 respirators**
    - Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand**. During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.
  - **Guidance in the event of a shortage of face masks**
  - **Guidance in the event of a shortage of eye protection**
  - **Guidance in the event of a shortage of gowns/coveralls**

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case*)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19		X			
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact				X	X
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case* (but not performing temperature checks or providing medical care)		Face mask, eye protection, and gloves as local supply and scope of duties allow.			
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons		X	X	X	X
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	X**		X	X	X
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	X		X	X	X
Staff handling laundry or used food service items from a COVID-19 case or case contact				X	X
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X

Classification of Individual Wearing PPE

* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.
** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

The guidance above recommends verbal screening and temperature checks for incarcerated/detained persons, staff, volunteers, and visitors who enter correctional and detention facilities, as well as incarcerated/detained persons who are transferred to another facility or released from custody. Below, verbal screening questions for COVID-19 symptoms and contact with known cases, and a safe temperature check procedure are detailed.

- **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**
  - *Today or in the past 24 hours, have you had any of the following symptoms?*
    - *Fever, felt feverish, or had chills?*
    - *Cough?*
    - *Difficulty breathing?*
  - *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*
- **The following is a protocol to safely check an individual's temperature:**
  - Perform hand hygiene
  - Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
  - Check individual's temperature
  - **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
  - Remove and discard PPE
  - Perform hand hygiene

Page last reviewed: March 23, 2020

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of Eye Protection

Audience: These considerations are intended for use by federal, state, and local public health officials; leaders in occupational health services and infection prevention and control programs; and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of eye protection in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare facilities can refer to COVID-19 preparedness plans.

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of eye protection during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve eye protection supplies along the continuum of care.

- Conventional capacity: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and personal protective equipment (PPE) controls should already be implemented in general infection prevention and control plans in healthcare settings.
- Contingency capacity: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily during periods of expected eye protection shortages.
- Crisis capacity: strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known eye protection shortages.

The following contingency and crisis strategies are based upon these assumptions:

1. Facilities understand their eye protection inventory and supply chain
2. Facilities understand their eye protection utilization rate
3. Facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies
4. Facilities have already implemented other engineering and administrative control measures including:
    - Reducing the number of patients going to the hospital or outpatient settings
    - Excluding HCP not essential for patient care from entering their care area
    - Reducing face-to-face HCP encounters with patients
    - Excluding visitors to patients with confirmed or suspected COVID-19
    - Cohorting patients and HCP
    - Maximizing use of telemedicine
5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

Conventional Capacity Strategies

Use eye protection according to product labeling and local, state, and federal requirements.

Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which eye protection is typically used by HCP.

Shift eye protection supplies from disposable to re-usable devices (i.e., goggles and reusable face shields).

- Consider preferential use of powered air purifying respirators (PAPRs) or full-face elastomeric respirators which have built-in eye protection.
- Ensure appropriate cleaning and disinfection between users if goggles or reusable face shields are used.

Implement extended use of eye protection.

Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices.

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
  - If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. See protocol for removing and reprocessing eye protection below.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- HCP should take care not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene.
- HCP should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below.

Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which eye protection is typically used by HCP.

Use eye protection devices beyond the manufacturer-designated shelf life during patient care activities.

If there is no date available on the eye protection device label or packaging, facilities should contact the manufacturer. The user should visually inspect the product prior to use and, if there are concerns (such as degraded materials), discard the product.

Prioritize eye protection for selected activities such as:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures.
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.

Consider using safety glasses (e.g., trauma glasses) that have extensions to cover the side of the eyes.

Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients.

- During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients.

- It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Selected Options for Reprocessing Eye Protection

Adhere to recommended manufacturer instructions for cleaning and disinfection.

When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields, consider:

1. While wearing gloves, carefully wipe the *inside, followed by the outside* of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe.
2. Carefully wipe the *outside* of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution.
3. Wipe the outside of face shield or goggles with clean water or alcohol to remove residue.
4. Fully dry (air dry or use clean absorbent towels).
5. Remove gloves and perform hand hygiene.

Additional Resources

Strategies for Optimizing the Supply of Isolation Gowns

Strategies for Optimizing the Supply of Facemasks

Strategies for Optimizing the Supply of N95 Respirators

Page last reviewed: March 17, 2020

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of Facemasks

Audience: These considerations are intended for use by federal, state, and local public health officials; leaders in occupational health services and infection prevention and control programs; and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of facemasks in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare facilities can refer to COVID-19 preparedness plans.

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of facemasks during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve facemask supplies along the continuum of care.

- Conventional capacity: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and personal protective equipment (PPE) controls should already be implemented in general infection prevention and control plans in healthcare settings.
- Contingency capacity: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily during periods of expected facemask shortages.
- Crisis capacity: strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known facemask shortages.

The following contingency and crisis strategies are based upon these assumptions:

1. Facilities understand their facemask inventory and supply chain
2. Facilities understand their facemask utilization rate
3. Facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies.
4. Facilities have already implemented other engineering and administrative control measures including:
    - Reducing the number of patients going to the hospital or outpatient settings
    - Excluding HCP not essential for patient care from entering their care area
    - Reducing face-to-face HCP encounters with patients
    - Excluding visitors to patients with confirmed or suspected COVID-19
    - Cohorting patients and HCP
    - Maximizing use of telemedicine
5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

Conventional Capacity Strategies

Use facemasks according to product labeling and local, state, and federal requirements.

- FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures.

- Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which a facemask is typically used by HCP.

Remove facemasks for visitors in public areas.

Healthcare facilities can consider removing all facemasks from public areas. Facemasks can be available to provide to symptomatic patients upon check in at entry points. All facemasks should be placed in a secure and monitored site. This is especially important in high-traffic areas like emergency departments.

Implement extended use of facemasks.

Extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- HCP must take care not to touch their facemask. If they touch or adjust their facemask they must immediately perform hand hygiene.
- HCP should leave the patient care area if they need to remove the facemask.

Restrict facemasks to use by HCP, rather than patients for source control.

Have patients with symptoms of respiratory infection use tissues or other barriers to cover their mouth and nose.

Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which a facemask is typically used by HCP.

Use facemasks beyond the manufacturer-designated shelf life during patient care activities.

If there is no date available on the facemask label or packaging, facilities should contact the manufacturer. 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 facemasks.

Limited re-use of facemasks is the practice of using the same facemask by one HCP for multiple encounters with different patients but removing it after each encounter. As it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, care should be taken to ensure that HCP do not touch outer surfaces of the mask during care, and that mask removal and replacement be done in a careful and deliberate manner.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- Not all facemasks can be re-used.
  - Facemasks that fasten to the provider via ties may not be able to be undone without tearing and should be considered only for extended use, rather than re-use.
  - Facemasks with elastic ear hooks may be more suitable for re-use.
- HCP should leave patient care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.

Prioritize facemasks for selected activities such as:

- For provision of essential surgeries and procedures

- 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

When No Facemasks Are Available, Options Include

Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients.
During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients.
It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Use a face shield that covers the entire front (that extends to the chin or below) and sides of the face with no facemask.

Consider use of expedient patient isolation rooms for risk reduction.
Portable fan devices with high-efficiency particulate air (HEPA) filtration that are carefully placed can increase the effective air changes per hour of clean air to the patient room, reducing risk to individuals entering the room without respiratory protection. NIOSH has developed guidance for using portable HEPA filtration systems to create expedient patient isolation rooms. The expedient patient isolation room approach involves establishing a high-ventilation-rate, negative pressure, inner isolation zone that sits within a "clean" larger ventilated zone.

Consider use of ventilated headboards
NIOSH has developed the ventilated headboard that draws exhaled air from a patient in bed into a HEPA filter, decreasing risk of HCP exposure to patient-generated aerosol. This technology consists of lightweight, sturdy, and adjustable aluminum framing with a retractable plastic canopy. The ventilated headboard can be deployed in combination with HEPA fan/filter units to provide surge isolation capacity within a variety of environments, from traditional patient rooms to triage stations, and emergency medical shelters.

HCP use of homemade masks:
In settings where facemasks are not available, HCP might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.

Additional Resources

Strategies for Optimizing the Supply of Eye Protection

Strategies for Optimizing the Supply of Isolation Gowns

Strategies for Optimizing the Supply of N95 Respirators

Page last reviewed: March 17, 2020

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of Isolation Gowns

Audience: These considerations are intended for use by federal, state, and local public health officials; leaders in occupational health services and infection prevention and control programs; and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of isolation gowns in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare facilities can refer to COVID-19 preparedness plans.

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no widely accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of isolation gowns during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve isolation gown supplies along the continuum of care.

- Conventional capacity: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and personal protective equipment (PPE) controls should already be implemented in general infection prevention and control plans in healthcare settings.
- Contingency capacity: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily during periods of expected isolation gown shortages.
- Crisis capacity: strategies that are not commensurate with standard U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known isolation gown shortages.

The following contingency and crisis strategies are based upon these assumptions:

1. Facilities understand their current isolation gown inventory and supply chain
2. Facilities understand their isolation gown utilization rate
3. Facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies
4. Facilities have already implemented other engineering and administrative control measures including:
    - Reducing the number of patients going to the hospital or outpatient settings
    - Excluding HCP not directly involved in patient care
    - Reducing face-to-face HCP encounters with patients
    - Excluding visitors to patients with confirmed or suspected COVID-19
    - Cohorting patients and HCP
    - Maximizing use of telemedicine
5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

Conventional Capacity Strategies

Use isolation gown alternatives that offer equivalent or higher protection.

Several fluid-resistant and impermeable protective clothing options are available in the marketplace for HCP. These include isolation gowns and surgical gowns. When selecting the most appropriate protective clothing, employers should consider all of the available information on recommended protective clothing, including the potential limitations. Nonsterile, disposable

patient isolation gowns, which are used for routine patient care in healthcare settings, are appropriate for use by HCP when caring for patients with suspected or confirmed COVID-19. In times of gown shortages, surgical gowns should be prioritized for surgical and other sterile procedures. Current U.S. guidelines do not require use of gowns that conform to any standards.

Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which a gown is typically used by HCP.

Shift gown use towards cloth isolation gowns.

Reusable (i.e., washable) gowns are typically made of polyester or polyester-cotton fabrics. Gowns made of these fabrics can be safely laundered according to routine procedures and reused. Care should be taken to ensure that HCP do not touch outer surfaces of the gown during care.

- Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles
- Systems are established to routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties), and replace reusable gowns when needed (e.g., when they are thin or ripped)

Consider the use of coveralls.

Coveralls typically provide 360-degree protection because they are designed to cover the whole body, including the back and lower legs, and sometimes the head and feet as well. While the material and seam barrier properties are essential for defining the protective level, the coverage provided by the material used in the garment design, as well as certain features including closures, will greatly affect the protective level. HCP unfamiliar with the use of coveralls must be trained and practiced in their use, prior to using during patient care.

In the United States, the NFPA 1999 standard specifies the minimum design, performance, testing, documentation, and certification requirements for new single-use and new multiple-use emergency medical operations protective clothing, including coveralls for HCP.

Use of expired gowns beyond the manufacturer-designated shelf life for training.

The majority of isolation gowns do not have a manufacturer-designated shelf life. However, consideration can be made to using gowns that do and are past their manufacturer-designated shelf life. If there is no date available on the gown label or packaging, facilities should contact the manufacturer.

Use gowns or coveralls conforming to international standards.

Current guidelines do not require use of gowns that conform to any standards. In times of shortages, healthcare facilities can consider using international gowns and coveralls. Gowns and coveralls that conform to international standards, including with EN 13795 and EN14126, could be reserved for activities that may involve moderate to high amounts of body fluids.

Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which a gown is typically used by HCP.

Extended use of isolation gowns.
Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridioides difficile*) among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices .

Re-use of cloth isolation gowns.
Disposable gowns are not typically amenable to being doffed and re-used because the ties and fasteners typically break during doffing. Cloth isolation gowns could potentially be re-used and could be considered for re-use without

during doffing. Cloth isolation gowns could potentially be untied and retied and could be considered for re-use without laundering in between.

In a situation where the gown is being used as part of standard precautions to protect HCP from a splash, the risk of re-using a non-visibly soiled cloth isolation gown may be lower. However, for care of patients with suspected or confirmed COVID-19, HCP risk from re-use of cloth isolation gowns without laundering among (1) single HCP caring for multiple patients using one gown or (2) among multiple HCP sharing one gown is unclear. The goal of this strategy is to minimize exposures to HCP and not necessarily prevent transmission between patients. Any gown that becomes visibly soiled during patient care should be disposed of and cleaned.

Prioritize gowns.
Gowns should be prioritized for the following activities:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures
- During the following high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as:
  - Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care

Surgical gowns should be prioritized for surgical and other sterile procedures. Facilities may consider suspending use of gowns for endemic multidrug resistant organisms (e.g., MRSA, VRE, ESBL-producing organisms).

When No Gowns Are Available

Consider using gown alternatives that have not been evaluated as effective.

In situation of severely limited or no available isolation gowns, the following pieces of clothing can be considered as a last resort for care of COVID-19 patients as single use. However, none of these options can be considered PPE, since their capability to protect HCP is unknown. Preferable features include long sleeves and closures (snaps, buttons) that can be fastened and secured.

- Disposable laboratory coats
- Reusable (washable) patient gowns
- Reusable (washable) laboratory coats
- Disposable aprons
- Combinations of clothing: Combinations of pieces of clothing can be considered for activities that may involve body fluids and when there are no gowns available:
  - 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

Reusable patient gowns and lab coats can be safely laundered according to routine procedures.

- Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles
- Systems are established to routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties) and replace reusable gowns when needed (e.g., when they are thin or ripped)

Additional Resources

Strategies for Optimizing the Supply of Eye Protection

Strategies for Optimizing the Supply of Facemasks

Strategies for Optimizing the Supply of N95 Respirators

Page last reviewed: March 17, 2020

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of N95 Respirators

Updated February 29, 2020

Summary of Changes

- Clarification of introductory language
- Information added on Crisis/Alternative Strategies
- Information added to expand upon strategies, including two new resources:
  - Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response
  - Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response

Audience: These considerations are intended for use by federal, state, and local public health officials, respiratory protection program managers, occupational health service leaders, infection prevention and control program leaders, and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

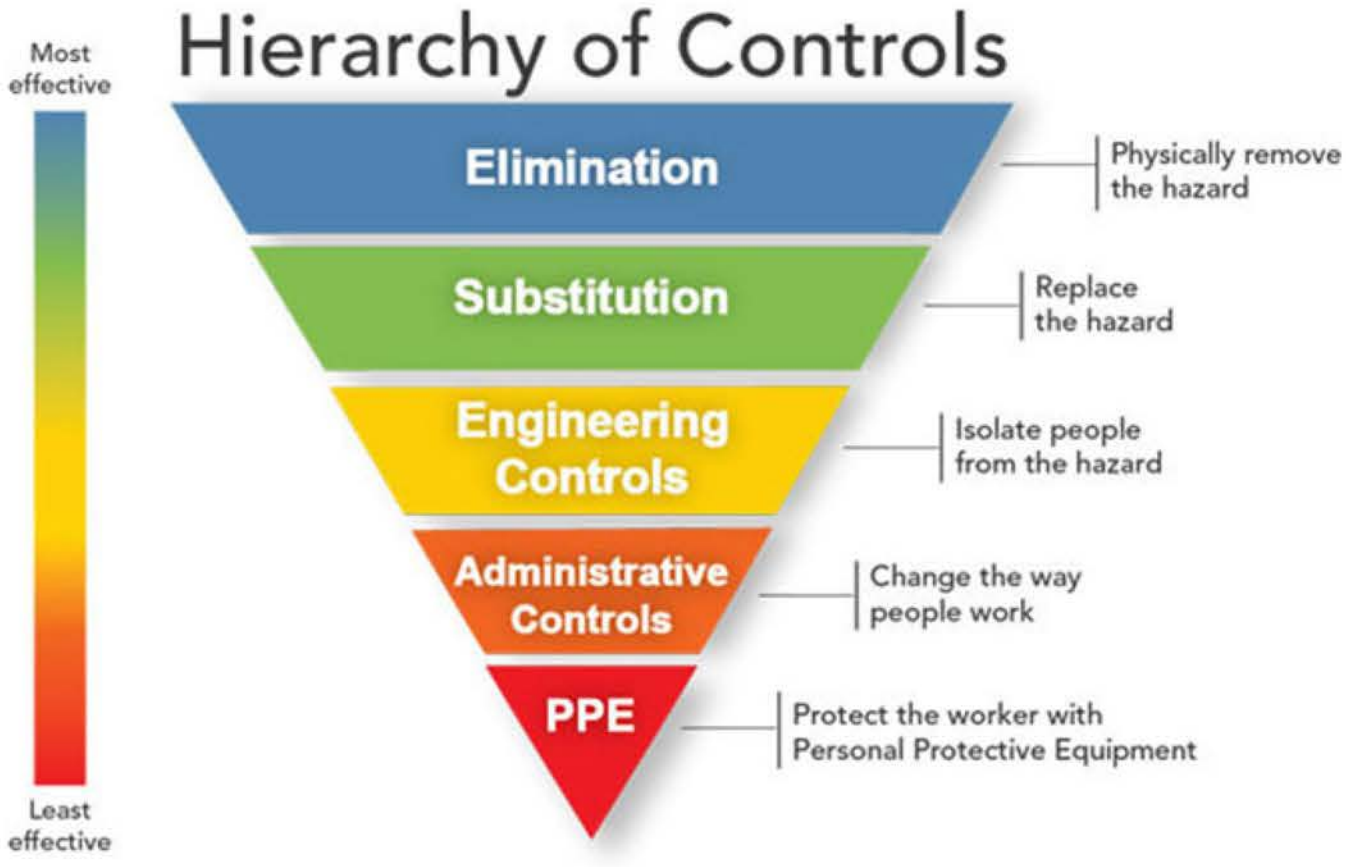
Purpose: This document offers a series of strategies or options to optimize supplies of disposable N95 filtering facepiece respirators (commonly called "N95 respirators") in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare settings can refer to existing influenza preparedness plans to address other aspects of preparing to respond to novel coronavirus disease 2019 (COVID-19). The strategies are also listed in order of priority and preference in the Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response in an easy-to-use format for healthcare facilities.

The following strategies are based upon these assumptions: 1) facilities understand their current N95 respirator inventory and supply chain, 2) facilities understand their N95 respirators utilization rate, and 3) facilities are in communication with state and local public health partners (e.g., public health emergency preparedness and response staff) and healthcare coalitions. While these strategies are targeted for optimizing the supply of N95 respirators, some of these strategies may be applicable to optimizing the supply of other personal protective equipment such as gowns, gloves, and eye protection.

Controlling exposures to occupational hazards is a fundamental way to protect personnel. Conventionally, a hierarchy has been used to achieve feasible and effective controls. Multiple control strategies can be implemented concurrently and or sequentially. This hierarchy can be represented as follows:

- Elimination
- Substitution
- Engineering controls
- Administrative controls
- Personal protective equipment (PPE)

To prevent infectious disease transmission, elimination (physically removing the hazard) and substitution (replacing the hazard) are not typically options for the healthcare setting. However, exposures to transmissible respiratory pathogens in healthcare facilities can often be reduced or possibly avoided through engineering and administrative controls and PPE. Prompt detection and effective triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel (HCP), and visitors at the facility.



N95 respirators are the PPE most often used to control exposures to infections transmitted via the airborne route, though their effectiveness is highly dependent upon proper fit and use. The optimal way to prevent airborne transmission is to use a combination of interventions from across the hierarchy of controls, not just PPE alone. Applying a combination of controls can provide an additional degree of protection, even if one intervention fails or is not available.

Respirators, when required to protect HCP from airborne contaminants such as infectious agents, must be used in the context of a comprehensive, written respiratory protection program that meets the requirements of OSHA's Respiratory Protection standard . The program should include medical evaluations, training, and fit testing.

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of N95 respirators during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve N95 respirator supplies along the continuum of care.[1]

- Conventional capacity: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings.
- Contingency capacity: measures may change daily contemporary practices but may not have any significant impact on the care delivered to the patient or the safety of the HCP. These practices may be used temporarily when demands exceed resources.
- Crisis capacity: alternate strategies that are not commensurate with contemporary U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of expected or known N95 respirator shortages.

Decisions to implement measures in contingency capacity and then crisis capacity should be based on:

- Consideration of all conventional capacity strategies first.
- The availability of N95 respirators and other types of respiratory protection.
- Consultation with entities that include some combination of: local healthcare coalitions, federal, state, or local public health officials, appropriate state agencies that are managing the overall emergency response related to COVID-19, and state crisis standards of care committees. Even when state/local coalitions or public health authorities can shift resources between health care facilities, these strategies may still be necessary.

References

1. Hick JL, Barbera JA, Kelen GD. Refining surge capacity: conventional, contingency, and crisis capacity. Disaster Med Public Health Prep . 2009;3(2 Suppl): S59-67.

MEMORANDUM

GEO Secure Services™
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Date: March 3, 2020

To: Regional VP's, Health Service Directors, Regional DO, Facility Administrators, HS Managers, Executive Vice President, Continuum of Care and Reentry

From: John E. Christakis, M.D.
Chief Medical Officer

RE: GEO Visitors Awareness Poster

The attached document was created to be posted in areas easily seen by our visitors. The main objective is to bring awareness of key symptoms of COVID-19 and to reduce the possible exposure to the facility from the community.

The CDC is working with the Department of Health and Human Services, WHO and throughout government agencies to offer a public health response to COVID-19.

Should you have any questions or concerns, please contact our Health Services team.

The GEO Group, Inc.®

PLEASE DO NOT VISIT

IF THE FOLLOWING APPLIES TO YOU

If you travelled to China and/or from or through any of the locations identified by the Centers for Disease Control and Prevention (CDC) or World Health Organization (WHO) or have had close contact to individual(s) with a confirmed case of COVID-19.

And/or if you have any of the following symptoms:

- **Fever**
- **Cough**
- **Shortness of Breath (SOB)**
- **Chills**
- **Muscle and Joint Aches**

Thank you for your understanding and cooperation

03-3-2020

The GEO Group, Inc.®

POR FAVOR NO VISITE

SI LO SIGUIENTE LE APLICA A USTED

Si viajó a China y / o desde o a través de cualquiera de los lugares identificados por el Centro para el Control y la Prevención de Enfermedades (CDC) o la Organización Mundial de la Salud (WHO) o ha tenido contacto cercano con personas con un caso confirmado de COVID-19.

y/o si tiene alguno de los siguientes síntomas:

- **Fiebre**
- **Tos**
- **Falta de respiracion (SOB)**
- **Escalofríos**
- **Dolores musculares y articulares**

Gracias por su comprensión y cooperación

03-03-2020

The GEO Group, Inc.	CORRECTIONAL HEALTH SERVICES CHAPTER: INFECTION CONTROL TITLE: CORONAVIRUS (COVID-19) MANAGEMENT	NUMBER: 531-A SUPERSEDES: 02/10/2020 EFFECTIVE: 02/28/2020

TREATMENT PROTOCOL

Symptoms

Fever, cough, shortness of breath; infection can vary in severity from mild to severe respiratory failure and even death are possible.

Transmission

Person-Person via airborne transmission (droplets can travel six [6] feet). It is currently unclear if transmission can occur related to direct contact with contaminated surfaces, respiratory secretions, and bodily fluids.

Infectious Period

From illness onset through 5-13 days following illness onset.

Incubation Period

Estimated to be 4-7 days.

Clinical Observations

Fever 100.4° F WITH presence of either cough, fatigue and/or shortness of breath. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. The presentation of acute respiratory illness with recent onset of at least two of the following: Cough (with or without fever or chills) AND a history of recent travel to China (within 14 days) OR contact with a person who has been diagnosed with COVID-19.

Testing

Currently, confirmation of COVID-19 infection is performed at CDC using the CDC real-time RT-PCR assay for COVID-19 on respiratory specimens (which can include nasopharyngeal or oropharyngeal aspirates or washes, nasopharyngeal or oropharyngeal swabs, bronchioalveolar lavage, tracheal aspirates or sputum) and serum. Local public health departments will be contacted regarding potential cases and make the decision for specimen collection and testing.

Treatment

1. No specific treatment for COVID-19 infection or vaccination is currently available. Clinical management includes prompt implementation of recommended infection prevention and control measures and supportive management of complications, including advanced organ support if indicated. **(5-ACI-6A-12 (M))**
2. Healthcare personnel will care for patients in an Airborne Infection Isolation Room (AIIR). Standard Precautions, Contact Precautions, and Airborne Precautions to include mask and eye protection should be used when caring for the patient.

Infection Control

Precautions – Follow respiratory/airborne isolation precautions – See Isolation Precautions policy.

Infirmary/Medical Observation Area

1. Place Respiratory Isolation Precautions Sign HS-203 on door at entrance to patient's room (see Attachment 1); **(5-ACI-6A-12 (M))**

2. N-95 respirators and gloves prior to entering a patient's room;

3. Gloves and gown during procedures and patient care activities where there is a possibility of contact of clothing, exposed skin with blood/body fluids, secretions, and excretions;

4. Remove gloves by turning glove inside-out and discard in wastebasket in patient's room;

5. Wash hands, including between the fingers, with soap and water ASAP after exiting patient's room; use non-alcohol-based hand gel; and

6. Change linens daily for acutely symptomatic cases and follow Laundry policy
    a. Wear gloves, gown, and mask
    b. Roll-up dirty linens with minimum agitation and place in water-soluble laundry bag
    c. Place water-soluble laundry bag inside a yellow laundry bag for transport to the laundry
    d. Wash hands with soap and water after handling contaminated laundry

Housing

1. Isolate individuals with suspected COVID-19 in an Airborne Infection Isolation Room (AIIR) when possible; if no AIIR is available and the I/D/R must be transferred to the local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms. **(5-ACI-6A-12 (M))**

2. Continue isolation until the I/D/R is no longer symptomatic; and

3. Cohorting
   a) If numerous I/D/R become ill, house them in an area separate from those who are not ill.
   b) Implement cohorting with restricted movement for detainees housed with the ill I/D/R or who have been in close contact with the ill I/D/R for the duration of the most recent incubation period (14 days after last exposure to the ill I/D/R)
   c) Monitor cohorted I/D/Rs daily to observe for fever and symptoms of respiratory illness **(5-ACI-6A-12 (M))**
   d) Refer exposed I/D/Rs with new onset respiratory illness to a medical provider for evaluation
   e) Report cohorting through routine client required cohort reporting protocols
   f) Document any ill I/D/R who is suspected of having COVID-19 on the client tracking tool.
   g) Document any asymptomatic I/D/R meeting the criteria for observation on the appropriate client tracking tool. **(5-ACI-6A-12 (M))**
   h) Recommend to client monitor or designee that I/D/Rs cohorted due to known exposure to an ill person not be transferred or transported.
   i) If a cohorted I/D/R must be released in the U.S., notify the local health department including the intended address and telephone numbers of the I/D/R's intended destination.
   j) Discontinue cohorting when:
      i. The index patient receives an alternate diagnosis that excludes COVID-19, or
      ii. A 14-day incubation period is completed with no new cases

General Prevention Recommendations within the Facility

1. Encourage all persons within the facility to cover their cough or sneeze with a tissue or cough or sneeze into their inner elbow region and dispose of tissue immediately after use; **(5-ACI-6A-12 (M))**

2. Maintain good hand hygiene by washing with soap and water, to include between the fingers and using a non-alcohol based hand disinfectant, especially after coughing or sneezing;

3. Avoid touching eyes, nose, and mouth, to include facial hair, without cleaning hands;

4. Provide means for hand hygiene readily available throughout the facility, including intake areas, visitor entries and exits, visitation rooms, common areas, staff-restricted areas, and food preparation and dining areas;

5. Use disinfectant cloths or the approved facility disinfectant to clean electronic items such a computer keys, mouse, and phones;

6. Cancel internal group gatherings and stagger group meals and other activities to provide more personal space between individuals, if possible; and

7. Consider temporarily suspending visitation or modifying visitation programs, when appropriate.

Housekeeping - Increasing the frequency of housekeeping can help control an outbreak

1. Follow Housekeeping policy; **(5-ACI-6A-12 (M))**

2. Clean all common areas when visibly soiled with the facility's approved disinfectant;

3. Clean all high touch areas (doorknobs, bathroom sinks & faucets, commode handles, etc.); and

4. Allow disinfectant to air dry.

Notification of staff – Follow respiratory/airborne isolation precautions

1. In addition to the Respiratory Precaution signs (see attachment), post information at entry points to the facility; and

2. Post signs instructing staff to notify their supervisors immediately if they have signs/symptoms of influenza-like or other illness. **(5-ACI-6A-12 (M))**

Transfer/Movement of I/D/R

1. I/D/R transfer will be delayed until resolution of symptoms in consultation with facility provider;

2. If the I/D/R must be transferred, then the receiving institution, office, court, etc. must be informed of the I/D/R potential infectious status;

3. The I/D/R will be instructed to wear a surgical mask during transport and until the I/D/R can be isolated into a separate area; and

4. For required I/D/R movement within the facility, out of the isolation area, showering, etc., the I/D/R will be instructed to wear a mask.

Investigation of Contacts

1. The goal is to limit and control a potential COVID-19 outbreak.

2. Whenever a case of COVID-19 is diagnosed, the identification will trigger potential intervention measures including cohorting, isolation, and quarantine.

3. In facilities with a Health Services Department, the Health Services Administrator (HSA) will be responsible for conducting an investigation of the exposed individuals.

4. A significant exposure to is defined as:
   a. Close face-to-face interaction with an ill person
   b. Sharing indoor air space (usually within 6 feet) or sharing the same indoor air space in the same small room or adjacent beds in a large housing unit)

5. Process for Contact Investigation
   a. Identify closest contacts (cellmates, workmates, and friends) and other housing unit contacts, as well as any recent visitors.
   b. Screen contacts for temperature, cough, sore throat, or shortness of breath
   c. Record results on the Influenza/H1N1/COVID-19 Contact Investigation List Form HS-241 (see Attachment 2).

6. Isolate any contacts who develop COVID-19 symptoms
   a. Decide which groups of contacts to quarantine
   b. There is no simple answer regarding who should be quarantined. The simplest measure may be to quarantine the entire housing unit. If this is impractical, quarantine the I/D/R with the closest contact, if possible.
   c. Quarantine of exposed contacts should be maintained for 14 days after exposure.
   d. Screen quarantined contacts twice daily for temperature and COVID-19 symptoms and record results on the quarantine line item.
   e. Assure I/D/R who are known to have been exposed to the virus are kept separate from other I/D/R to assess if flu symptoms develop.
   f. If possible, quarantined I/D/R should have beds placed at least 3-6 feet apart.
   g. Quarantined I/D/R should be restricted from transfer, not have visits, and not be mixed with the general population.
   h. Note: Once multiple COVID-19 cases occur within multiple housing units, a decision may be made to *abandon contact investigation and quarantine of contacts as a control strategy. In this case, everyone in the facility has become a "contact"*

and contact investigation and quarantine are no longer useful or appropriate control strategies.

i. If questions about isolation, cohorting, or quarantine arise, contact the local/state health department for assistance.

Reporting

1. Cases that are positive for symptoms, as well as the results of the confirmatory test [Positive or Negative] completed by the state or local Health Department, and the CDC RT-PCR assay for COVID-19 will be reported to the: **(5-ACI-6A-12 (M))**:
   a. Facility Administrator/designee
   b. Regional Director for Health Services
   c. Chief Medical Officer
   d. Local and State Health Department
   e. Client
   f. Corporate Chief of Nursing

2. Reporting will result in involving the chain of command to influence decisions on I/D/R movement, court issues, transfers, or limiting new intake.

Staff issues

1. Exposure
   a. No pregnant female staff will be assigned in the areas that may have contact with an I/D/R diagnosed with COVID-19 during the contagious period. A pregnant employee will be advised to discuss issues of exposure with her personal physician.
   b. Exposed security , administrative, and healthcare staff with/without chronic illnesses will be instructed of the signs and symptoms of COVID-19 and advised that, if symptoms develop, they will need to contact personal physician and remain away from work until cleared by personal physician.
   c. Exposed staff with chronic illnesses, especially HIV, Diabetes, Asthma, and COPD will be instructed to contact their personal physicians for guidance.
   d. Local and State Health Department will by notified by the staff member or personal physician as required.

2. Confirmation of COVID-19
   a. An employee with COVID-19 (or signs and symptoms) will be excused from duty and asked to leave the facility immediately and will be referred to seek healthcare as soon as possible.

   b. Staff identified as having COVID-19 or influenza-like illness will be allowed to return after resolution of symptoms and being cleared by their personal physician.

c. Staff with a family member diagnosed with COVID-19 will report this to their supervisors as per policy. Considerations should be made to limit the employee's contact with I/D/R and other staff members.

Visitors

1. In case of a confirm case of COVID-19 within the facility, the local leadership will consider a temporary suspension of visitation; and

2. If visitation will continue to occur, all visitors will be notified about the possible risk of exposure to COVID-19.

Procurement of Personal Protective Equipment (PPE)

1. Facility Administrator/designee will assure an adequate supply of PPE is maintained on-site; and

2. In cases where PPE supplies cannot be procured, the Facility Administrator/designee will contact the Regional Director for Health Services for guidance.

APPROVED: _____ Effective Date: 02/28/2020
John E. Christakis, M.D., Chief Medical Officer

Resources for Additional Information at the Centers for Disease Control and Prevention

1. **CDC Interim Guidance for Healthcare Professionals @ https://www.cdc.gov/coronavirus/COVID-19/clinical-criteria.html Accessed February 8, 2020.**

2. **The World Health Organization @ http://who.int/csr/disease/swineflu/en/index.html Accessed February 8, 2020.**

ATTACHMENTS

1. **Respiratory Precautions Sign HS-203**
2. **Influenza/H1N1/COVID-19 Contact Investigation List Form HS-241**

The GEO Group, Inc.	CORRECTIONAL HEALTH SERVICES CHAPTER: INFECTION CONTROL TITLE: CORONAVIRUS (COVID-19) MANAGEMENT	NUMBER: 531 SUPERSEDES: 02/10/2020 EFFECTIVE: 02/28/2020

POLICY

The identification, monitoring, and treatment of COVID-19 Coronavirus signs and symptoms shall be handled in accordance with the recommendations of the Centers for Disease Control and Prevention.

APPROVED: _____ Effective Date: 02/28/2020

John E. Christakis, M.D., Chief Medical Officer

REFERENCES

1. American Correctional Association 5-ACI-6A-12 (M)
2. National Commission on Correctional Health Care J/P-B-01

MEMORANDUM

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Date: February 26, 2020

To: Regional VP's, Health Service Directors,
Health Service Managers, Health Service Administrators,
Facility Administrators, Regional DO's

From: John E. Christakis, M.D.
Chief Medical Officer

RE: CORONAVIRUS COVID-19 EDUCATIONAL GUIDANCE

GEO Health Services, in collaboration with the other GEO Corporate divisions, has developed a forthcoming Interim Guidance policy document, as well as a Facilities Emergency Plan for our custody and healthcare staff. This is to be utilized for the screening and prevention of Coronavirus (COVID-19) within our facilities.

We encourage the facilities to post the attached Centers for Disease Control (CDC) awareness pamphlets at the front entrance, in visiting areas, health services unit, housing units, RHU and staff break rooms.

We ask our facility leadership to discuss with staff during shift briefings, meetings with staff and Department heads, the important role of prevention in the spreading of germs. Every effort should be made to be vigilant in maintaining a clean and safe environment within our facilities for the greater good of all.

Should you have any questions, please contact myself, Jason Wright, Chief of Nursing or Dr. Juan Castillo, VP of HS.

COVID 19 CORONAVIRUS DISEASE

What you need to know about coronavirus disease 2019 (COVID-19)

What is coronavirus disease 2019 (COVID-19)?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

Can people in the U.S. get COVID-19?

COVID-19 is spreading from person to person in China, and limited spread among close contacts has been detected in some countries outside China, including the United States. At this time, however, this virus is NOT currently spreading in communities in the United States. Right now, the greatest risk of infection is for people in China or people who have traveled to China. Risk of infection is dependent on exposure. Close contacts of people who are infected are at greater risk of exposure, for example health care workers and close contacts of people who are infected with the virus that causes COVID-19. CDC continues to closely monitor the situation.

Have there been cases of COVID-19 in the U.S.?

Yes. The first case of COVID-19 in the United States was reported on January 21, 2020. The current count of cases of COVID-19 in the United States is available on CDC's webpage at https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.

How does COVID-19 spread?

The virus that causes COVID-19 probably emerged from an animal source, but now it seems to be spreading from person to person. It's important to note that person-to-person spread can happen on a continuum. Some diseases are highly contagious (like measles), while other diseases are less so. At this time, it's unclear how easily or sustainably the virus that causes COVID-19 is spreading between people. Learn what is known about the spread of newly emerged coronaviruses at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html.

What are the symptoms of COVID-19?

Patients with COVID-19 have had mild to severe respiratory illness with symptoms of

- fever
- cough
- shortness of breath

What are severe complications from this virus?

Many patients have pneumonia in both lungs.

How can I help protect myself?

The best way to prevent infection is to avoid being exposed to the virus that causes COVID-19.

There are simple everyday preventive actions to help prevent the spread of respiratory viruses. These include

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.

If you are sick, to keep from spreading respiratory illness to others, you should

- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces.

What should I do if I recently traveled to China and got sick?

If you were in China within the past 14 days and feel sick with fever, cough, or difficulty breathing, you should seek medical care. Call the office of your health care provider before you go, and tell them about your travel and your symptoms. They will give you instructions on how to get care without exposing other people to your illness. While sick, avoid contact with people, don't go out and delay any travel to reduce the possibility of spreading illness to others.

Is there a vaccine?

There is currently no vaccine to protect against COVID-19. The best way to prevent infection is to avoid being exposed to the virus that causes COVID-19.

Is there a treatment?

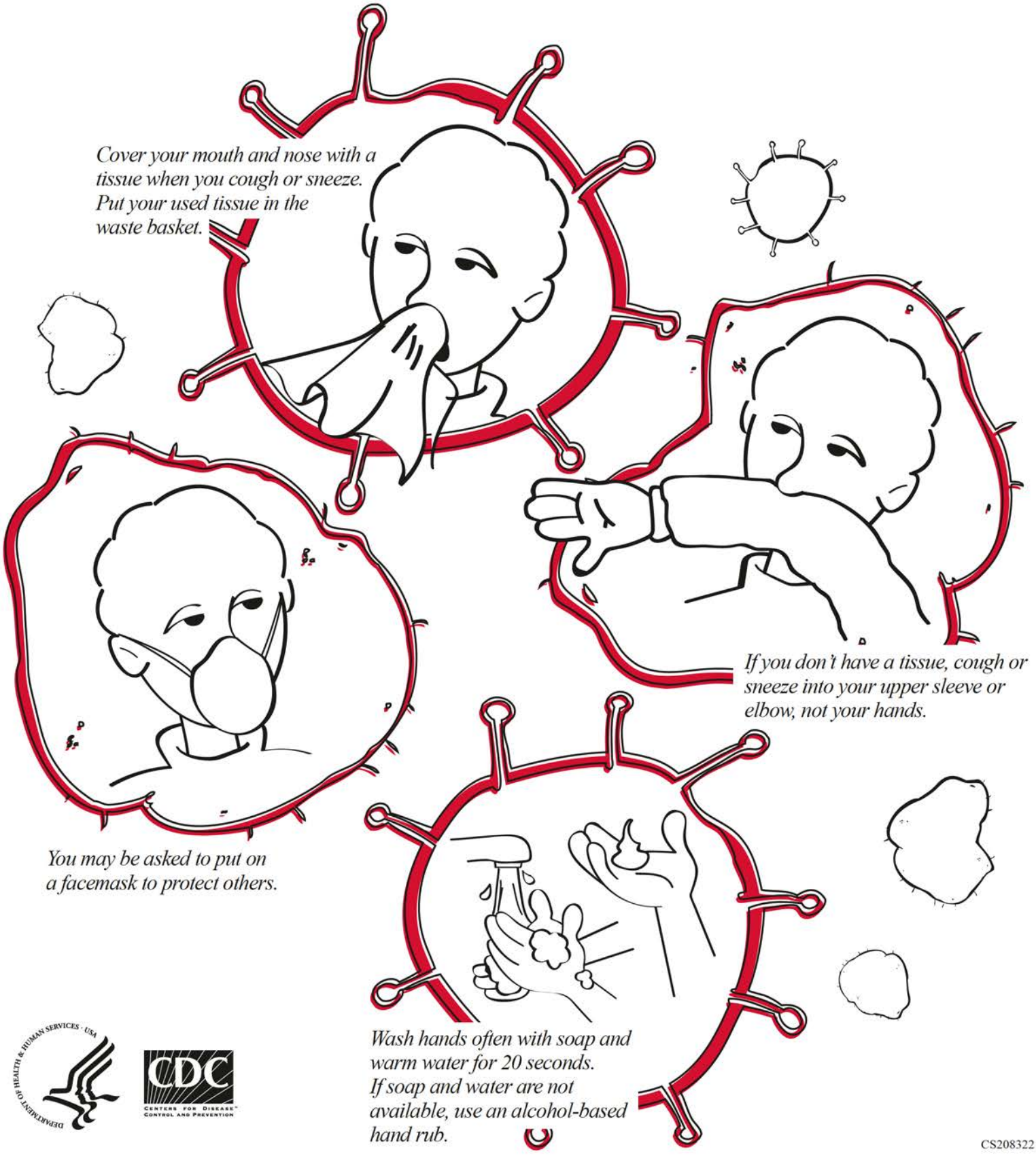
There is no specific antiviral treatment for COVID-19. People with COVID-19 can seek medical care to help relieve symptoms.

For more information: **www.cdc.gov/COVID19**

CS 314937-A 02/21/2020

Cover your Cough

Stop the spread of germs that can make you and others sick!



Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.

If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.

You may be asked to put on a facemask to protect others.

Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CS208322

COVID 19
CORONAVIRUS DISEASE

STOP THE SPREAD OF GERMS

Help prevent the spread of respiratory diseases like COVID-19.

Avoid close contact with people who are sick.

Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

Avoid touching your eyes, nose, and mouth.

Clean and disinfect frequently touched objects and surfaces.

Stay home when you are sick, except to get medical care.

Wash your hands often with soap and water for at least 20 seconds.

For more information: www.cdc.gov/COVID19

CS314915-A

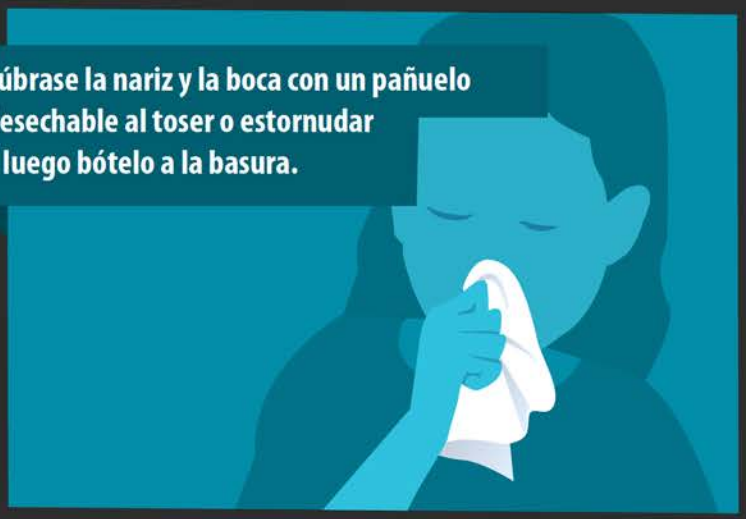
2019 nCoV CORONAVIRUS

DETENGA LA PROPAGACIÓN DE MICROBIOS

Ayude a prevenir la propagación de virus respiratorios como el nuevo coronavirus 2019

Evite el contacto cercano con las personas enfermas.

Cúbrase la nariz y la boca con un pañuelo desechable al toser o estornudar y luego bótelo a la basura.



Evite tocarse los ojos, la nariz y la boca.

Limpie y desinfecte los objetos y las superficies que se tocan frecuentemente.

Quédese en casa si está enfermo, excepto para buscar atención médica.

Lávese las manos frecuentemente con agua y jabón por al menos 20 segundos.

Para obtener más información: **www.cdc.gov/nCoV**

CS314915-B

COVID 19 CORONAVIRUS DISEASE

Share Facts About COVID-19

Know the facts about coronavirus disease 2019 (COVID-19) and help stop the spread of rumors.

FACT 1 Diseases can make anyone sick regardless of their race or ethnicity.

People of Asian descent, including Chinese Americans, are not more likely to get COVID-19 than any other American. Help stop fear by letting people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.

FACT 2 Some people are at increased risk of getting COVID-19.

People who have been in close contact with a person known to have COVID-19 or people who live in or have recently been in an area with ongoing spread are at an increased risk of exposure.

FACT 3 Someone who has completed quarantine or has been released from isolation does not pose a risk of infection to other people.

For up-to-date information, visit CDC's coronavirus disease 2019 web page.

FACT 4 You can help stop COVID-19 by knowing the signs and symptoms:

- Fever
- Cough
- Shortness of breath

Seek medical advice if you

- Develop symptoms

AND

- Have been in close contact with a person known to have COVID-19 or if you live in or have recently been in an area with ongoing spread of COVID-19.

FACT 5 There are simple things you can do to help keep yourself and others healthy.

- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

For more information: **www.cdc.gov/COVID19**

CS 315446-A 03/06/2020

COMPARTA LA INFORMACIÓN SOBRE EL COVID-19

Infórmese sobre la enfermedad del coronavirus 2019 (COVID-19) y ayude a detener los rumores.

DATO 1

Las enfermedades pueden afectar a cualquier persona, sin importar su raza o grupo étnico.

El miedo y la ansiedad relacionados con el COVID-19 pueden provocar que la gente evite o rechace a otras personas aun cuando no estén en riesgo de propagar el virus.

DATO 2

Para la mayoría de las personas, se piensa que el riesgo inmediato de enfermarse gravemente por el virus que causa el COVID-19 es bajo.

Los adultos mayores y las personas de cualquier edad que tengan afecciones graves subyacentes podrían tener un mayor riesgo de presentar complicaciones más graves a causa del COVID-19.

DATO 3

Alguien que haya completado el periodo de cuarentena o que ya salió del aislamiento no presenta un riesgo de infección para las demás personas.

Para obtener información actualizada, visite la página web de los CDC sobre la enfermedad del coronavirus 2019.

DATO 4

Hay cosas simples que puede hacer para ayudar a que usted y los demás se mantengan sanos.

- Lávese las manos frecuentemente con agua y jabón por al menos 20 segundos, especialmente después de sonarse la nariz, toser o estornudar; después de ir al baño; y antes de comer o preparar la comida.
- Evite tocarse los ojos, la nariz y la boca con las manos sin lavar.
- Quédese en casa si está enfermo.
- Cúbrase la nariz y la boca con un pañuelo desechable al toser o estornudar y luego bótelo a la basura.

DATO 5

Usted puede ayudar a detener el COVID-19 conociendo los signos y los síntomas:

- Fiebre
- Tos
- Dificultad para respirar

Consulte a un médico si le ocurre lo siguiente:

- Tiene síntomas

Y

- Ha estado en contacto cercano con una persona que se sepa que tiene el COVID-19, o si usted vive o ha estado recientemente en un área con propagación en curso del COVID-19.

cdc.gov/COVID-19-es

CS 315446-B 03/18/2020

分享有关 COVID-19 的事实

了解冠状病毒疾病 2019 (COVID-19) 有关的事实，帮助遏制谣言的传播。

事实 1

无论是何种族或族群，任何人均有可能感染。

对 COVID-19 的恐惧和焦虑会让人们逃避或排斥他人，即使他们并没有传播病毒的风险。

事实 2

对于大多数人来说，诱发 COVID-19 的病毒引起重症的直接风险被认为很低。

老年人和患有严重基础疾病的任何年龄的人，可能会因 COVID-19 导致更严重并发症的风险更高。

事实 3

完成隔离或从隔离中解除的人不会对其他人构成感染风险。

有关最新信息，请访问美国疾病控制和预防中心（CDC）的冠状病毒疾病 2019 网页。

事实 4

您可以通过做一些简单的事情来帮助自己和他人保持健康。

- 用肥皂和水洗手至少 20 秒，特别是在擤鼻涕、咳嗽或打喷嚏后；去洗手间；以及吃饭或做饭前。
- 避免用未清洗过的手触碰眼睛、鼻子和嘴巴。
- 生病时待在家里。
- 咳嗽或打喷嚏时用纸巾遮住，然后将纸巾丢进垃圾里。

事实 5

了解下列体征和症状有助于遏制 COVID-19：

- 发热
- 咳嗽
- 呼吸困难

如果您符合以下描述，请就医，

- 出现症状

并且

- 与确诊 COVID-19 的人密切接触或如果您居住在或最近曾到过 COVID-19 正在传播的地区。

cdc.gov/COVID19-ch

CS 315446-C 03/16/2020

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case*)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19		X			
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact				X	X
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case* (but not performing temperature checks or providing medical care)		Face mask, eye protection, and gloves as local supply and scope of duties allow.			
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons		X	X	X	X
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	X**		X	X	X
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	X		X	X	X
Staff handling laundry or used food service items from a COVID-19 case or case contact				X	X
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			X	X

Classification of Individual Wearing PPE

* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.
** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of Eye Protection

Audience: These considerations are intended for use by federal, state, and local public health officials; leaders in occupational health services and infection prevention and control programs; and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of eye protection in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare facilities can refer to COVID-19 preparedness plans.

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of eye protection during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve eye protection supplies along the continuum of care.

- Conventional capacity: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and personal protective equipment (PPE) controls should already be implemented in general infection prevention and control plans in healthcare settings.
- Contingency capacity: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily during periods of expected eye protection shortages.
- Crisis capacity: strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known eye protection shortages.

The following contingency and crisis strategies are based upon these assumptions:

1. Facilities understand their eye protection inventory and supply chain
2. Facilities understand their eye protection utilization rate
3. Facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies
4. Facilities have already implemented other engineering and administrative control measures including:
    - Reducing the number of patients going to the hospital or outpatient settings
    - Excluding HCP not essential for patient care from entering their care area
    - Reducing face-to-face HCP encounters with patients
    - Excluding visitors to patients with confirmed or suspected COVID-19
    - Cohorting patients and HCP
    - Maximizing use of telemedicine
5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

Conventional Capacity Strategies

Use eye protection according to product labeling and local, state, and federal requirements.

Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which eye protection is typically used by HCP.

Shift eye protection supplies from disposable to re-usable devices (i.e., goggles and reusable face shields).

- Consider preferential use of powered air purifying respirators (PAPRs) or full-face elastomeric respirators which have built-in eye protection.
- Ensure appropriate cleaning and disinfection between users if goggles or reusable face shields are used.

Implement extended use of eye protection.

Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices.

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
  - If a disposable face shield is reprocessed, it should be dedicated to one HCP and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. See protocol for removing and reprocessing eye protection below.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- HCP should take care not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene.
- HCP should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below.

Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which eye protection is typically used by HCP.

Use eye protection devices beyond the manufacturer-designated shelf life during patient care activities.

If there is no date available on the eye protection device label or packaging, facilities should contact the manufacturer. The user should visually inspect the product prior to use and, if there are concerns (such as degraded materials), discard the product.

Prioritize eye protection for selected activities such as:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures.
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.

Consider using safety glasses (e.g., trauma glasses) that have extensions to cover the side of the eyes.

Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients.

- During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients.

- It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Selected Options for Reprocessing Eye Protection

Adhere to recommended manufacturer instructions for cleaning and disinfection.

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of Facemasks

Audience: These considerations are intended for use by federal, state, and local public health officials; leaders in occupational health services and infection prevention and control programs; and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of facemasks in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare facilities can refer to COVID-19 preparedness plans.

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of facemasks during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve facemask supplies along the continuum of care.

- Conventional capacity: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and personal protective equipment (PPE) controls should already be implemented in general infection prevention and control plans in healthcare settings.
- Contingency capacity: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily during periods of expected facemask shortages.
- Crisis capacity: strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known facemask shortages.

The following contingency and crisis strategies are based upon these assumptions:

1. Facilities understand their facemask inventory and supply chain
2. Facilities understand their facemask utilization rate
3. Facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies.
4. Facilities have already implemented other engineering and administrative control measures including:
    - Reducing the number of patients going to the hospital or outpatient settings
    - Excluding HCP not essential for patient care from entering their care area
    - Reducing face-to-face HCP encounters with patients
    - Excluding visitors to patients with confirmed or suspected COVID-19
    - Cohorting patients and HCP
    - Maximizing use of telemedicine
5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

Conventional Capacity Strategies

Use facemasks according to product labeling and local, state, and federal requirements.

- FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures.

- Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which a facemask is typically used by HCP.

Remove facemasks for visitors in public areas.

Healthcare facilities can consider removing all facemasks from public areas. Facemasks can be available to provide to symptomatic patients upon check in at entry points. All facemasks should be placed in a secure and monitored site. This is especially important in high-traffic areas like emergency departments.

Implement extended use of facemasks.

Extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- HCP must take care not to touch their facemask. If they touch or adjust their facemask they must immediately perform hand hygiene.
- HCP should leave the patient care area if they need to remove the facemask.

Restrict facemasks to use by HCP, rather than patients for source control.

Have patients with symptoms of respiratory infection use tissues or other barriers to cover their mouth and nose.

Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which a facemask is typically used by HCP.

Use facemasks beyond the manufacturer-designated shelf life during patient care activities.

If there is no date available on the facemask label or packaging, facilities should contact the manufacturer. 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 facemasks.

Limited re-use of facemasks is the practice of using the same facemask by one HCP for multiple encounters with different patients but removing it after each encounter. As it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, care should be taken to ensure that HCP do not touch outer surfaces of the mask during care, and that mask removal and replacement be done in a careful and deliberate manner.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- Not all facemasks can be re-used.
  - Facemasks that fasten to the provider via ties may not be able to be undone without tearing and should be considered only for extended use, rather than re-use.
  - Facemasks with elastic ear hooks may be more suitable for re-use.
- HCP should leave patient care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.

Prioritize facemasks for selected activities such as:

- For provision of essential surgeries and procedures

- 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

When No Facemasks Are Available, Options Include

Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients.
During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients.
It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Use a face shield that covers the entire front (that extends to the chin or below) and sides of the face with no facemask.

Consider use of expedient patient isolation rooms for risk reduction.
Portable fan devices with high-efficiency particulate air (HEPA) filtration that are carefully placed can increase the effective air changes per hour of clean air to the patient room, reducing risk to individuals entering the room without respiratory protection. NIOSH has developed guidance for using portable HEPA filtration systems to create expedient patient isolation rooms. The expedient patient isolation room approach involves establishing a high-ventilation-rate, negative pressure, inner isolation zone that sits within a "clean" larger ventilated zone.

Consider use of ventilated headboards
NIOSH has developed the ventilated headboard that draws exhaled air from a patient in bed into a HEPA filter, decreasing risk of HCP exposure to patient-generated aerosol. This technology consists of lightweight, sturdy, and adjustable aluminum framing with a retractable plastic canopy. The ventilated headboard can be deployed in combination with HEPA fan/filter units to provide surge isolation capacity within a variety of environments, from traditional patient rooms to triage stations, and emergency medical shelters.

HCP use of homemade masks:
In settings where facemasks are not available, HCP might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.

Additional Resources

- Strategies for Optimizing the Supply of Eye Protection
- Strategies for Optimizing the Supply of Isolation Gowns
- Strategies for Optimizing the Supply of N95 Respirators

Page last reviewed: March 17, 2020

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of Isolation Gowns

Audience: These considerations are intended for use by federal, state, and local public health officials; leaders in occupational health services and infection prevention and control programs; and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of isolation gowns in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare facilities can refer to COVID-19 preparedness plans.

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no widely accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of isolation gowns during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve isolation gown supplies along the continuum of care.

- Conventional capacity: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and personal protective equipment (PPE) controls should already be implemented in general infection prevention and control plans in healthcare settings.
- Contingency capacity: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily during periods of expected isolation gown shortages.
- Crisis capacity: strategies that are not commensurate with standard U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known isolation gown shortages.

The following contingency and crisis strategies are based upon these assumptions:

1. Facilities understand their current isolation gown inventory and supply chain
2. Facilities understand their isolation gown utilization rate
3. Facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies
4. Facilities have already implemented other engineering and administrative control measures including:
    - Reducing the number of patients going to the hospital or outpatient settings
    - Excluding HCP not directly involved in patient care
    - Reducing face-to-face HCP encounters with patients
    - Excluding visitors to patients with confirmed or suspected COVID-19
    - Cohorting patients and HCP
    - Maximizing use of telemedicine
5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

Conventional Capacity Strategies

Use isolation gown alternatives that offer equivalent or higher protection.

Several fluid-resistant and impermeable protective clothing options are available in the marketplace for HCP. These include isolation gowns and surgical gowns. When selecting the most appropriate protective clothing, employers should consider all of the available information on recommended protective clothing, including the potential limitations. Nonsterile, disposable

patient isolation gowns, which are used for routine patient care in healthcare settings, are appropriate for use by HCP when caring for patients with suspected or confirmed COVID-19. In times of gown shortages, surgical gowns should be prioritized for surgical and other sterile procedures. Current U.S. guidelines do not require use of gowns that conform to any standards.

Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which a gown is typically used by HCP.

Shift gown use towards cloth isolation gowns.

Reusable (i.e., washable) gowns are typically made of polyester or polyester-cotton fabrics. Gowns made of these fabrics can be safely laundered according to routine procedures and reused. Care should be taken to ensure that HCP do not touch outer surfaces of the gown during care.

- Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles
- Systems are established to routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties), and replace reusable gowns when needed (e.g., when they are thin or ripped)

Consider the use of coveralls.

Coveralls typically provide 360-degree protection because they are designed to cover the whole body, including the back and lower legs, and sometimes the head and feet as well. While the material and seam barrier properties are essential for defining the protective level, the coverage provided by the material used in the garment design, as well as certain features including closures, will greatly affect the protective level. HCP unfamiliar with the use of coveralls must be trained and practiced in their use, prior to using during patient care.

In the United States, the NFPA 1999 standard specifies the minimum design, performance, testing, documentation, and certification requirements for new single-use and new multiple-use emergency medical operations protective clothing, including coveralls for HCP.

Use of expired gowns beyond the manufacturer-designated shelf life for training.

The majority of isolation gowns do not have a manufacturer-designated shelf life. However, consideration can be made to using gowns that do and are past their manufacturer-designated shelf life. If there is no date available on the gown label or packaging, facilities should contact the manufacturer.

Use gowns or coveralls conforming to international standards.

Current guidelines do not require use of gowns that conform to any standards. In times of shortages, healthcare facilities can consider using international gowns and coveralls. Gowns and coveralls that conform to international standards, including with EN 13795 and EN14126, could be reserved for activities that may involve moderate to high amounts of body fluids.

Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which a gown is typically used by HCP.

Extended use of isolation gowns.
Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridioides difficile*) among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices .

Re-use of cloth isolation gowns.
Disposable gowns are not typically amenable to being doffed and re-used because the ties and fasteners typically break

during doffing. Cloth isolation gowns could potentially be untied and retied and could be considered for re-use without laundering in between.

In a situation where the gown is being used as part of standard precautions to protect HCP from a splash, the risk of re-using a non-visibly soiled cloth isolation gown may be lower. However, for care of patients with suspected or confirmed COVID-19, HCP risk from re-use of cloth isolation gowns without laundering among (1) single HCP caring for multiple patients using one gown or (2) among multiple HCP sharing one gown is unclear. The goal of this strategy is to minimize exposures to HCP and not necessarily prevent transmission between patients. Any gown that becomes visibly soiled during patient care should be disposed of and cleaned.

Prioritize gowns.
Gowns should be prioritized for the following activities:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures
- During the following high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as:
    - Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care

Surgical gowns should be prioritized for surgical and other sterile procedures. Facilities may consider suspending use of gowns for endemic multidrug resistant organisms (e.g., MRSA, VRE, ESBL-producing organisms).

When No Gowns Are Available

Consider using gown alternatives that have not been evaluated as effective.

In situation of severely limited or no available isolation gowns, the following pieces of clothing can be considered as a last resort for care of COVID-19 patients as single use. However, none of these options can be considered PPE, since their capability to protect HCP is unknown. Preferable features include long sleeves and closures (snaps, buttons) that can be fastened and secured.

- Disposable laboratory coats
- Reusable (washable) patient gowns
- Reusable (washable) laboratory coats
- Disposable aprons
- Combinations of clothing: Combinations of pieces of clothing can be considered for activities that may involve body fluids and when there are no gowns available:
    - 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

Reusable patient gowns and lab coats can be safely laundered according to routine procedures.

- Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles
- Systems are established to routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties) and replace reusable gowns when needed (e.g., when they are thin or ripped)

Additional Resources

Strategies for Optimizing the Supply of Eye Protection

Strategies for Optimizing the Supply of Facemasks

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of N95 Respirators

Updated February 29, 2020

Summary of Changes

- Clarification of introductory language
- Information added on Crisis/Alternative Strategies
- Information added to expand upon strategies, including two new resources:
  - Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response
  - Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response

Audience: These considerations are intended for use by federal, state, and local public health officials, respiratory protection program managers, occupational health service leaders, infection prevention and control program leaders, and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of disposable N95 filtering facepiece respirators (commonly called "N95 respirators") in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare settings can refer to existing influenza preparedness plans to address other aspects of preparing to respond to novel coronavirus disease 2019 (COVID-19). The strategies are also listed in order of priority and preference in the Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response in an easy-to-use format for healthcare facilities.

The following strategies are based upon these assumptions: 1) facilities understand their current N95 respirator inventory and supply chain, 2) facilities understand their N95 respirators utilization rate, and 3) facilities are in communication with state and local public health partners (e.g., public health emergency preparedness and response staff) and healthcare coalitions. While these strategies are targeted for optimizing the supply of N95 respirators, some of these strategies may be applicable to optimizing the supply of other personal protective equipment such as gowns, gloves, and eye protection.

Controlling exposures to occupational hazards is a fundamental way to protect personnel. Conventionally, a hierarchy has been used to achieve feasible and effective controls. Multiple control strategies can be implemented concurrently and or sequentially. This hierarchy can be represented as follows:

- Elimination
- Substitution
- Engineering controls
- Administrative controls
- Personal protective equipment (PPE)

c. Staff with a family member diagnosed with COVID-19 will report this to their supervisors as per policy. Considerations should be made to limit the employee's contact with I/D/R and other staff members.

Visitors

1. In case of a confirm case of COVID-19 within the facility, the local leadership will consider a temporary suspension of visitation; and

2. If visitation will continue to occur, all visitors will be notified about the possible risk of exposure to COVID-19.

Procurement of Personal Protective Equipment (PPE)

1. Facility Administrator/designee will assure an adequate supply of PPE is maintained on-site; and

2. In cases where PPE supplies cannot be procured, the Facility Administrator/designee will contact the Regional Director for Health Services for guidance.

APPROVED: _____ Effective Date: 02/28/2020
John E. Christakis, M.D., Chief Medical Officer

Resources for Additional Information at the Centers for Disease Control and Prevention

1. **CDC Interim Guidance for Healthcare Professionals @ https://www.cdc.gov/coronavirus/COVID-19/clinical-criteria.html Accessed February 8, 2020.**

2. **The World Health Organization @ http://who.int/csr/disease/swineflu/en/index.html Accessed February 8, 2020.**

ATTACHMENTS

1. **Respiratory Precautions Sign HS-203**
2. **Influenza/H1N1/COVID-19 Contact Investigation List Form HS-241**

The GEO Group, Inc.	CORRECTIONAL HEALTH SERVICES CHAPTER: INFECTION CONTROL TITLE: CORONAVIRUS (COVID-19) MANAGEMENT	NUMBER: 531 SUPERSEDES: 02/10/2020 EFFECTIVE: 02/28/2020

POLICY

The identification, monitoring, and treatment of COVID-19 Coronavirus signs and symptoms shall be handled in accordance with the recommendations of the Centers for Disease Control and Prevention.

APPROVED: _____ Effective Date: 02/28/2020
John E. Christakis, M.D., Chief Medical Officer

REFERENCES

1. American Correctional Association 5-ACI-6A-12 (M)
2. National Commission on Correctional Health Care J/P-B-01

COVID 19 CORONAVIRUS DISEASE

What you need to know about coronavirus disease 2019 (COVID-19)

What is coronavirus disease 2019 (COVID-19)?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

Can people in the U.S. get COVID-19?

COVID-19 is spreading from person to person in China, and limited spread among close contacts has been detected in some countries outside China, including the United States. At this time, however, this virus is NOT currently spreading in communities in the United States. Right now, the greatest risk of infection is for people in China or people who have traveled to China. Risk of infection is dependent on exposure. Close contacts of people who are infected are at greater risk of exposure, for example health care workers and close contacts of people who are infected with the virus that causes COVID-19. CDC continues to closely monitor the situation.

Have there been cases of COVID-19 in the U.S.?

Yes. The first case of COVID-19 in the United States was reported on January 21, 2020. The current count of cases of COVID-19 in the United States is available on CDC's webpage at https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.

How does COVID-19 spread?

The virus that causes COVID-19 probably emerged from an animal source, but now it seems to be spreading from person to person. It's important to note that person-to-person spread can happen on a continuum. Some diseases are highly contagious (like measles), while other diseases are less so. At this time, it's unclear how easily or sustainably the virus that causes COVID-19 is spreading between people. Learn what is known about the spread of newly emerged coronaviruses at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html.

What are the symptoms of COVID-19?

Patients with COVID-19 have had mild to severe respiratory illness with symptoms of

- fever
- cough
- shortness of breath

What are severe complications from this virus?

Many patients have pneumonia in both lungs.

How can I help protect myself?

The best way to prevent infection is to avoid being exposed to the virus that causes COVID-19.

There are simple everyday preventive actions to help prevent the spread of respiratory viruses. These include

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.

If you are sick, to keep from spreading respiratory illness to others, you should

- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces.

What should I do if I recently traveled to China and got sick?

If you were in China within the past 14 days and feel sick with fever, cough, or difficulty breathing, you should seek medical care. Call the office of your health care provider before you go, and tell them about your travel and your symptoms. They will give you instructions on how to get care without exposing other people to your illness. While sick, avoid contact with people, don't go out and delay any travel to reduce the possibility of spreading illness to others.

Is there a vaccine?

There is currently no vaccine to protect against COVID-19. The best way to prevent infection is to avoid being exposed to the virus that causes COVID-19.

Is there a treatment?

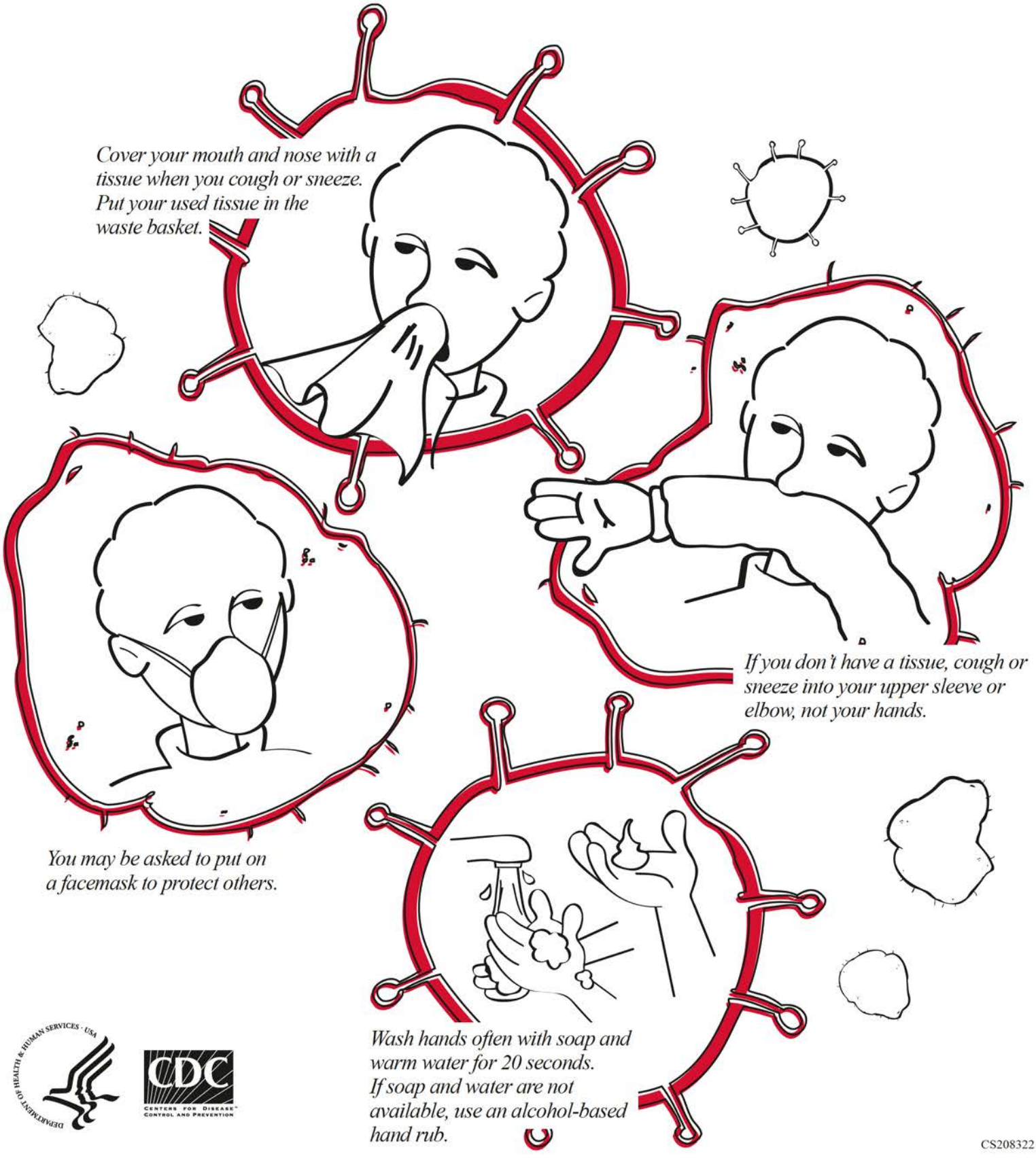
There is no specific antiviral treatment for COVID-19. People with COVID-19 can seek medical care to help relieve symptoms.

For more information: **www.cdc.gov/COVID19**

CS 314937-A 02/21/2020

Cover your Cough

Stop the spread of germs that can make you and others sick!



Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.

If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.

You may be asked to put on a facemask to protect others.

Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CS208322

COVID 19
CORONAVIRUS DISEASE

STOP THE SPREAD OF GERMS

Help prevent the spread of respiratory diseases like COVID-19.

Avoid close contact with people who are sick.

Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

Avoid touching your eyes, nose, and mouth.

Clean and disinfect frequently touched objects and surfaces.

Stay home when you are sick, except to get medical care.

Wash your hands often with soap and water for at least 20 seconds.

For more information: www.cdc.gov/COVID19

CS314915-A

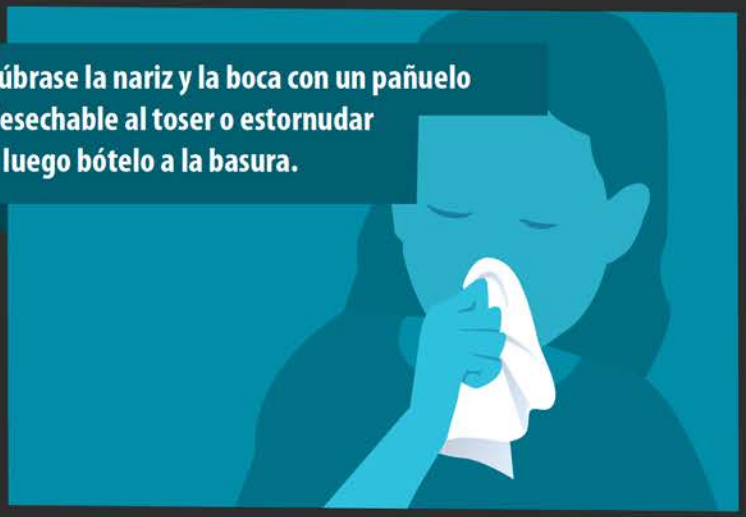
2019 nCoV CORONAVIRUS

DETENGA LA PROPAGACIÓN DE MICROBIOS

Ayude a prevenir la propagación de virus respiratorios como el nuevo coronavirus 2019

Evite el contacto cercano con las personas enfermas.

Cúbrase la nariz y la boca con un pañuelo desechable al toser o estornudar y luego bótelo a la basura.



Evite tocarse los ojos, la nariz y la boca.

Limpie y desinfecte los objetos y las superficies que se tocan frecuentemente.

Quédese en casa si está enfermo, excepto para buscar atención médica.

Lávese las manos frecuentemente con agua y jabón por al menos 20 segundos.

Para obtener más información: **www.cdc.gov/nCoV**

CS314915-B