Management of Patients and Healthcare Personnel for the COVID-19 Pandemic
Updated January 8, 2021

In order to address this rapidly changing situation, this document outlines strategies to address the situation, and enable UCDH to continue our mission of delivering the highest quality of care to our community. Our strategy is informed by CDC guidelines, Sacramento County Public Health and our own Infectious disease experts.

For questions related to information in this document, please follow your department chain of command. If further clarification is needed from outside the department, this should be completed directly by the Manager/Supervisor.

Current Practice
These strategies are founded upon UCDH standards and policies, and references the following guidance:

- Sacramento County Public Health: https://www.saccounty.net/COVID-19/Pages/default.aspx
- Sacramento County Public Health – COVID-19 Laboratory Prioritization Advisory; March 16, 2020
- SOLANO COUNTY COVID-19 MANAGEMENT OF GENERAL COMMUNITY AND HEALTHCARE PERSONNEL INTERIM GUIDANCE, Solano, Public Health, March 9, 2020
- “Viral RNA load as determined by cell culture as a management tool for discharge of SARS-CoV-2 patients from infectious disease wards”: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7185831/
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Visitor Management

Our care philosophy has always emphasized family and loved ones as part of the healing process. However, due to the ongoing community spread of COVID-19 (coronavirus) and the local public health emergency, we must take extra steps to protect our patients, staff, visitors and the community.

We are limiting visitations within UC Davis Medical Center in order to help keep the virus out of the hospital.

The decision to restrict visitors was difficult and made only after very careful considerations. With schools, houses of worship, and most other gathering places closed or highly restricted to help prevent the spread of COVID-19, hospitals and health clinics are also making public safety the top priority. Additionally, nearly every patient in the hospital is at an elevated level of risk for complications from COVID-19.

We know there are a few situations when having a loved one (visitor) present is necessary to care delivery. In these cases, visitors will be allowed based on the exceptions listed below. However, in all cases, loved ones are only allowed if they do not have symptoms of illness (fever, runny nose, cough, shortness of breath). Additionally, children under the age of 16 are not allowed.

UC Davis Health recognizes the importance that patient’s loved ones play in the mental well-being of patients. This is especially evident for some such as pediatric patients, patients in labor and delivery, and patients at end-of-life.

All Patients, who are not positive for COVID-19, may have one loved one (visitor) and must stay in the room and have no symptoms for/or recently confirmed having COVID-19. Patients will identify two designated loved ones who may visit and may not be modified during their hospitalization. A loved one will be welcomed between 9am to 9pm, only one visitor is able to be present at a time with exception to the following areas and guidelines:

- Adult patients undergoing surgery or procedures may have one loved one.
- Children undergoing surgery may have two loved ones during surgery.
- Labor and Delivery patients may have one support person/partner.
- Neonatal Intensive Care Unit (NICU) patients may have one birth parent plus one significant other who must remain in the room for the duration of the visit.
• Pediatric Intensive Care patients may have 2 loved ones, either parents or guardians. They must remain in the room during the visit.
• Patients who are at the end-of-life may have 2 loved ones.
• Patients who have an appointment at UC Davis ambulatory clinics, laboratory, or radiology, may have one loved one with them.

Emergency Department:
No visitors are allowed in the ED except:
▪ If the patient is under 18 years old or over 65 years old – if so, they may have 1 visitor at the bedside
▪ Dying patients (patient receiving comfort care), or with a life-threatening diagnosis
▪ Patients in the Admission Pathway area-may have one visitor at bedside, during visiting hours only (9am-9pm)
▪ Patients admitted and in the ED > 24 hours may have one visitor at bedside, during visiting hours only (9am-9pm)
▪ Patient where a caregiver provider is part of patient safety and decision making
  o Physical (requires assistance for any ADLs - cane, walker, wheelchair)
  o Cognitive (Hx Alzheimer Dz, Dementia)
  o Disruptive behavior (TBI, Autistic)
  o Altered mental status (confused or developmental delayed)
  o Special circumstances approved on case by case basis as determined by care team (This may be relevant to patients with psychiatric needs but will defer to the ED psychiatric team)

** Any visitors allowed by this policy must stay at bedside and not in the waiting room.

Visitors will be restricted to the two designated visitors by the patient and provided to the hospital's information desk in the Pavilion. In any of these scenarios, loved ones will be screened for flu-like symptoms, i.e. fever, cough, sore throat. Visitors will also be required to wear a facemask, for the entirety of the visit. Visitors must stay in their patient's room for the entire time of the visit. Visitors are permitted to access the cafeteria and are encouraged to practice physical distancing and to keep the time in the public spaces brief. Visitors who are unable to adhere to these visitor guidelines may be asked to leave by department staff.

COVID positive patients and those who share living spaces with the patient, are subject to a Sacramento County Public Health Isolation and Quarantine order effective July 10, 2020 until further notice. Therefore, the following visitors’ guidelines for all COVID-19 positive patients are as follows:

Visitor guidance for COVID-19 positive adults (age 18 and above):
▪ No visitors will be allowed during the 14-day quarantine period for patients who are independent and do not require any care support persons.
• Adult patients at end-of-life or having physical, intellectual, cognitive and/or developmental disabilities, may permit a support person (loved one who is determined to be essential to the care of the patient or medically necessary), to remain with the patient. This individual must remain in the room at all times for the duration as part of the quarantine.

• Obstetrical/Postpartum & Labor and Delivery patients will be allowed one support person who is required to remain in the room with the patient for the duration of the quarantine period.

Visitor guidance for COVID-19 positive pediatric (under 18 years of age):

• Only one parent/guardian may stay and quarantine in the room with a pediatric patient at Children’s Hospital:
  o When the parent/guardian has no more than mild symptoms of COVID-19 disease
  o Meals will be provided to the parent/guardian in the room
  o The parent/guardian cannot leave the room. If they do, they can no longer stay with the child
  o If parent/guardian has more than mild symptoms of illness, he/she cannot stay with the child
  o The parent/guardian will wear a mask for source control whenever hospital staff members enter the room. They do not need to wear a mask if they are sleeping

• Patients in NICU – if parents and guardians are COVID-19 positive or have any symptoms of illness, they cannot enter the NICU. One asymptomatic caregiver will be given visitation rights, they cannot be from the same household as COVID-19 positive mother.

• In clinical cases where the above guidelines may not apply, the pediatric infection prevention MD should be consulted for recommendations on visitation.

Note that symptomatic patients of any age being ruled out for COVID-19 should be treated the same as COVID positive patients in regards to visitation (i.e. visitors restricted except for the exceptions mentioned above). If the patient being ruled out results negative, they may then be treated similar to COVID negative patients in terms of visitation (patients allowed one visitor, with some exceptions, as described above).

Management of Patients with Unknown, Suspected or Confirmed COVID-19

CDC recommends using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection.
All Points of Entry

At UCDH everyone entering the healthcare facility will be screened for signs and symptoms of COVID-19 as well as implementation of Universal Source Control Measures: (See appendix E)

- Universal facemasks (source control) that cover the person’s mouth and nose are required at the point of entry and must be worn at all time while in the facility by all patients, visitors and HCPs.

- HCPs walking into the healthcare facility that will be around other people before entering the building (ex. when coming from parking lot/structure or walking between buildings) should wear a mask for the entirety of the time they are at the healthcare facility.

- Face masks and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.

- Patients may remove their cloth face covering when in their rooms but must put it back on when around others (e.g., when visitors enter their room) or leaving their room.

- HCP must wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers.

- Healthcare personnel (HCP) in all patient facing departments must follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). They must also wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious materials.

- Healthcare personnel (HCP) performing high-risk aerosol producing procedures will follow our Aerosol Transmission Disease (ATD) policy 2002 mandated by Cal-OSHA for both COVID-19 patients as well as all other patients with known or suspect droplet or airborne infectious diseases.

- If airborne infection isolation rooms (AIIR) are available, they will be used for aerosol producing or high-risk procedures on COVID-19 positive patients.

- If an AIIR room is not available, a HEPA filter will be placed in the room and the door should remain closed.

Ambulatory Care and Cancer Center

- Ambulatory and Cancer Center care areas will consider rescheduling non-urgent appointments for patients with respiratory symptoms or convert to a video visit if appropriate.
• Advise patients to stay home until their symptoms have resolved, and to monitor for worsening symptoms and to seek further medical care if warranted.

• Advise patients to return to normal activities, e.g. work, after symptoms resolve.

• Ambulatory Care and Cancer Center discharge teaching when recovering at home.

• Patients and visitors presenting to the facility wearing cloth facemasks, bandanas, neck gaiters, or masks with exhalation valves will be provided a hospital approved face mask to ensure proper source control. Exceptions are children under the age of 2 years or anyone who has trouble breathing, is unconscious, incapacitated or otherwise unable to remove the mask without assistance.

• If an individual is unable to wear a face mask, a face shield will be provided to patients and visitors.

• HCPs must follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). They must also wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious material during rooming activities obtaining vital signs, and conducting basic examinations.

• COVID-19 swab collection requires enhanced droplet/contact precautions: N95 respirator of higher, goggles/face shield, gown and gloves. It is NOT an example of high-risk aerosol producing procedure.

• High-risk aerosol producing procedures in outpatient setting would be CPR, bronchoscopy, intubation and nebulizer treatments (refer to AGP list on page #10).

• Healthcare personnel (HCP) performing aerosol generating procedures for all known or suspected COVID-19 or patients with ILI must wear gloves, gown, eye protection, and N95 respirator or higher.

**Ambulatory Visits for Patients with Suspected or Confirmed COVID-19**

• Patients with suspected COVID-19 or confirmed COVID-19 (see below discontinuation of transmission-based precautions) who need face to face care in the ambulatory sites must be treated with the below additional precautions.

• Patients must be screened for signs and symptoms of COVID-19 and be provided a face mask (source-control) at the point of entry.

• HCPs must follow Standard Precautions and Transmission-Based Precautions if required based on the suspected diagnosis. They must also wear eye protection in addition to their respirator to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious material during rooming activities obtaining vital signs, and conducting basic examinations.
• Room the patient immediately or if not possible, have them wait in their car or well distanced from other patients and staff. If possible, schedule these patients at a time which will minimize contact with other patients.

• Healthcare personnel (HCP) performing aerosol generating procedures for any known or suspect COVID-19 patient will wear gloves, gown, eye protection, and N95 respirator or higher.

• Patients who have had COVID-19 diagnoses (lab confirmed) will have a flag on their outpatient chart for 30 days after the initial diagnosis. This flag is to alert HCP to screen for the need to follow COVID-19 transmission-based precautions.

• Discontinuation of Transmission-Based Precautions in the Ambulatory Clinics for patients who have been diagnosed with COVID-19: must meet the following criteria using the CDC symptom based strategy [https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html]:
  o At least 10 days (mild to moderate illness) and 20 days (severe to critical illness or severely immunocompromised) have passed since symptoms first appeared and at least 24 hours have passed since last fever without the use of fever-reducing medications and improvement in symptoms.

• For Sacramento County residents, provide the patient a copy of the Sacramento County Department of Public Health order for Isolation and/or Quarantine dated July 10, 2020 at the time of discharge.

**Home Care Services**

• Home Care will perform Infectious Disease Screening on all patients prior to each patient contact and document findings as well as PPE to be used during home visit.

• Home Care staff will consider telephonic visits for patients with respiratory symptoms in place of home visits, if appropriate.

• Home visits will be scheduled last in the day.

• Every effort to cohort patients will be made to minimize risk.

• Instruct patients to monitor for worsening symptoms and notify the Home Care team as needed. Home Care on-call services available 24/7 for all Home Care patients.

• Instruct caregivers on patient care needs.

• Patients must be provided a mask (source-control) to wear for duration of home visit.

• Social distance of six (6) feet or greater from all person(s) must be maintained whenever possible during visit.
• Those providing direct patient care must don an N95 respirator or higher, goggles/face shield, gown and gloves during the home visit.

• Symptomatic non-patient person(s) in the home will be asked to self-quarantine in another room. If they must participate in visit and cannot maintain social distance, they will don a face covering.

• High-risk aerosol producing procedures in the Home Care setting include hands-only CPR, Hi-Flow nasal cannula, BiPAP/CPAP, tracheostomy change and care, chest physiotherapy, and nebulizer treatments.

• Healthcare personnel performing aerosol generating procedures for COVID-19 or patients with ILI will wear gloves, gown, eye protection, and N95 respirator or higher.

• Patients who have had COVID-19 diagnoses will have a flag on their outpatient chart for 30 days after the initial diagnosis. This flag is to alert HCP to screen for the need to follow COVID-19 care precautions or routine precautions.

• Discontinuation of Transmission-Based Precautions in the Ambulatory Clinics for patients who have been diagnosed with COVID-19: must meet the following criteria using the CDC symptom based stagey (https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html):
  o At least 10 days (mild to moderate illness) and 20 days (severe to critical illness or severely immunocompromised) have passed since symptoms first appeared and at least 24 hours have passed since last fever without the use of fever-reducing medications and improvement in symptoms.

**Inpatient Care and Rooming Guide**
Implement universal source control measures and PPE for all patients presenting for care. These precautions include:

• Universal masking of all patients and visitors while in the healthcare facility.

• Patients may remove their face when in their rooms but must put it back on when around others (e.g., when visitors enter their room) or leaving their room.

• Universal personal protective equipment (PPE) for all staff participating in direct patient care now requires use of a face mask, eye protection (face shield or goggles) in addition to standard and transmission-based precautions based on clinical presentation and suspected diagnosis.

• Maintain physical distancing greater than 6 feet, especially when the patient is unmasked.

• Airborne isolation rooms (negative pressure rooms) are reserved for patients with known airborne infectious diseases (AID). Continue to follow the rooming algorithm for symptomatic patients with ILI.
• As part of the aerosol transmissible disease (ATD) standard (Cal-OSHA 2009), an N95 respirator or higher is required when caring for patients with novel respiratory viral pathogens. COVID-19 is considered to be a novel virus at this time.
• **HCP must wear an N95 respirator when caring for COVID-19 positive patients or symptomatic rule outs.**
• We will continue to use PAPR or N95 respirators with eye protection during aerosol generating procedures (AGP) such as intubation, bronchoscopy and nebulizer treatments for Covid positive and symptomatic rule outs (see AGP list)
• **Patients in a shared room, receiving asymptomatic surveillance testing, can remain in that room while tests results are pending. Please refer to the Inpatient Rooming Algorithm.**

**Guidelines for Patient Pairings with Influenza Like Illness (ILI)**

• Encourage patients to wear facemasks at all times unless prevented by medical condition or clinical treatments or therapies.
• When possible maintain 6 feet of physical distancing between patients and visitors
• Only 1 patient uses the bathroom & is placed closest to the bathroom. The other patient is either bed bound or uses the bedside commode.
• Use hospital disinfectant wipes on surfaces in bathroom and room frequently.
• Keep the curtains closed between the patients.
• HCW: Consider staffing with different nurses.
• **Do not cohort these immunocompromised patients: Patients undergoing chemotherapy, BMT current admission, new leukemic without count recovery from induction, Neutropenia (ANC count <500), solid organ transplant, HIV with CD4<200.**
• Visitors must wear facemask at all times, follow Isolation signage, stress hand hygiene.
**Inpatient Rooming Algorithm**
Revised 11/5/2020

**Droplet & Contact Precautions**
(face mask, eye protection, gloves, gown. When AGPs are performed then use N95 respirator or higher)

- **Influenza Like Illness (ILI)** (suspect or confirmed)
  - Flu, Rhinovirus, Pertussis etc.

  - **Private Room preferred if continuous AGPs.**
    - If AGPs are performed and a private room not available, close curtain and door during procedure.

  - **If none available,**
    - **Cohort with Like Pathogens if known**

    - **If none available,**
      - **Cohort ILI Patients in Droplet + Contact Precautions**

**Enhanced Droplet & Contact Precautions**
(N95 respirator or higher for all direct care and AGPs, eye protection, gloves and gown)

- **Influenza Like Illness (ILI)** (suspect or confirmed)
  - COVID 19 or Novel Influenza etc.

  - **Private room If AGPs are performed.**
    - If Continuous AGP Negative Air Room (if available) or private room with door closed + adjunct HEPA filter (if available).

  - **If AGPs are performed and a private room not available,**
    - close curtain and door during procedure.

  - **For confirmed COVID-19 or Novel flu, only cohort with like virus**

**NOTE Droplet includes Mask and eye protection**

If possible avoid placing COVID-19 positive patients receiving aerosol generating procedures in the following Positive Pressure Rooms:
- BMTU Davis 8
- Davis 7 Room #7757 & 7759
- Tower 7 Blue-7661
**Guidance for Aerosol Generating Procedures (AGP)**

Aerosol Generating Procedures (AGPs) are any procedure carried out on a patient/resident/client, which can induce the production of aerosols of various sizes, including droplet nuclei. Procedures that generate aerosols or droplet nuclei in high concentration present a risk for opportunistic airborne transmission of pathogens not otherwise spread by the airborne route (e.g., SARS, SARS CoV 2, influenza) and increase the risk for transmission of organisms known to spread by the airborne route (e.g., TB). **Alternatively, a regular cough and procedures that may induce a regular cough would not be considered AGP.**

A negative air room if available, or a private room with the door closed is preferred. If cohorted, close curtain and keep door closed during procedure. The ‘AGP In Progress’ sign (Appendix C) must be posted outside of the room for the duration of the procedure. For additional cohorting and AGP recommendations, see Appendix C and D. Consult Respiratory Therapy for AGP questions.

- During the aerosol-generating procedure: Limit non-essential personnel during AGP and remove visitors from the room during AGP and for 1 hour afterward when applicable.
- Limit transport and movement of the patient outside of the room to medically essential purposes.
- Consider providing portable x-ray equipment to reduce the need for patient transport.
- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).

- Available AGP education in UC Learning Module course titled "COVID-19 and Droplet Precautions: Respiratory Therapies and Aerosol-Generating Procedures" or under course code "DAHS-NGNCDP20"

<table>
<thead>
<tr>
<th>Type of Procedure</th>
<th>PPE</th>
<th>Room criteria</th>
<th>PPE</th>
<th>Room criteria</th>
<th>PPE</th>
<th>Room criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerosol Generating Procedure (AGP)</td>
<td>PAPR or N95 with goggles or face shield, gown, gloves</td>
<td>Airborne Isolation room</td>
<td>PAPR or N95 with goggles or face shield, gown, gloves</td>
<td>Refer to Rooming Algorithms</td>
<td>PAPR or N95 with goggles or face shield, gown, gloves</td>
<td>Refer to Rooming Algorithms</td>
</tr>
<tr>
<td>Not Aerosol Generating Procedure</td>
<td>PAPR or N95</td>
<td>Airborne Isolation room</td>
<td>Face mask with goggles or face shield, gown, gloves</td>
<td>Refer to Rooming Algorithms</td>
<td>PAPR or N95 with goggles or face shield, gown, gloves</td>
<td>Refer to Rooming Algorithms</td>
</tr>
</tbody>
</table>
List of Aerosol Generating Procedures (AGP)

Aerosol Generating Procedures (AGP):

<table>
<thead>
<tr>
<th>Procedure</th>
<th>AGP</th>
</tr>
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<tbody>
<tr>
<td>Endotracheal Intubation/Extubation</td>
<td>Tracheostomy Change</td>
</tr>
<tr>
<td>Bronchoscopy, BAL, Mini-BAL</td>
<td>Tracheostomy Mist/Care</td>
</tr>
<tr>
<td>High Frequency oscillatory ventilation</td>
<td>Nebulized Treatments</td>
</tr>
<tr>
<td>Non-Invasive Ventilation (BiPAP, CPAP)</td>
<td>Deep Suction</td>
</tr>
<tr>
<td>MV Circuit Break (with flow)</td>
<td>Cuffless ETT</td>
</tr>
<tr>
<td>Manipulation of ETT (cuff deflation)</td>
<td>Direct Laryngoscopy</td>
</tr>
<tr>
<td>Operative/Procedural invasive nasopharyngeal/sinus washing, aspirate,</td>
<td>Operative/Procedural excision or biopsy of extrapulmonary TB (e.g.</td>
</tr>
<tr>
<td>and scoping</td>
<td>Potts Disease)</td>
</tr>
<tr>
<td>Autopsy/Biopsy of lung tissue</td>
<td>High Flow Nasal Cannula Oxygen delivery system (including Optiflow</td>
</tr>
<tr>
<td></td>
<td>and Airvo)</td>
</tr>
</tbody>
</table>

1. Per Cal-OSHA regulation Title 8, Section 5199, (g) (3) (B), [http://www.dir.ca.gov/Title8/5199.html](http://www.dir.ca.gov/Title8/5199.html)
2. [https://www.dir.ca.gov/title8/5199a.html](https://www.dir.ca.gov/title8/5199a.html) and [https://infectioncontrol.ucsfmedicalcenter.org/isolation-table](https://infectioncontrol.ucsfmedicalcenter.org/isolation-table)
3. Novel Respiratory Isolation Precautions (Airborne Isolation with eye protection, gloves and gown in Negative Pressure Room) must be in place for patients with frequently ongoing or continuous HRAGP, Respiratory Isolation Precautions (face mask with eye protection, gloves and gown) are in place for patients with discrete HRAGP or no HRAGP
4. Other Droplet Transmitted infections not outlined by ATD Standards (e.g. RSV, rhinovirus, parainfluenza, human metapneumovirus), negative respiratory viral evaluation, no concern for respiratory infection

Discharge

If a patient is discharged still on isolation for COVID-19, they must be advised to remain under home isolation until they have had no fever for at least 24 hours (that is one full day of no fever without the use medicine that reduces fevers) AND other symptoms have improved (for example, when their cough or shortness of breath have improved) AND at least 10 days (mild to moderate illness) and 20 days (severe to critical illness or severely immunocompromised) have passed since symptoms first appeared.

Symptomatic patients discharged with pending COVID-19 tests must be instructed to go on home isolation until test results are known. Asymptomatic patients discharged with a pending COVID-19 surveillance tests do not need to be instructed to go on home isolation unless they subsequently develop symptoms.

Pre-approval from either county public health or Infection Prevention is not required to discharge a COVID-19 positive patient. Clinical Case Management notifies the patient’s county of residence via fax
for COVID-19 positive discharged patients. Providers should consult the “FAQ For Providers Discharging COVID-19 Patients” for additional discharge related information.

**Post-Mortem Care for COVID and COVID rule out**


Additionally, the following are recommendations form CAHAN & Sacramento County Coroner, Dr. Kimberly Gin.

**California Dept. of Public Health**
[https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-24.aspx](https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-24.aspx)

- Follow standard precautions.
- When lifting and moving the body, because of the possibility that air may be expelled from the body, the face of the deceased must be covered temporarily with a disposable face mask and placed in a body bag. Enclosing the deceased in a body bag also contains body fluids to prevent contact.

**Sacramento County Coroner’s Office**

- Wear appropriate PPE (Gloves, gown & googles)
- Place face mask on expired patient
- Handwrite “infectious – COVID positive” or “COVID rule out” on toe tag and UCDMC Decedent Affairs Expiration worksheet
- Double bag patient (body bag)
- Wipe down outer body bag with a sanitizing wipe

**Testing Strategy**

**Symptomatic Diagnostic Testing**

UC Davis Health tests all individuals with symptoms consistent with COVID-19 using the Symptomatic diagnostic testing workflow which is associated with the EPIC ICON Isolation and Beaker (lab) workflows.

- **Symptoms compatible with COVID-19:** fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills muscle pain, headache, sore throat, new loss of taste or smell, diarrhea.
- **Symptoms unlikely to be consistent with COVID-19:** rhinorrhea, sinus congestion or pain, conjunctivitis, lymphadenopathy, nausea, vomiting, rash.

*When seeing these patients, the full differential diagnosis should be considered, and testing done appropriately. Consider making diagnosis and testing based on clinical presentation. Testing that
maybe helpful includes COVID-19 + Flu A/B testing, as well as chest x-ray. If the patient tests positive for influenza further viral testing is unlikely to be helpful.

*Repeat testing of positive patients should be done through the Symptomatic Diagnostic Testing workflow.*

**Recommended Testing Guidelines (November 5, 2020)**

<table>
<thead>
<tr>
<th>Exposure to known COVID-19 patient</th>
<th>Symptoms: fever/acute respiratory symptoms (cough shortness of breath), myalgia</th>
<th>Testing</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Additional Comments</th>
</tr>
</thead>
</table>
| No                                | Not recommended unless for admission, pre-op, high risk patients needing rapid turnaround or required for discharge to group setting. | COVID 2019 RNA, QUAL Surveillance order pathway | COVID2019 RNA, Qual or QUEST depending on current lab selection guidelines. Roche Liat POCT COVID 19 + Flu A/B PCR test is an option in the ED and ambulatory settings. | Asymptomatic testing should not be done for social reasons. This is supported by CDPH guidelines.  
  • Pre-travel  
  • Prior to a visit with an elderly relative  
  • Patient just wants to know  
  • Patient’s employer wants it  
  • To test for resolution (use CDC clinical guidelines). |
| No                                | Yes                                                                            | Test   | COVID 2019 + Flu A/B Symptomatic order pathway | POCT COVID 2019 + Flu A/B or QUEST depending on current lab selection guidelines. | Consider not testing if the result will not change care or isolation. |
| Yes                                | No                                                                            | May test on a case by case basis depending on data of exposure or epi investigation | COVID 2019 RNA QUAL Surveillance order pathway | COVID2019 RNA, Qual or QUEST depending on current lab | Consider testing asymptomatic patients who have had close exposure to a COVID-19 patient, use the QUEST order. |
Close contact is defined as someone who was within 6 feet of an infected person for at least 15 minutes cumulative, without masking starting from 2 days before illness onset until the patient is considered non-contagious. *Masking greatly reduces the risk of transmission and is considered when assessing contacts risk.*

- Do not test if exposure occurred after the index patient became non-contagious or more than 14 days have passed from the exposure.
- Consider not testing if you will not change care or quarantine based on the result.

| Yes | Yes | Test | COVID 2019 + Flu A/B Symptomatic order pathway | POCT COVID 2019 + Flu A/B or QUEST depending on current lab selection guidelines. | Consider not testing if the result will not change care or isolation. |

To test symptomatic inpatients, use the COVID-2019 + Flu A/B order and select the COVID-19 Symptomatic Diagnostic Testing and Isolation panel. NOTE: This panel sets the patient infection status to Rule Out COVID-19 and includes isolation precaution orders.

Beginning November 3, 2020 in addition to the COVID-19 + Flu A/B order, the ED and Ambulatory settings will have limited access to a new POCT rapid 10-minute PCR test that tests for both flu A/B
and COVID-19. This combined influenza A/B and SARS CoV2 rapid POC test useful when the rapid results facilitate timely anti-viral treatment and support PPE decisions.

This new rapid point of care test (Cobas Liat, Roche Diagnostics) is a PCR test and exhibits clinical sensitivity and specificity of > 99.9% with 100% agreement with our current high throughput/high sensitivity cobas 6800 laboratory-based PCR method even with low viral load samples.

This means that patients who receive a POCT test in the ED or in the ambulatory setting do not require an additional SARS CoV2 RNA Qual test just to “be sure” that the results are accurate.

The results of the POCT test can be found in the Results Tab the same as all other POC test results.

A POSITIVE POC test performed in the ED will follow the same isolation workflows as the SARS CoV2 RNA qual test currently in use and drive the appropriate isolation (Enhanced Droplet -Contact) which will appear in the patient’s banner.

**Asymptomatic Surveillance Screening**

We are now doing COVID-19 Surveillance Screening for the following asymptomatic patient populations:

**HCP working in facilities located in areas with moderate to substantial community transmission** are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection. If COVID-19 is not suspected in a patient presenting for care (based on symptom and exposure history), HCP must follow Standard Precautions and Transmission-Based Precautions if required based on the suspected diagnosis. They must also:

- Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious material from others. (See appendix E)
- Escalate PPE to enhanced respiratory protection (N95 respirator or higher) for any AGP.
- All Admissions to the hospital will undergo surveillance testing (unless clinically indicated testing more appropriate) unless proof of a negative or positive PCR test within 48 hours of admission is available. This includes patients from the ED, transfers from other facilities, and direct admits from clinics or other UCDH ambulatory sites.
- Test results from outside hospitals (OSH) should be uploaded into EMR. If test is positive notify Infection Prevention at 916-734-3377 during normal business hours M-F who will update the patient’s infection banner in EPIC. After hours or on weekends leave a message with the callers name and contact number as well as the patient’s MRN and IP will follow up on the next business day.
- Known COVID-19 positive patients transferred in from other facilities for a higher level of care and not retested, must be
placed on Enhanced Droplet + Contact isolation AND notify Infection Prevention during business hours M-F or the Nursing Supervisors after hours. Infection Prevention staff will manually add the infection which will then be displayed in the patient banner.

- All patients undergoing operative surgery or any procedure (therapeutic or diagnostic) deemed to be aerosol generating (see AGP list) in one of our procedural areas in the hospital or ambulatory sites will undergo surveillance testing (ideally 24-96 hours in advance). This does not apply to inpatients who tested negative upon hospital admission who later go for a procedure or operation.
- All OB patients on Labor and Delivery will undergo surveillance testing.
- The following ambulatory patients will undergo surveillance testing:
  - All patients with symptoms of influenza like illness (not technically part of asymptomatic surveillance screening process but included for completeness sake)
  - Patients the clinic is arranging an admission (regardless of admit reason)
  - All patients that require a negative COVID test for them to go to a congregated living facility (i.e., 5150, Prisoners, Skilled Nursing Facility, Board and Care)
  - Cancer Center:
    - Patients receiving outpatient chemotherapy
    - Patients who have developed neutropenia
    - Head and neck cancer patients undergoing radiation therapy

To screen asymptomatic patients, use the COVID-2019 RNA Qual order and select the COVID-19 Asymptomatic Screening panel.

Providers can use their discretion if they feel patients do not require pre-op testing, especially if the surgery or procedure is not an aerosol generating procedure (AGP).

NOTE: This panel does NOT set the Rule Out Infection status on the patient but does include a COVID-19 surveillance communication order for nursing.

Based on current CDC recommendations (August 10, 2020) repeat testing of previously known positives admitted for COVID-19 has no clinical benefit and as such repeat testing (<90 days since last previous positive) has been restricted. This restriction only applies to the asymptomatic testing workflow in EPIC. There is no 90 day restriction for patients who have been previously tested negative or patients who present with symptoms consistent with COVID-19 regardless of last positive test.

**Risk Factors and Testing Considerations**

When choosing testing, consider how your management would change with the result. There is no specific treatment for COVID-19 virus. However, there are treatments for influenza. Patients with risk for severe disease – such as age over 60, diabetes mellitus, cardiovascular disease, pulmonary diseases or immunosuppression – may warrant testing because a specific diagnosis may help with
hospital care and treatment if the patient’s condition worsens. Obtaining an ID consult will help direct antiviral therapy patients.

Because the sensitivity of SARS-CoV-2 testing is not 100% and may additionally be limited early in infection and in real world testing conditions a single negative test, while helpful, is not always definitive. In some circumstances a repeat SARS-CoV-2 test is appropriate. Always consider consulting with ID who can help guide any decision to retest or not.

**Isolation Removal Workflow**

All Units

A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. See the Decision Memo. As previously discussed in the 90-day lockout explanation above.

**Symptom-Based Strategy for Discontinuing Transmission-Based Precautions:**

*Patients with mild to moderate illness who are not severely immunocompromised:*

- At least 10 days have passed since symptoms first appeared and
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved

Note: For patients who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

*Patients with severe to critical illness or who are severely immunocompromised:*

- At least 10 days and up to 20 days have passed since symptoms first appeared and
- At least 24 hours have passed since last fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved
- Consider consultation with infection control experts

Note: For severely immunocompromised patients who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

As described in the Decision Memo, an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after
onset of symptoms; no patients had replication-competent virus more than 20 days after onset of symptoms. The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered in determining the appropriate duration for specific patient populations. https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

- Infection Prevention nurses will continue to follow standard workflows for reviewing isolation on all units. If the Infection Prevention nurse notes a COVID-19 related EMR isolation-infection flag mismatch, they will contact the charge nurse/bedside nurse of the patient to recommend isolation removal. This Infection Prevention review does not obviate the need for unit nurses to follow the above-mentioned isolation removal workflow.

- If COVID positive patient is readmitted greater than 10 days from symptom onset with continued respiratory symptoms, isolation must be started. If admission COVID screen is negative, Infectious Disease COVID physician should be contacted to determine need for repeat testing and isolation.

- For adult inpatients, all COVID positive patients are reviewed daily after 10 days of isolation by Infectious Diseases (ID). Isolation should only be removed after the patient has been reviewed and approved by ID.

**Pediatric Patients**

For pediatric patients, isolation for COVID-19 negative patients will be removed through normal isolation workflow (contact the physician teams and obtain an order to discontinue isolation). For any situations that are unclear, please contact Pediatric Infection Prevention physician on call.

**PPE for COVID-19 Testing**

For all settings, when obtaining nasopharyngeal specimens wear appropriate PPE; including N95 respirator or higher, eye protection, gown and gloves. Keep exam/room door closed. Masking of patients for whom it is not contraindicated is outlined below.

All patients must be source controlled when leaving their rooms for medically necessary procedures. Encourage masking of all patients when any one is present in the room or when it is not possible to maintain 6 feet of physical distancing. All staff must wear appropriate PPE based on Standard and Transmission Based Precautions: Asymptomatic patients pending COVID-19 surveillance testing must be masked (as tolerated) whenever a staff member is present in the patient’s room.
Specimen Collection Process

Testing for COVID-19 involves inserting a 6-inch long swab (like a long Q-tip) into the cavity between the nose and mouth (nasopharyngeal swab) for 15 seconds and rotating the swab several times. The swabbing is then repeated on the other side of the nose to make sure enough material is collected. The swab is then inserted into a container and sent to a lab for testing. Refer to the testing video on our web page: https://health.ucdavis.edu/coronavirus/coronavirus-testing.html
Management of Healthcare Personnel (HCP)

Now that community spread is occurring, all healthcare personnel (HCP) are at some risk for exposure to COVID-19, whether in the workplace or in the community. A conservative approach and a lower threshold for evaluating HCPs is used in order to quickly identify early symptoms in HCPs to prevent transmission from potentially infectious HCPs. The signs and symptoms for HCP assessment are broader than those used for the general public and include fever (either measured temperature ≥100.0°F or subjective fever), cough, shortness of breath, sore throat or rhinorrhea. Other symptoms that may be considered include muscle aches, nausea, vomiting, diarrhea, abdominal pain, headache or fatigue.

Healthcare personnel (HCP) If symptoms develop, remain at home until asymptomatic and follow the guidance in Appendix A.

Employee Symptom Screening
We will be symptom screening all employees before they enter the hospital or clinic location.

Employees will need to complete a symptom screening survey (certifying they are not ill) prior to entering.

Hospital Process:
1. Employees reporting to work must complete an online form, available by scanning this QR code with a smart phone’s camera
   - A link to the form is on the InsideOut employee website, near the top of the page.
   - QR codes will be also be posted in multiple places near entry points.
   - Employees may want to bookmark the link, as they will be using the form every workday.
   - Some paper surveys will be available but take longer.
   - The online form takes less than a minute to fill out on a smart phone.
   - There will also be a computer available, but there will likely be a line, so it’s much better if staff complete the survey before getting into line.
   - Employees must have their badge with them. (Badges are to be displayed at all times.)
2. After completing the form, if they have no symptoms, staff will have an ‘Approved to Work’ screen to show to the screener.
3. They will receive a colored dot for their badge to show they have been screened for the day.
   - The employee will also receive an email they can show at the front desk, if needed.
4. Employees who do not pass symptom screening, must contact their manager or supervisor immediately to let them know they are unable to report for work.
• Non-employees (vendors, etc.) who do not pass symptom screening will be encouraged to reach out to their primary care provider.

Only four hospital entries will be open. These are the Main Entry (South side), the West Entrance, the East Entry door (near the ED), and the North Addition main entry doors. Screening will be in place at these entries 24 hours a day, 7 days a week. All other doors into the hospital building will not open for employee access.

**Ambulatory Care and Cancer Center Process:**
Everyone will use the same online screening form on a daily basis (via QR code or link on Inside Out). Outpatient clinics will be issuing the same color-coded stickers in specific clinic locations where employees and providers travel from clinics to the hospital to allow them to bypass a second screening of the day.

Managers and supervisors will need to re-direct employees without the ‘dot of the day’ on their badge back to be screened.

**Pregnant Provider COVID-19 Staffing Recommendations**
Given that pregnant women have been at higher risk of severe outcomes in other novel respiratory infections, the potential risks of indicated preterm delivery, and the possibility that pregnant women may still be at greater risk of complications from COVID-19 due to our minimal data available on severity/complications in pregnancy, **we recommend that pregnant faculty, trainees, and staff limit direct care of patients with confirmed or suspected COVID-19 whenever possible.** In the event that the needs of our patients prevent removing pregnant employees from caring for COVID-19 patients, pregnant employees must wear Level II PPE (N95 respirator or higher) and face shield or eye protection while caring for these patients. We will continue to monitor the available data and will update this recommendation in the future if necessary.

**During the COVID-19 pandemic, we recommend that pregnant faculty, trainees, and staff avoid in-person patient care and patient contact after 37 weeks of gestation.** This will minimize maternal infection risk, thus minimizing risk of mother/infant separation after birth if a mother is COVID-19 positive.

**Masking and Respirator Guidelines**
Beginning Wednesday November 4, 2020 UCDH will implement new changes to PPE and Isolation of COVID-19 positive patients or symptomatic rule outs.
As a result of updates to Cal/OSHA safety standards and the current stability of the supply chain, UCDH will transition to enhanced respiratory protection (e.g. N95 respirators or higher) for all confirmed or suspect COVID-19 patients, effective at all UCDH System hospital and clinics.

Additionally, UCDH Hospital Epidemiology and Infection Prevention has recommended use of Enhanced Droplet/Contact Precautions for patient with suspect or confirmed COVID-19 patients.

- **Confirmed COVID-19** patients are defined as having a positive PCR test and remain on enhanced droplet and contact isolation.
- **Suspect COVID-19** patients are defined as patients who do not have a COVID-19 test result and are experiencing influenza-like illness (ILI) symptoms including fever and cough, shortness of breath, sore throat, or nasal congestion.

*Despite the changes in Cal/OSHA safety recommendations, we continue to believe that surgical masks and eye protection provide adequate protection against COVID-19 in this setting based on scientific evidence, and the lack of COVID-19 transmission among UCDH Health Care Workers (HCWs) utilizing Level I PPE during non-aerosol generating procedures (AGP).*


1. **All** staff observe standard precautions and:
   a. Universal source control (masking of both staff and patients) **AND**
   b. Universal PPE (eye protection or face shield) for all staff while in patient care areas.
   c. Enhanced respiratory protection (N95 or higher) for all AGPs.

   This applies to patients who have been tested and ruled out as well as COVID + patients who have entered the convalescent phase of their illness or completed the necessary isolation period.

2. For known COVID + and symptomatic rule outs use Enhanced Droplet + Contact isolation with eye protection at all times. Enhanced Droplet + Contact isolation requires the use of an N95 respirator or higher for all direct care and AGPs. UCD uses a PAPR first model.

3. Elastomeric Respirators
   a. Fit testing is required for healthcare personnel donning an elastomeric full or half face respirator with exhalation valve.
b. Until data are available to describe how effectively valved elastomeric respirators perform as a measure of source control, a face mask should be used to cover the exhalation valve.

c. The valved elastomeric respirators can be used for:
   1. Enhanced Droplet + Contact or Airborne Precautions
   2. AGPs
   3. Sterile Procedures

Universal Source Control Measures

We will be implementing Universal Masking effective June 19, 2020. Source control refers to use of cloth face coverings or facemasks that cover a person’s mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19.

- At UCDH all patients and visitors will be screened for signs and symptoms of COVID-19 and offered a facemask upon entry to the healthcare facility.
  o Patients may remove their cloth face covering when in their rooms but must put it back on when around others (e.g., when visitors enter their room) or leaving their room.
  o Facemasks and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- HCPs must wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers.
  o When available, facemasks are preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others.
    ▪ Cloth face coverings must NOT be worn instead of a respirator or facemask if more than source control is needed.
    ▪ Cloth face coverings may be worn in non-clinical areas.
  o To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same respirator or facemask (extended use) throughout their entire work shift, instead of intermittently switching back to their cloth face covering. (See Appendix B for Extended Use and Reuse Guidelines.)
    ▪ Respirators with an exhalation valve are not recommended for source control, as they allow unfiltered exhaled breath to escape.
HCP must remove their eye protection, respirator or facemask, perform hand hygiene, and put on their cloth face covering when leaving the facility at the end of their shift.

- Educate patients, visitors, and HCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth face covering.
- In our outpatient clinics, staff and providers will receive masks at the entrances of clinical buildings at the screening stations. In smaller practices, staff and providers may receive masks in the clinical areas from the manager.
- Unit and Department Managers should ensure that N95 respirators or higher are used for aerosol generating procedures on ALL patients.

- Universal Masking is required in all non-clinical buildings. Employees must maintain physical distancing 6 feet apart at all times, or there should be a barrier in place (example: cubicle walls). In non-clinical areas, these face coverings can be cloth or homemade (with no logos).

- N95 respirators with valves must not be used by visitors, patients, or healthcare workers in healthcare facilities where universal source control is necessary for all persons in the facility. N95 respirators with valves allow the wearer to exhale through the valve and this would fail to provide source control of secretions.

Patients and visitors for whom masking is required should not be used include all children younger than 2 years of age and persons who cannot easily remove a mask on their own should it become necessary (e.g. impaired neurologic or cognitive function).

It is the responsibility of all staff and faculty to be effective and vigilant stewards of PPE, in particular face masks, as masks which are used and thrown away. Please refer to Appendix B- Extended Use and Reuse Guidelines.

While asymptomatic cases of COVID-19 can exist, whether and how asymptomatic people may infect others is still unknown. In fact, if asymptomatic patients shed live virus, it may be more likely that environmental contamination is more common than droplet spray, in the absence of coughing. People wearing masks need to remember this does not reduce the need to ensure clean hands when touching your face – including to adjust the mask.

**Emergency Department (ED) Extended Use and Reuse Masking Procedure for Undifferentiated Patients**

**Purpose:** In order to care for the undifferentiated patient population presenting to the ED, all ED staff must continuously wear a *regular face mask and eye protection* during their shift by following the principles outlined in the ED (See appendix E).
**Extended use** refers to the practice of wearing the same *face mask* and *eye protection* for repeated encounters with multiple patients, without removing the mask between the encounters (See appendix B)

**Reuse** refers to the practice of using the same face mask for multiple encounters with patients but removing it (“doffing”) between some of the encounters. Reuse is not approved by Cal-OSHA at this time.

**Guiding Principles:**

- Implement universal source control for all patients and visitors.
- HCP must follow [Standard Precautions](#) and [Transmission-Based Precautions](#) if required based on the suspected diagnosis. They must also:
  - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious material from others.
  - Wear an N95 or higher respirator, instead of a facemask, for
    - For all patients when engaging in aerosol generating procedures or during direct care of Covid positive/symptomatic rule-outs.
    - Surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract)
  - Respirators with exhalation valves should be source controlled with a surgical mask when used for direct care, AGPS and during surgical procedures as unfiltered exhaled breath would compromise the sterile field.
  - Extended use is preferred over reuse because it is safer to leave a mask in place, to reduce the risk of self-contamination through frequent donning and doffing of the same equipment. At this time Cal-OSHA has not approved reuse of any N95 or face masks in the clinical setting.
  - Guidance applies to masks for a single person (no sharing).

**General Guidelines**

- All supplies of face masks and respirators will be readily available and accessible to all staff.
- Aerosol Generating Procedures: If participating in an aerosol generating procedures, staff must use enhanced respiratory protection (N95 respirator or higher) with eye protection.
  - Follow [Appendix B: Extended Use and Reuse Guidelines](#).
  - Replace the N95 when it has reached the end of its use through being damaged, distorted in shape/form, obviously soiled or moistened, difficult to breathe through or removed for any reason.
• Collection of Nasopharyngeal swab for testing also requires gown, gloves, enhanced respiratory protection (N95 respirator or higher) with eye protection.
• **Staff must not place masks or eye protection on chin, forehead or neck.** Masks and other PPE used in this manner will be considered contaminated and must be discarded.

**Doffing Face Mask/Eye Protection Process***

1. Perform hand hygiene.
2. Remove the mask by holding the ear loops. The front may be contaminated, so remove slowly and carefully.
3. Discard the mask.
4. Perform hand hygiene.

*Mask may be doffed per process when eating, during breaks, etc. Version 3, March 30, 2020*

## Appendix A: HCP Process for COVID-19 Exposure and ILI Symptoms

**Updated 12/29/2020**

### Known COVID-19 Exposure and Asymptomatic Positives
(e.g. family member or close contact with + COVID test)

<table>
<thead>
<tr>
<th>Asymptomatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons who are not currently experiencing symptoms = Asymptomatic</td>
</tr>
<tr>
<td><strong>•</strong> All staff must wear a clinical mask at all times while in the healthcare facility, including staff in non-clinical areas for 14-days after exposure.</td>
</tr>
<tr>
<td><strong>•</strong> Be restricted from contact with severely immunocompromised patients during masking period (e.g., Patients undergoing chemotherapy, BMT current admission, new leukemic without count recovery from induction, Neutropenia (ANC count &lt;500), solid organ transplant,) HIV with CD4&lt;200.</td>
</tr>
</tbody>
</table>
| **•** Adhere to hand hygiene, respiratory hygiene, and cough etiquette in 
[CDGs interim infection control guidance](https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html) (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles). |
| **•** Self-monitor for symptoms: Monitor for fever (>100) with shortness of breath and/or cough. |
| **If tested Positive and Asymptomatic:**
| *Time-based strategy* (for persons who tested positive without symptoms) |
| May return to work when 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* strategy should be used. If employee is immunocompromised or has severe to critical illness (see this CDC [link](https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html) for definition) the 10 day period from first symptoms is extended to 20 days. |
| Employee **may return** to work while test is pending. |

<table>
<thead>
<tr>
<th>Influenza Like Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptomatic</strong></td>
</tr>
<tr>
<td>• Follow sick policy for calling off (inform supervisor if COVID or ILI symptoms)</td>
</tr>
<tr>
<td>• Complete the COVID-19 Employee Screening and Testing Form to be contacted for testing: <a href="https://hr.ucdavis.edu/departments/elr/unit-assigments-health">https://hr.ucdavis.edu/departments/elr/unit-assigments-health</a></td>
</tr>
<tr>
<td>• Contact PCP if symptoms warrant</td>
</tr>
</tbody>
</table>
| **If Tested Positive and Symptomatic:**
| *Symptom-based strategy* |
| Home isolate. May return to work when at least 10 days have passed since symptoms first appeared **and** at least 24 hours have passed since last fever without the use of fever-reducing medications **and** symptoms (e.g., cough, shortness of breath) have improved. If employee is immunocompromised or has severe to critical illness (see this CDC [link](https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html) for definition) the 10 day period from first symptoms is extended to 20 days. |
| **If tested Negative:** |
| • HCP with ILI symptoms must home isolate. |
| • HCP may return to work when signs and symptoms of ILI are resolved for 24 hours without the use of antipyretics. |
| • Return to work clearance through Employee Health is not necessary. |
| • Follow policy #2150 Communicable Disease Management for Employees. |
| **If test Declined:**
| HCP May return to work when at least 10 days have passed since symptoms first appeared **and** at least 24 hours have passed since last fever without the use of fever-reducing medications **and** symptoms (e.g., cough, shortness of breath) have improved. |
| Employee **may not return** to work if tests are pending. |
| Extended Use Process by PPE                      | Extended/Reuse | DEFINITIONS: Extended use Mask and/or Face shield/goggles  
Continually wearing Mask and/or Eye Protection between multiple patients; 
REUSE of Mask: Use mask, store and eappend until soiled or damaged |
|------------------------------------------------|----------------|-----------------------------------------------------------------|
| Once a Day Mask given upon entry to Hospital  | Mask Extended Use Yes  
Mask Reuse YES | Intended for REUSE for face to face with other employees, wearing in hallways, cafeteria or desk. May take on and off throughout the day.  
Note: if worn for patient care must dispose of mask when removed unless exceptions apply below. |

Follow guidelines for PPE Appropriate Use and Discard Indications  
NOTE: DO NOT WEAR HOMEMADE OR COTTON MASKS INSIDE PATIENT CARE AREAS

| Masking Policy for Extended Use and Reuse during Patient Care Interactions |
|-----------------------------|-------------------|-----------------------------------------------------------------|
| Face Mask with Eye Protection (goggles or face shield) | Mask with eye protection Extended Use Yes  
MASK REUSE NO | For Enhanced Droplet Precautions or areas multiple influenza like illness patients are seen  
Extended use or Continuous wear of mask  
alone or with face shield  
between patients is allowed  
Do not wear for AGPs |

PPE Appropriate Use and Discard Indications  
1. PPE general use guidelines  
   - Always perform hand hygiene before donning AND after doffing PPE  
   - Do not touch mask exterior. If mask is touched perform hand hygiene |

2. Mask or N95 Respirator Discard information  
   For all scenarios, discard masks or N95 respirator,  
   - If wet, soiled, or damaged, fit or seal cannot be maintained or difficult to breathe through  
   In patient care areas:  
   - Discard prior to leaving work area  
   - Discard if mask has been removed for ANY reason  
   - Discard N95 after AGP if faceshield not used |

3. Inappropriate mask use:  
   Do NOT allow mask to hang off one ear, or sit below the nose or face

4. Respirator, Goggle or Face Shield use information  
   - Do not touch exterior or face shield or goggles during use.  
   Remove and clean Respirator, goggles or face shield  
   - if visibly soiled.  
   - May Reuse after disinfecting  

Discard face shield or goggles  
- If damaged  

Inappropriate eyewear use:  
- Do NOT wear goggles on top of head between uses  

Cloth Skull Cap/Hair Cover  
- Not considered PPE.  
- Employee may wear own cloth skull cap to cover hair if desired as long dress code is followed.  
Shoe Covers: Do not need to be worn.
NOTE: Based on identified air exchanges some rooms may need less than an hour of PAPR or N95 use post procedure.
The following table is a guide based on the in vivo evidence available on bioaerosol dispersion distance to limit the exposure to people in the room during an APG:

<table>
<thead>
<tr>
<th>Nebulizers</th>
<th>Avoid unnecessary nebulization and cough inducing aerosolized medication. Consider metered dose inhaler (MDI) with spacer or soft mist inhaler (SMI). RT to deliver nebulizer via filter (Respirgaurd image below). Patient will communicate via hand raise when they need a break.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oxygen Therapy and High Flow Nasal Cannula (HFNC)</strong></td>
<td>Avoid using Venturi systems, which contain large open ports on the mask. When using HFNC, place a loop mask over HFNC when room cohorting.</td>
</tr>
<tr>
<td>Tracheostomy Mist/Oxygen Delivery</td>
<td>Avoid using Venturi systems, which contain large open ports on the mask. Use HME and avoid heated mist.</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Non-Invasive Ventilation (BiPAP/CPAP)</td>
<td>Place ‘blue elbow’ connector between the mask and circuit. Place HME filter between blue connector and exhalation valve. Assure the mask properly fits the patient to avoid leaking.</td>
</tr>
<tr>
<td>Manual Ventilation</td>
<td>Utilize HME filter between AmbuBag and mask or artificial airway.</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
</tbody>
</table>

![AmbuBag](image1.jpg)

![Artifact with Airway](image2.jpg)
**Chest Physiotherapy (CPT)**

CPT procedures cause coughing to clear secretions. Consider first: High Frequency Chest Wall Oscillation (HFCWO) or Manual CPT with the patient donning a loop mask during procedure.
Positive Airway Pressure (PAP), Oscillatory Positive Expiratory Pressure (OPEP), and IPV cannot be performed while wearing a loop mask and should be avoided while patient is cohorting.

References


Appendix: E Universal PPE Guidance

Updated 11/4/20

Universal PPE Guidance

All Patient Facing Healthcare Personnel

ALL Ambulatory, Cancer Center, Procedural, ED, Inpatient

- Universal masking (source control)
- **Universal eye protection (face shield or goggles)**-REQUIRED
- Physical distancing (6 feet)

Additional safety precautions:

- Re-evaluate admitted patients for signs and symptoms of COVID-19. All fevers and symptoms consistent with COVID-19 among admitted patients should be properly managed and evaluated (e.g., place any patient with unexplained fever or symptoms of COVID-19 on appropriate Transmission-Based Precautions and evaluate).
- Elevate to enhanced respiratory protection (N95 respirator or higher) during AGPs for ALL patients.
# Appendix F: Respiratory Protection Grid

## At a Glance - UC Davis Health Respiratory Protection Program

<table>
<thead>
<tr>
<th>Respiratory Protection Options</th>
<th>Who Is Fit Tested</th>
<th>Who Needs to Be Fit Tested</th>
<th>Requirements of Use</th>
<th>Training Documents</th>
<th>Where to get Respiratory Protection Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powered Air Purifying Respirator</td>
<td>Anyone – Just in Time Training and Video is Available Online</td>
<td>Everyone, This Should Be the First Choice in Respiratory Protection Due To Being Sustainable</td>
<td>No Fit Testing Medical Evaluation Annual Training Module</td>
<td>3M Versaflo TR-300 PAPR Video PAPR Donning PAPR Training Form Required Training for PAPR Just in Time Training in Cart</td>
<td>Hospital Infor Lawon Cart – 134826 Ambulatory Clinic Provided</td>
</tr>
<tr>
<td>Elastomeric Air Purifying Respirator</td>
<td>Selected Nursing ICTs and Code Teams Emergency Department, Pulmonary, Internal Medicine, Home Health, Trauma Surgeons, Anesthesiology, Infectious Disease, Select Perioperative Services Staff, UF Team, Respiratory Therapy</td>
<td>Staff That Perform Aerosol Generating Procedures (AGPs) Departments That Have a High Use of N95s Staff That Have Failed the Fit of All N95s</td>
<td>Annual Fit Testing Medical Evaluation Annual Training Module</td>
<td>Filter Replacement for Elastomeric Half Face - Donning and Doffing Half Face - Donning and Doffing UC Davis Health Fit Testing Form Elastomeric Respirator Use Policy</td>
<td>Infor Lawon Numbers Honeywell North 5500 Half Face Respirator Small: 124156 Medium: 124155 Large: 130270 Replacement Filters: 124404</td>
</tr>
<tr>
<td>Halyard 46828 S N95 Halyard 46728 R N95</td>
<td>Available December 2020 Departments that Participate in Annual Fit Testing</td>
<td>Anyone Who Normally Wears 3M 1860/1860s and 3M 1870+</td>
<td>Annual Fit Testing Medical Evaluation Annual Training Module</td>
<td>Seal Check for Halyard Fluid Shield UC Davis Health Fit Testing Form</td>
<td>Available December 2020 Infor Lawon Numbers Halyard 46828 S – 154217 Halyard 46728 R – 154218</td>
</tr>
<tr>
<td>BYD DE2322 N95</td>
<td>Department that Participate in Annual Fit Testing</td>
<td>Anyone Currently Not Fit Tested Individuals that Fail the Fit of the Halyard Respirators</td>
<td>Annual Fit Testing Medical Evaluation Annual Training Module</td>
<td>Seal Check for BYD DE2322 N95 Respirator UC Davis Health Fit Testing Form</td>
<td>Infor Lawon Number BYD DE2322 – 154218</td>
</tr>
<tr>
<td>3M 1870+ N95 (or 3M 9205+ with Face Shield)</td>
<td>Department that Participate in Annual Fit Testing</td>
<td>Individuals that Fail the Fit of the BYD and Halyard Respirators</td>
<td>Annual Fit Testing Medical Evaluation Annual Training Module</td>
<td>Seal Check for 1870+ N95 Respirator UC Davis Health Fit Testing Form</td>
<td>Infor Lawon Numbers 3M 1870+ – 105817 3M 9205+ – 105841</td>
</tr>
<tr>
<td>3M 1860/1860S N95 (or 3M 8210/8310S with Face Shield)</td>
<td>Department that Participate in Annual Fit Testing</td>
<td>Individuals that Fail the Fit of the BYD or Halyard Respirators</td>
<td>Annual Fit Testing Medical Evaluation Annual Training Module</td>
<td>Seal Check for 1800 and 1800s N95 Respirator UC Davis Health Fit Testing Form</td>
<td>Infor Lawon Numbers 3M 1860 – 103509 3M 1860S – 103180 3M 8210/8310S – Currently Unavailable At This Time</td>
</tr>
</tbody>
</table>

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**UC Davis Health**

Environmental Health and Safety

Updated: 11/3/2020
Appendix G: EXPOSED COVID PATIENT ROOMING ALGORITHM 1/4/2021

COVID-19 Exposed patient identified and requires a transfer to a different room
(Consider question at right side of this document)

- Private room preferred especially with AGPs
- If no Private Room available
  - Cohort with a non-isolated patient with prior COVID + that within the last 90 days AND has met discontinuation of Enhanced Droplet & Contact isolation criteria
  - If no Previous COVID + roommate available
    - Cohort with another Asymptomatic immunocompetent COVID-19 Exposure patient
      - If no asymptomatic immunocompetent COVID-19 Exposure patient available
        - Block bed until appropriate roommate is available

If COVID-19 Exposed patient is already roomed with a Clean Roommate:
Has it been more than 48 hours from COVID-19 Exposed patient’s first exposure to Index patient AND has COVID-19 Exposed patient been roomed with Clean Roommate for more than 15 minutes?

YES
- DO NOT TRANSFER EITHER COVID-19 Exposed Patient or Clean Roommate unless medically necessary
- Mask BOTH patients
- Initiate Enhanced Droplet & Contact isolation for BOTH patients until the COVID-19 Exposed patient has finished quarantine

NO
- Transfer clean roommate- room per regular rooming
  - OR
- Transfer COVID-19 Exposed patient by following the COVID-19 exposed patient rooming algorithm on Left side of this document

Terminology:
- COVID +: Positive source/index patient
- COVID-19 Exposed: roommate of COVID Positive Patient
- Clean Roommate: Negative COVID and no exposure
Appendix H: Transportation of Rule Out COVID or Confirmed COVID Patients

Last Updated: 12/23/2020

Prior to Patient Transport: Ensure room/equipment is ready. Complete receiving department handoff report including isolation precautions. KEY POINT: Source control patient (see below).

Standard Transport: Follow Enhanced Droplet & Contact Precautions during patient transfer to wheelchair/bed/gurney. Wipe all surfaces to be handled on transport with disinfectant wipes. Remove gloves and gown. Perform hand hygiene. Staff transporting the patient will continue to wear respiratory protection (PAPR, N95 or Elastomeric respirator with eye protection) during patient transport.

Critically Ill Transport: If hands on care is needed during the transport, designated staff will wear Enhanced Droplet & Contact Precautions PPE (PAPR, N95 or Elastomeric respirator with eye protection, gown and gloves). Additional staff supporting transport will wear either a PAPR, N95 or elastomeric with eye protection and use clean hands to open doors and push elevator buttons (may carry gloves in the event of an emergency).

Is the patient receiving oxygen?

YES

Non-AGP
Low Flow Oxygen Delivery Devices

Nasal Cannula (NC): Place facemask on patient
Simple Mask: Place facemask over simple mask
Partial Non-Rebreather Mask or Non-Rebreather: Place face shield on patient

AGP
High Flow Oxygen Delivery Devices

High Flow Nasal Cannula (HFNC): Place facemask on patient
Non-invasive Positive Pressure Ventilation (NIPPV) aka BiPAP: Place face shield on patient
*RT to assess – additional travel device may be available

Hallways and elevator path should be cleared of any patients or staff if possible – Nursing Supervisor or designee can assist

For mechanically ventilated patients: RT will transport with viral filter in place – Bag Valve Mask (BVM) can be used with viral filter in place for emergencies

Transport patient via bed/gurney/wheelchair
Disinfect equipment used to transport before and after leaving the room

NO

Place facemask on patient
Document Updates

1/8/2021
- Documented updated to reflect change in practice for use of N95 respirator or higher for ALL AGPs
- Updated isolation removal workflow for Covid positive adult inpatients now requiring ID review and approval after day 10.
- Added source control for PAPR use on Appendix B
- Removed outdated language from the visitor management guidelines

1/5/2021
- Added Appendix G: Exposed COVID Patient Rooming Algorithm
- Added Appendix H: Transportation of Rule Out COVID or Confirmed COVID Patients

12/29/2020
- Updated Appendix A - moved Test Based Return to Work cirteiron from the right (Symptomatic) column to the left (Asymptomatic) column as well as adding “positive asymptomatic” who test positive for COVID-19, in the left side column header for added clarity.

12/8/2020
- Updated visitor management to include mask wearing during entirety of the visit.
- Updated testing grid to include the POCT and inpatient COVID-19 + Flu A/B option
- Instructions to obtain test results both positive and negative for patients transferring in from OSH.
- Updated the Pregnant provider COVID-19 PPE from level I to level II PPE

11/30/2020
- Added statement to 1st page to utilize chain of command for questions related to this document.
- Updated Emergency Department visitor policy.

11/5/2020
- Addition of New Appendix F: Respiratory Protection Grid
- Update to rooming algorithm

11/4/2020
- Addition of enhanced respiratory protection for the care of confirmed or susoect COVID-19 patients to align with Cal-OSAH ATD Standard requirements for novel respiratory viral illnesses
- Addition of enhanced droplet/contact isolation which requires use of N95 respirator or higher for all COVID-19 patients.
- Addition of the 90 day lockout for testing of previously positive asymptomatic COVID-19 patients
- Change to ED visitor management to allow one visitor with a patient.

9/29/2020
- Updated Mask Guidelines to Mask and Respirator Guidelines. Added Valved Respirator guidance to source control with face mask when used.
- Updated Appendix B with Elastomerics and took out pictures with our eye protection
• Isolation Removal section changed from All Adult Units to All Units.

9/16/2020
• Updated Emergency Department (ED) Extended Use and Reuse Masking Procedure for Undifferentiated Patients
• Updated General Guidelines to remove reuse guidance
• Updated Doffing Face Mask/Eye Protection Process* to remove reuse guidance
• Updated Appendix B: Extended Use and Reuse Guidelines Updated-no reuse approved.
• Removal of Appendix F- COVID-19 MIS-c Guidelines

8/28/2020
• Update to Testing grid for ambulatory services to add COVID-19 RNA Qual in addition to Quest.
• Updated language to the visitor management in the ambulatory setting excluding bandanas, neck gaiters, and masks with exhalation valves as appropriate source control.

8/13/2020
• Updated MIS-C Guidance for Pediatrics-Appendix F

8/10/2020
• Updated “Removal of Isolation” to Symptom-Based strategy
• Additional masking guidance for COVID-19 positive or symptomatic rule outs including pediatric patients who cannot wear a mask.
• Three new references added on first page to support change to symptom-based removal of isolation, health clearance for healthcare workers with COVID-19 and UCD publication “Transmissions of SARS CoV2 to HCWs by droplet rather than airborne route”
• Addition of MIS-C guidance for pediatric patients New Appendix F
• Addition of staff education for AGPs in UC Learning course code "DAHS-NGNCDP20"

7/30/2020
• Update to visitor management re symptomatic rule out patients
• Update to All Points of Entry regarding wearing a mask when walking to a clinical building
• Clarified immunosuppressed
• Updated discharge section related to to home isolation - change from 72 to 24 hours
• Updated removal of isolation section – change from 72 to 24 hours
• Updated Appendix A
• Updated Appendix B to align with CDC

7/24/2020
• Update to Appendix A - Return to Work Criteria for symptomatic employees who decline testing

7/21/2020
• Update to pediatric visitors in the Visitor Management section
• Update to rooming algorithm to avoid certain positive pressure rooms for COVID positive patients receiving AGPs.
• Appendix A updated to reflect CDC Return to work for healthcare personnel with SARS-CoV2 Infection updated July, 17, 2020
7/15/2020
• Updated visitor guidelines
• CDPH AFL recommendations to limit visitors for COVID positive patients due to July 10, 2020 Isolation and Quarantine PH order
• Updated guidance to universal eye protection for all patient facing departments irrespective of Covid status.
• Updated isolation removal workflows to Symptom Based strategies and removed need for two negative tests.
• Appendix A updated to include home isolation and no cloth masks allowed for 14 days post exposure.
• Pediatric testing algorithm deleted

7/6/2020
• Added new CDC Infection control guidance throughout document to include:
  • Universal source control
  • Physical distancing
  • Universal PPE
  • Appendix E- Universal PPE

6/26/20
• Updated Visitor Management section
• Updated Universal Masking section

6/10/20
• Updated Visitor Management section

5/21/20
• Updated Isolation Removal Workflow
• Updated Appendix A – RTW criteria to reflect updated CDC guidance

5/13/20
• Updated Discharge section
• Update to AGP list for clarification
• Update to Asymptomatic Surveillance Screening
• Update to PPE for COVID-19 Testing

5/8/20
• Update to Home Care Services section
• Update to Isolation Removal Workflow
• Update to Symptomatic Diagnostic Testing

5/6/20
• Added section: Ambulatory Visits for Patients with Suspected or Confirmed COVID-19
• Updated Visitor Management section
• Updated Employee Symptom Screening section to remove temperature checks
• Added language to Universal Masking about patients/visitors who should not be masked

4/29/20
• Updated Appendix A – RTW language for asymptomatic
• Symptoms compatible with COVID-19 updated to reflect new CDC guidelines
• Updated Isolation Removal Workflow for adult units

4/24/20
• Updated Appendix A – updated screening link, added test declined language
• Updated Isolation Removal Workflow to remove nursing supervisor
• Updated Isolation Removal Workflow to add 2 negative tests language
• Update to Asymptomatic Surveillance Screening

4/20/20
• Updated Appendix A
• Added Isolation Removal Workflow for pediatric patients
• Updated Asymptomatic Surveillance Screening (added clarifying language)
• Added language to Symptomatic Diagnostic Testing
• Updated Universal Masking (minor changes for clarification)

4/16/20
• Added section: Employee Symptom Screening
• Added section: Employee Universal Masking
• Added sections to Testing Strategy: Symptomatic Diagnostic Testing and Asymptomatic Surveillance Screening
• Updated Isolation Removal Workflow
• Updated date on Appendix A (to 4/14)

4/14/20
• Updated Appendix A
• Clarification on visitor restrictions to include ED
• Clarification on isolation removal workflow (adult ICU’s)

4/10/20
• Updated Isolation Removal Workflow
• Updated Masking Guidelines for clarification
• Removed Extended Use of Disposable Face Masks section – refer to Appendix B
• Updated: Emergency Department (ED) Extended Use and Reuse Masking Procedure for Undifferentiated Patients to align with Appendix B Extended Use and Reuse Guidelines
• Notation added to bottom of Appendix C

4/6/20
• Updated Pediatric COVID-19 Testing Algorithm
• Added Appendix B: Extended Use and Reuse Guidelines
• Reordered appendices
4/3/20
- Updated Appendix A
- Updated Aerosol Generating Procedures Tables
- Addition to Discharge section regarding coordination for positive patients
- Updated Post Mortem Care to clarify it applies to positive and rule out patients
- Update to Risk Factors and Testing Considerations
- Added section: Isolation Removal Workflow
- Clarified language around masks for consistency
- Removal of definitions language under Management of HCP
- Removed Adult Testing Algorithm
- Added Home Care Services

4/1/20
- Updated Masking Considerations section based on 4/1/20 email from Dr. Kirk
- Added: Emergency Department (ED) Extended Use and Reuse Masking Procedure
- Added “gown” (correction) to Ambulatory Care and Cancer Center section
- Addition to Inpatient Care and Rooming Guide regarding asymptomatic rule-out patients
- Re-ordered section: Moved Rooming Algorithm ahead of Inpatient Care and Rooming Guide language
- Updated Appendix A
- Updated Testing Strategy Chart
- Updated Guidance for Aerosol Generating Procedures (AGP) and AGP Table.
- Updated Testing Considerations

3/26/20
- Added: Table of Contacts
- Updated Aerosol Generating Procedure table:
- Added to Guidelines for Patient Pairings with ILI, under list of immunocompromised patients we do not cohort: post transcatheter valve (MitraClip or TAVR)
- Added section: Masking Considerations
- Added section: Extended Use of Disposable Face Masks, N95 Respirators, Goggles/Face Shields
- Added section: Pregnant Provider COVID-19 Staffing Recommendations
- Added section: Specimen Collection Process
- Updated Attachment A: HCP Process for COVID-19 Exposure and ILI Symptoms (several changes)
- Added clarification language, “In an outpatient setting” to: Risk Factors and Testing Considerations