RESPIRATORY COMMUNICABLE ILLNESS CLINICAL MANAGEMENT

Federal Bureau of Prisons

Clinical Guidance

May 2024

WHAT'S NEW IN THIS DOCUMENT?

This guidance is an update to the December 2023 version. The following major changes were made in this guidance:

- **PULMONARY TUBERCULOSIS:** Information included related to pulmonary tuberculosis when it might be confusing to exclude this diagnosis from the other the respiratory illnesses included. For more information on clinical management of pulmonary tuberculosis, consult the Tuberculosis clinical guidance.
- **MASK REQUIREMENTS:** Specification when a N95 or a surgical mask are required. See *Table 1 Recommended Use of Personal Protective Equipment for Employees and Adult in Custody Workers.*
- **POINT-OF-CARE (POC) TESTING:** Clarification provided for actions to take based on point-of-care screening tests for symptomatic patients. *Section 4*
- **ISOLATION PROCEDURES:** Significant updates to *medical isolation section*, aligning with other program statements and guidelines for appropriate isolation procedures.
- **PATIENT MANAGEMENT SYMPTOM PRESENTATION:** Changed previous section on "release from medical isolation" to "*patient management by symptom presentation*", to further define processes based on symptom presentation and risks of progression or spread, and included a new *flowchart*.

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1. PURPOSE

This guidance provides information on the management of common communicable respiratory illnesses, including influenza, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2, referred to hereafter as COVID-19), and respiratory syncytial virus (RSV). This document focuses on these viruses since they cause the most common communicable respiratory illnesses, are testable, generally cause more severe illness, and have individual management considerations. Viruses that cause respiratory illness usually circulate more heavily in the community during fall and winter; however, COVID-19 may have an unpredictable seasonal pattern. Although some patients have mild symptoms when infected with influenza, COVID-19, or RSV, others require hospitalization. The specific strains circulating and local immunity to these strains will determine the severity of seasonal transmission of respiratory viruses. This document provides basic information to help reduce the transmission of respiratory illnesses in FBOP facilities and guide a care provider when presented with a patient with respiratory illness of unknown origin. The topic of pulmonary tuberculosis is outside the scope of this document, and references to pulmonary tuberculosis are only included when it might be confusing to exclude them. For more information on clinical management of pulmonary tuberculosis, consult the tuberculosis clinical guidance.

2. INFECTION PREVENTION AND CONTROL

HEALTH HABITS

Good **HEALTH HABITS** —including those listed below—should be promoted using multiple strategies (e.g., educational programs, TRULINCS, poster campaigns) to help reduce transmission of respiratory illnesses:

- Avoid close contact with persons who are sick.
- Avoid touching the eyes, nose, or mouth.
- Wash hands often (after contact with high-touch surfaces, before eating, after using the restroom, after removing gloves, etc.) with soap and water for at least 20 seconds. If soap and water are not readily available, then use a BOP-approved hand sanitizer that is at least 60% alcohol.
- Cover sneezes or coughs with a tissue, then throw the tissue in the trash and wash hands. If a tissue is not available, cough or sneeze into your sleeve or arm.

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

The more people that an individual with a respiratory illness interacts with and the longer those interactions last, the higher the risk of others becoming infected. The following controls should be adopted when planning congregate activities during periods of high respiratory virus transmission:

- Increase flow of fresh air through the meeting area by:
  - Increasing the percentage of outdoor air circulated by the HVAC system
  - Opening windows when possible
- Encourage people to bring their own pens, water bottles, and other personal items to avoid cross contamination.
- Clean and disinfect frequently touched surfaces between every gathering.
- Issue reminders to avoid physical contact, including handshakes, hugs, and fist bumps.

Environmental Cleaning and Disinfecting

ROUTINE CLEANING AND DISINFECTING

- Develop a local daily cleaning schedule incorporated into a facility-specific housekeeping plan to clean and disinfect, when indicated, all areas of the facility.
- Ensure there are adequate supplies to support cleaning and disinfecting of all high-traffic/high-touch areas at least daily, with increased disinfection during periods of high respiratory illness.
- Surfaces should be cleaned prior to disinfection to remove any visible dirt or debris.
- Clean and disinfect according to product label instructions**.**
- The Centers for Disease Control and Prevention (CDC) recommends using an EPA-registered, hospital-grade disinfectant from List N for disinfecting surfaces.

CLEANING AND DISINFECTING MEDICAL ISOLATION ROOMS

Spaces where quarantined or medically isolated patients have spent time must be cleaned and disinfected while in-use and after discharge.

- If possible, patients can assist with cleaning and disinfecting their living areas prior to discharge from medical isolation.
- Ensure that persons cleaning and disinfecting medical isolation areas are wearing the recommended personal protective equipment (PPE) for the virus (if known), using the correct disinfecting product, and verify that the space has been cleaned.

3. PERSONAL PROTECTIVE EQUIPMENT

Surgical Masks and NIOSH-Approved Respirators

- All patients suspected or known to have a communicable respiratory illness (e.g., influenza, COVID-19, RSV, pulmonary tuberculosis or other or unknown respiratory febrile illness) must wear a surgical mask during their medical isolation period when outside of a medical isolation area.
- All employees assigned to work in medical isolation areas with patients diagnosed with COVID-19 or pulmonary tuberculosis (TB) must wear a NIOSH-approved N-95 respirator. These individuals are required to be properly fit-tested according to Occupational Safety and Health Administration regulations regarding N-95 respirator wear.
    - Employees must wear the brand and size of N-95 respirator for which they were fit-tested.

TABLE 1. RECOMMENDED USE OF PERSONAL PROTECTIVE EQUIPMENT FOR EMPLOYEES AND ADULT IN CUSTODY WORKERS

INDIVIDUAL WEARING PPE	N-95 RESPIRATOR	SURGICAL MASK	EYE PROTECTION	GLOVES	GOWN/ COVERALLS
ADULT IN CUSTODY WORKERS					
Orderlies performing cleaning in **MEDICAL ISOLATION**	Additional PPE may be needed based on disinfectant Safety Data Sheet			X	X
Laundry and food service workers handling items from **MEDICAL ISOLATION**				X	X
EMPLOYEES					
Health care workers providing care, or other employees in direct contact with patients suspected or diagnosed with COVID-19 or TB in **MEDICAL ISOLATION**	X		X	X	X
Health care workers providing care, or other employees in direct contact with patients diagnosed with a communicable respiratory illness (other than COVID-19 and TB) in **MEDICAL ISOLATION**		X	X	X	X
Laundry and food service employees handling items from **MEDICAL ISOLATION**				X	X
Employees performing intake screenings during periods of high transmission of respiratory illness (due to risk of COVID-19)	X		X	X	

DONNING AND DOFFING PERSONAL PROTECTIVE EQUIPMENT

- Follow CDC recommendations for donning and doffing PPE. Important considerations and tips for proper wearing, removal, and disposal can be found here.
- Donning and doffing areas should include **POSTERS** (available here) demonstrating correct PPE donning and doffing procedures. These posters can also be printed as an easy reference for the correct donning and doffing sequence.

4. SCREENING AND TESTING

INDICATIONS FOR SCREENING

All arrivals to any FBOP facility will be screened at intake.

- Includes those returning from the hospital and court appearances (if greater than 72 hours).
- Documentation of any positive screening findings should be recorded in the BEMR intake note (or on a clinical encounter if an intake is not being performed), along with disposition to general population or medical isolation.

SCREENING PROCESS

- **SYMPTOM SCREENING:** During peak season or known local outbreaks, Adults in Custody should be asked if they are experiencing any symptoms suggestive of common communicable respiratory illness; these might include:
  - Cough, shortness of breath
  - Chills
  - Fatigue
  - Muscle or body aches, headache
  - Sore throat, congestion, or runny nose
  - Nausea, vomiting, or diarrhea
  - New loss of taste or smell
- **VITAL SIGNS (INCLUDING OXYGEN SATURATION):** obtained on intake and as needed for clinical indications of respiratory illness. Ensure complete documentation in BEMR.
- **TEMPERATURE CHECK:** Temperature checks should be performed:
  - On intake
  - When symptoms of a respiratory illness develop
  - Upon entry into medical isolation and daily (at a minimum) while in medical isolation
  - When screening cellmates of patients testing positive for certain respiratory illnesses

  The threshold for an elevated temperature varies depending on the type of thermometer used:

    - Oral: ≥ 100.4 ˚F
    - Ear: ≥ 101.0 ˚F
    - Forehead: ≥ 100.0 ˚F
- Patients who are symptomatic and have a fever need to wear a surgical mask and be promptly medically isolated and evaluated.

  Anyone who has trouble breathing, is unable to remove their mask without assistance or is unconscious or incapacitated should not wear a face mask.

INDICATIONS FOR TESTING

- **SYMPTOMATIC PATIENTS:** Patients with symptoms of a respiratory illness not suspected to be pulmonary TB should be tested for COVID- 19 and influenza. RSV point-of-care (POC) testing is generally not available in FBOP institutions. If RSV is suspected in a high-risk individual (i.e., adults age 60 years and older or who are pregnant or immunocompromised), send out testing is required.

  Co-existing viral respiratory infections are possible; therefore, POC testing for COVID-19 and influenza, and if appropriate RSV is advised.

  - If a test is **POSITIVE**, the patient should be placed in **MEDICAL ISOLATION** specific for their particular virus.
  - If testing is **NEGATIVE AND THE PATIENT HAS A FEVER**, they should be placed in a separate **MEDICAL ISOLATION.** Consider other causes and/or subspecialty consultation.
  - If testing is **NEGATIVE AND THE PATIENT DOES NOT HAVE A FEVER,** and with no clinical suspicion for pulmonary tuberculosis, they may enter/return to general population with instructions to contact Health Services if they continue to have symptoms or if they worsen. Patients should be issued a medical idle for 5 days through the medical duty status form with instructions to avoid any activities that would put them in contact with others (such as a work assignment, recreation, education classes) and given a surgical mask to wear when they must be in contact with others. Such actions serve to minimize infectious risk to others.
- **ASYMPTOMATIC CELLMATES OF A PERSON DIAGNOSED WITH COVID-19, RSV, OR INFLUENZA:** Consider medically assessing and testing individuals identified as **CELLMATES** of patients diagnosed with these communicable respiratory illnesses. (Note that in the absence of local POC RSV testing, symptom screening should guide patient management regarding the necessity of sending out RSV testing in high-risk individuals). If testing of asymptomatic cellmates is performed, they should be tested on day 1 after exposure and, if negative, on day 5 after exposure while staying in the general population.
- **TESTING IN HOUSING UNITS:** Routine broad-based testing is not encouraged or required due to the endemic nature of these respiratory viruses. Decisions for expanded testing should be made in consultation with the Regional Infection Prevention and Control Consultant and Regional Medical Director.

MANAGING PATIENTS WHO REFUSE TESTING

- **SYMPTOMATIC PATIENTS:** Symptomatic patients who refuse testing should be placed in **MEDICAL ISOLATION.**
- **ASYMPTOMATIC CELLMATES:** Asymptomatic cellmates who refuse testing should be counseled on the importance of testing. They do not require quarantine if they refuse testing. If cellmates become symptomatic, refer to instructions for *symptomatic patients*.

5. MEDICAL ISOLATION

Regardless of where medical isolation is effectuated, it should be distinct in name and practice from disciplinary housing. If medical isolation is implemented using cells in SHU, the conditions of confinement are governed under PS 5270.12 Special Housing Units and the patient will be placed in *administrative detention status* for the duration of their isolation period in SHU. If the medical isolation is implemented elsewhere in the institution (e.g., general population cells, airborne infection isolation rooms, medical observation cells, etc.), the administrative requirements for the observation of these cells are outlined in PS 5500.14 Correctional Services Procedures Manual, Section 310, Special Accountability, and the medical requirements are outlined in PS6031.05 Patient Care, Section 10, Medical Observation Units.

- *Psychology Services and the Captain should be consulted as required in PS 5270.12 Special Housing Units, prior to initiating single-cell medical isolation (regardless of whether the isolation will take place in the SHU or elsewhere in the facility). Procedures regarding written approval and the Single-Cell Review Form should be followed when applicable to ensure that appropriate measures are in place for the patient's safety while single cell status is necessary.*

  - **INDICATIONS FOR MEDICAL ISOLATION:** Plan for separate physical locations (dedicated housing areas and bathrooms) to medically isolate the following:
    - Those with a respiratory illness and a confirmatory positive test (either individually or as a cohort, according to the causative pathogen of their respiratory illness).
    - Those with a respiratory illness who have a fever and negative test result until their symptoms are improving and they are fever-free for 24 hours without fever-reducing medication. Generally, this period of medical isolation should last approximately 5 days from symptom onset. Following completion of medical isolation, patients should be issued a medical idle for 5 additional days through the medical duty status form with instructions to avoid any activities that would put them in contact with others (such as a work assignment, recreation, education classes) and given a surgical mask to wear when they must be in contact with others.
  - **SIGNAGE:** Medical isolation rooms/areas should be clearly delineated.
  - **MOVEMENT:** To the extent possible, medically isolated patients should not be transferred, have visitors, or mix with other medically isolated groups or with the general population.

LAUNDRY

- Adults in custody who are laundry workers should wear gloves and gowns/coveralls when handling laundry from patients in respiratory illness medical isolation.
- Laundry from patients in respiratory illness medical isolation can be washed with other individuals' laundry.
- To minimize the potential of dispersing virus particles through the air, dirty laundry should not be shaken.
- Dirty clothes bins should be cleaned and disinfected after use.

Food Service

- Adults in custody who are food service workers should wear gloves and gowns/coveralls when handling items from patients in respiratory illness medical isolation.
- Meals should be provided to medically isolated patients in their respective units.
- Disposable food service items can be disposed of in regular trash.
- Non-disposable food service items should be handled with gloves and washed as normal.

Recreation

Generally, patients in medical isolation will need to engage in recreational activities within their cell. The facility should provide means for individuals to occupy their time, such as by supplying reading and educational materials, so long as these materials are disposable or can be disinfected. In the case of multiple patients in medical isolation for an illness with the same causative pathogen, recreational activities may be performed as a group. The recreation area should be cleaned and disinfected before and after use.

Housing and Other Considerations

Ideally, medical isolation rooms should be well-ventilated with a solid door and an attached bathroom. If no shower is present, then patients may be escorted (while wearing surgical masks) to showers when not in use by the general population. Patients with a viral illness with the same causative pathogen may share living quarters, and single-cell placement should be a last resort. Psychology Services should be consulted prior to all single-cell placements.

- **Aerosol-generating procedures:** If a patient who is in medical isolation must undergo a procedure that is likely to generate aerosols (e.g., suctioning, administering nebulized medications, testing), they should be placed in a separate room. Appropriate PPE is to be used as previously defined in this document.
- **Medical equipment:** If possible, use disposable or dedicated medical equipment (e.g., blood pressure cuffs) in medical isolation areas. If not available, equipment should be decontaminated after use in accordance with manufacturer's instructions.

Monitoring and Documentation

- Assess patients in medical isolation **at least daily** for fever and symptoms of illness and decompensation.

  ➔ *Symptomatic patients who are older or have co-existing medical conditions are at high risk for poor outcomes and may require more frequent assessments.*

- Assessments, along with date of entry in and exit from medical isolation, should be **documented** in the medical record.
- A physician or advanced practice provider will be notified of any of the following: blood oxygen level < 94%, pulse > 100 beats per minute, temperature > 100.4^{o} F, respiratory rate > 22 breaths per minute.

- A low threshold should be used for deciding to transport a patient to an **OUTSIDE HOSPITAL** if any of the following **EMERGENCY WARNING SIGNS** are noted:
  - Trouble breathing
  - Acute onset of hypoxia/oxygen desaturation (blood oxygen level < 90%)
  - Persistent chest pain or pressure
  - New confusion
  - Inability to wake or stay awake
  - Bluish lips or face

PATIENT MANAGEMENT BY SYMPTOM PRESENTATION

The FBOP uses the following **MANAGEMENT STRATEGIES** for COVID-19, influenza, and RSV:

Information may also be viewed below: *Patient Management by Symptom Presentation Flowchart*

- **ASYMPTOMATIC PATIENTS WHO TEST POSITIVE AND NEVER DEVELOP SYMPTOMS** (e.g., cellmates of symptomatic patients) do not need to be medically isolated. They should be issued a medical idle for **5 days** through the medical duty status form with instructions to avoid any activities that would put them in close contact with others (such as a work assignment, recreation, education classes) and given a surgical mask to wear when they must be in contact with others.
- **PATIENTS WHO TEST POSITIVE AND HAVE MILD OR MODERATE SYMPTOMS (WITH OR WITHOUT A FEVER)** can be released from medical isolation once their symptoms are improving and if a fever was present, they have been fever-free for 24 hours without use of fever reducing medication. Generally, this occurs approximately **5 days** after symptom onset.
  - If a patient will release to housing in close contact with others (e.g., large open dormitory), consideration should be given to extend the medical isolation period for an additional 5 days.
  - If a patient will release to housing where they are able to limit their contact with others (e.g., cells or small pods), they should be released with a medical idle for **5 days** through the medical duty status form with instructions to avoid any activities that would put them in contact with others (such as a work assignment, recreation, education classes) and given a surgical mask to wear when they must be in contact with others.
- **PATIENTS WHO TEST POSITIVE AND HAVE SEVERE SYMPTOMS (WITH OR WITHOUT FEVER), ARE SEVERELY IMMUNOCOMPROMISED, OR REQUIRE HOSPITALIZATION** can be released from medical isolation once their symptoms are improving and if a fever was present, they have been fever-free for 24 hours without use of fever reducing medication. Generally, this occurs approximately 10 days after symptom onset but may take longer.
  - If a patient will release to housing in close contact with others (e.g., large open dormitory), consult with the medical provider to determine whether to extend the medical isolation period for an additional 5 days.
  - If a patient will release to housing where they are able to limit their contact with others (e.g., cells or small pods), they should be released with a medical idle for **5 days** through the medical duty status form with instructions to avoid any activities that would put them in contact with others (such as a work assignment, recreation, education classes) and given a surgical mask to wear when they must be in contact with others.

- **PATIENTS WHO TEST NEGATIVE AND HAVE SYMPTOMS INCLUDING A FEVER** can be released from medical isolation once their symptoms are improving and they have been fever-free for 24 hours without use of fever reducing medication. Generally, this occurs approximately **5 days** after symptom onset. Consideration should be given to determining the causative pathogen.
  - If a patient will release to housing in close contact with others (e.g., large open dormitory), consideration should be given to extend the medical isolation period for an additional 5 days.
  - If a patient will release to housing where they are able to limit their contact with others (e.g., cells or small pods), they should be released with a medical idle through the medical duty status form for **5 days** with instructions to avoid any activities that would put them in contact with others (such as a work assignment, recreation, education classes) and given a surgical mask to wear when they must be in contact with others.
- **PATIENTS WHO TEST NEGATIVE AND HAVE SYMPTOMS BUT NO FEVER** can enter/return to general population with instructions to contact Health Services if they continue to have symptoms or if they worsen. Patients should be issued a medical idle for 5 days through the medical duty status form with instructions to avoid any activities that would put them in contact with others (such as a work assignment, recreation, education classes) and given a surgical mask to wear when they must be in contact with others. Such actions serve to minimize infectious risk to others.

DOCUMENTING RELEASE FROM MEDICAL ISOLATION

Release from **MEDICAL ISOLATION** should be documented in the medical record, and the Health Problem code should be updated to "**RESOLVED**".

6. TREATMENT

Several medications have FDA approval or Emergency Use Authorization for treatment of respiratory illnesses. It is recommended that providers consult with their Regional Medical Director and monitor updates from the CDC for current treatment guidelines.

➔ *Co-infection with respiratory viruses is possible and should be managed accordingly for each virus. Follow* ***MEDICAL ISOLATION CONSIDERATIONS*** *in this instance.*

7. VACCINATION

Vaccination is the safest way to build immunity to a virus, and the CDC recommends that all individuals stay up-to-date. For adults, this includes COVID-19 and influenza vaccinations. Adults 60 years of age and older or who are pregnant or immunocompromised may benefit from RSV vaccination and should have a discussion with their health care provider. The following recommendations are provided to help guide vaccination provision:

- Facilities are required to organize vaccination clinics for influenza and COVID-19 and ensure all patients have access to these vaccines.
- Patients can request any age- and medical condition-specific vaccination at any time.
- The CDC Advisory Committee on Immunization Practices provides vaccination recommendations here.
- Information is also available in the FBOP documents *Immunization Guidance*.

8. SURVEILLANCE

The purpose of respiratory illness surveillance is to monitor the current state of disease at a facility and its surrounding communities. It involves assessing epidemiological (disease-related) factors for appropriate management. Surveillance is essential to reducing respiratory illness transmission. It should ideally involve a combination of facility and community monitoring.

LOCAL FACILITY AND COMMUNITY MONITORING

- Monitoring the BOP Respiratory Surveillance Dashboard can help raise timely awareness of respiratory illness activity at the earliest stages in a facility.
- Monitoring respiratory illness outbreaks, hospitalizations, and deaths in communities where employees are known to live, visit, and commute can alert facilities to increases in transmission of communicable respiratory illnesses and aid in their prevention and management.
- The COVID-19 Procedures Data tab on the Exec Report Dashboard provides BOP facility isolation rates and community hospital admission rates for COVID-19, which can help identify periods of highest risk for COVID-19 transmission and associated morbidity/mortality.

SURVEILLANCE ACTIONS

Ongoing awareness of local facility and community cases should prompt facilities to activate processes to mitigate the spread of communicable respiratory illness—for instance, intensifying cleaning and disinfecting routines and implementing screening and vaccination clinics.

9. CUSTODY MOVEMENT

- Patients currently in or meeting criteria for **MEDICAL ISOLATION** should **NOT** be transferred or released from FBOP custody unless necessary (e.g., immediate release, completion of a sentence) and only with coordination of appropriate medical precautions and follow-up care.
- All patients may request a surgical mask for use during transport to their destination.
- Patients who present with symptoms of a respiratory illness should be tested for influenza and COVID-19 at any time, including at intake, prior to transfer, and at release. RSV POC testing is not available at this time and send out testing may be considered if there is a high suspicion of RSV in a high-risk patient.
  - If test results are negative but the patient is febrile (based on temperature check guidance), the patient should be placed in **MEDICAL ISOLATION** and released according to *Section 5. Patient Management by Symptom Presentation*.
  - If patients do not test positive for COVID-19 or influenza and are afebrile, they may join the general population or proceed with transfer. If joining the general population, patients should be issued a medical idle for 5 days through the medical duty status form with instructions to avoid any activities that would put them in contact with others (such as a work assignment, recreation, education classes, etc.) and given a surgical mask to wear when they must be in contact with others.
- **Asymptomatic routine testing at intake, transfer, and release is no longer recommended due to the seasonality and endemicity of respiratory illnesses.**
- If **MEDICAL ISOLATION** conditions are clinically indicated during transportation, the receiving institution should be notified, and travel arrangements coordinated accordingly.

IN-PERSON COURT APPEARANCES

Patients in **MEDICAL ISOLATION** should not attend court appearances in person unless absolutely necessary. Virtual appearances utilizing telephone or video teleconference equipment should be strongly considered.

DOCUMENTATION DURING MOVEMENT

For Adults in Custody with a history of respiratory illness who have recovered and are ready to transfer, ensure the health problem code denoting the respiratory illness has been marked as "resolved" prior to transfer.

10. REFERENCES

Centers for Disease Control and Prevention (2023). Guidance on management of COVID-19 in homeless service sites and in correctional and detention facilities. *https://archive.cdc.gov/www_cdc_gov/coronavirus/2019-ncov/community/homeless-correctional-settings.html*

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Centers for Disease Control and Prevention (2023). Respiratory viruses: Updated COVID-19 vaccine recommendations are now available. *https://www.cdc.gov/respiratory-viruses/whats- new/covid-vaccine-recommendations-9-12-2023.html#:~:text=On%20September%2012%2C%202023%2C%20CDC,%2C%20hospitalization%2C%20and%20even%20death.*

PATIENT MANAGEMENT BY SYMPTOM PRESENTATION FLOWCHART