PARTNERS INFECTION CONTROL GUIDANCE FOR
PATIENTS WITH SUSPECTED VIRAL RESPIRATORY ILLNESS INCLUDING
SUSPECT OR CONFIRMED COVID-19 IN EMERGENCY DEPARTMENT,
INPATIENT, AMBULATORY, AND PERI-PROCEDURAL LOCATIONS

This document supersedes all prior guidance.

Summary of March 24, 2020 changes:
- Updated list of signs or symptoms to add anosmia

Background:
The following guidance on implementation of identification and isolation of patients presenting with suspected viral respiratory illness. This guidance will be updated as appropriate.

Definition of Viral Respiratory Illness:
Viral respiratory illness includes all patients with any of the following signs or symptoms possibly consistent with a viral respiratory syndrome:
1. Fever, subjective or documented
2. New sore throat
3. New cough
4. New runny nose or nasal congestion
5. New muscle aches
6. New shortness of breath
7. New anosmia

Locations of Care:

I. Emergency Department

1. Protection of Triage Personnel.
   Any of the following 3 options should provide adequate protection:
   a. Erect a transparent barrier between patients and triage personnel, or
   b. Place physical barriers (e.g., table) to keep patients at least 6 feet apart from triage desk personnel, or
   c. Instruct triage personnel to wear a surgical mask and eye protection. When the following guidance are invoked, mask and eye protection may be worn for duration of shift in accordance with the Partners Infection Control Guidance on Extended Use and Reuse of N95 Respirators, Surgical Masks, Procedural Masks, and Eye Protection.

2. Identification of Patients with Suspected Viral Respiratory Illness.

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Partners Infection Control Guidance for Patients with Suspected Viral Respiratory Illness, Including Suspect or Confirmed COVID-19 in Emergency Department, Inpatient, Ambulatory, and Peri-Procedural Locations

Approved on: March 25, 2020
Effective on: March 25, 2020
Version 5.0

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a. Screen at triage for
   i. Fever, subjective or documented, or new sore throat or new cough or new runny nose or nasal congestion or new muscle aches or new shortness of breath or anosmia.
   ii. Contact with person with confirmed COVID-19 within the preceding 14 days.

b. All patients tested for influenza should be classified as having a suspected respiratory viral syndrome.

3. Immediate steps for patients identified with suspected Viral Respiratory Illness.
   a. Ask patient to don a surgical mask and place in room immediately.
   b. If not possible to room immediately, seat patients at least 6 feet apart, with physical barriers between patients if possible.

4. Isolation and Patient Placement.
   a. For all patients (default):
      i. Contact + Droplet (including Eye protection), private room, keep door closed. Negative pressure room and N95 respirator not required.

   b. For patients in whom an aerosol-generating procedure is needed or anticipated (e.g., severe illness or escalating oxygen requirements):
      i. Strict Isolation (Airborne + Contact + Eye protection) is required. This includes an N95 respirator or PAPR in addition to gown, gloves, and eye protection, and placement in an Airborne Infection Isolation Room (AIIR, "negative pressure room.")
      ii. Aerosol-generating procedures are defined by the Partners Infection Control List of Aerosol Generating Procedures (see policy in Policy Central under Covid-19 Domain)

   c. In the setting of limited availability of AIIR, discuss decision making with Infection Control/Biothreats:
      i. Priority will be the following order:
         1) Confirmed COVID-19 patients
         2) Suspect COVID-19 patients (test pending)
         3) Patients with need for AIIR (Confirmed tuberculosis, measles, disseminated zoster)
         4) All other patients, including those with diagnosed respiratory viruses (i.e., influenza, RSV)
      ii. If an AAIR is not available and the consensus is to proceed, procedures must be performed in room with the door closed. Providers must wear gown, gloves, N95 or PAPR, and eye protection.
      iii. Wipe down all high touch surfaces immediately after the procedure.
iv. Door to remain closed during and for one hour following completion of the procedure if non AAIR; if AAIR duration of closure depends on number of air exchanges per hour.

d. Limitations on use of Nebulizers
   i. Nebulization is an aerosolizing procedure and is strongly discouraged.
   ii. Consider inhalers or spacers instead of nebulizers
   iii. If nebulizer treatment is needed, preferentially perform in an Airborne Infection Isolation Room (AIIR, “negative pressure”). AIIR is required for COVID positive patients.
      ▪ If an AAIR is not available and the patient does not have proven COVID, discuss with Infection Control/Biothreats. If consensus is to proceed perform in room with the door closed. Providers must wear gown, gloves, N95 or PAPR, and eye protection.
        iv. Wipe down all high touch surfaces immediately after the procedure.
        v. Door to remain closed during and for one hour following completion of the procedure if non AAIR; if AAIR duration of closure depends on number of air exchanges per hour.

5. Testing for COVID-19
   a. Approved indications for testing for COVID-19 are being updated continually and will be posted on Partners Pulse.
   b. COVID-19 Testing Approval:
      i. Contact Biothreats / Infection Control to confirm that testing is indicated
   c. Specimen collection:
      i. NP/OP swabbing is not considered an aerosol-generating procedure; negative pressure room not required
      ii. Minimize staff in the room; single provider preferred.
      iii. Ensure door closed.
      iv. Ensure all provider(s) in the room are wearing N95 or PAPR, in addition to gown, gloves, and eye protection.
      v. If provider(s) not initially wearing N95 or PAPR, exit room, remove contaminated PPE; and put on fresh gown, gloves, N95 or PAPR, and eye protection to perform NP/OP swab.

6. CoV-Risk Infection Status
   a. Applied to patient record when patient is undergoing testing for COVID-19.

7. COVID-19 Infection Status

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8. Notification of Infection Control/Biothreats
   a. For patients with suspected COVID-19 or confirmed COVID-19, alert local contacts for Biothreats/Infection Control if not done so already.

9. Individuals who are not providing direct patient care or entering the rooms of patients with suspected respiratory viral infections need only wear a mask as per Partners universal mask policy.

II. Inpatient

1. Identification of Patients with Suspected Viral Respiratory Illness
   a. Screen daily for fever, or new sore throat or new cough or new runny nose or nasal congestion or new muscle aches or new shortness of breath or new anosmia.
   b. Any patient tested for influenza should be classified as having a suspected respiratory viral syndrome.

2. Immediate steps for patients identified with Suspected Viral Respiratory Illness
   a. Patient to put on surgical mask if not in private room. Close door.
   b. Initiate isolation (see item 3 below)
   c. If COVID-19 suspected, notify Infection Control/Biothreats
      i. Guidance regarding COVID-19 timing of testing will be provided.

3. Isolation and Patient Placement
   a. For all patients (default):
      i. Contact + Droplet (including Eye protection), private room, keep door closed. Negative pressure room and N95 respirator not required.
   b. For patients in whom an aerosol-generating procedure is needed or anticipated (e.g., severe illness or escalating oxygen requirements):
      i. Strict Isolation (Airborne + Contact + Eye protection) is required. This includes an N95 respirator or PAPR in addition to gown, gloves, and eye protection, and placement in an Airborne Infection Isolation Room (AIIR, “negative pressure room”)
      ii. Aerosol-generating procedures are defined by the Partners Infection Control List of Aerosol Generating Procedures (see Procedures in Policy Central under Covid-19 Domain)
   c. In the setting of limited availability of AIIR, discuss decision making with Infection Control/Biothreats:
      i. Priority will be the following order:
         1) Confirmed COVID-19 patients

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2) Suspect COVID-19 patients (test pending)
3) Patients with need for AIIR (Confirmed tuberculosis, measles, disseminated zoster)
4) All other patients, including those with diagnosed respiratory viruses (i.e., influenza, RSV)
   ii. If an AAIR is not available and the consensus is to proceed, procedures must be performed in room with the door closed. Providers must wear gown, gloves, N95 or PAPR, and eye protection.
   iii. Wipe down all high touch surfaces immediately after the procedure.
   iv. Door to remain closed during and for one hour following completion of the procedure if non AAIR; if AAIR duration of closure depends on number of air exchanges per hour.

d. Limitations on use of Nebulizers
   i. Nebulization is an aerosolizing procedure and is strongly discouraged.
   ii. Consider inhalers or spacers instead of nebulizers.
   iii. If nebulizer treatment is needed, preferentially perform in an Airborne Infection Isolation Room (AIIR, “negative pressure”). AIIR is required for COVID positive patients.
      ▪ If an AAIR is not available and the patient does not have proven COVID, discuss with Infection Control/Biothreats. If consensus is to proceed perform in room with the door closed. Providers must wear gown, gloves, N95 or PAPR, and eye protection.
   iv. Wipe down all high touch surfaces immediately after the procedure.
   v. Door to remain closed during and for one hour following completion of the procedure if non AAIR; if AAIR duration of closure depends on number of air exchanges per hour.

e. Cohorting Suspect and Confirmed COVID-19 patients:
   i. Suspect COVID-19 patients: not permitted.
   ii. Confirmed COVID-19 patients: permissible so long as there are no other infection status mismatches (e.g. MRSA, C. difficile, etc.)

4. Testing for COVID-19
   a. Approved indications for testing for COVID-19 are being updated continually and will be posted on Partners Pulse.
   b. COVID-19 Testing Approval:
      i. Contact Biothreats / Infection Control to confirm that testing is indicated
   c. Specimen collection:
      i. NP/OP swabbing is not considered an aerosol-generating procedure; negative pressure room not required
      ii. Minimize staff in the room; single provider preferred.

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iii. Ensure door closed.
iv. Ensure all provider(s) in the room are wearing N95 or PAPR, in addition to gown, gloves, and eye protection.
v. If provider(s) not initially wearing N95 or PAPR, exit room, remove contaminated PPE; and put on fresh gown, gloves, N95 or PAPR, and eye protection to perform NP/OP swab.

5. Notification of Infection Control/Biothreats
   a. For patients with suspected COVID-19 or confirmed COVID-19, alert local contacts for Biothreats/Infection Control if not done so already.

6. CoV-Risk Infection Status
   a. Applied to patient record when patient is undergoing testing for COVID-19.
   b. This Infection Status will remain in place for 14 days from when applied, unless resolved manually by Infection Control staff. Please note that this Infection Status may appear at the same time as COVID-19 in the interim between when a test results positive for COVID-19 and when CoV-Risk Infection Status is resolved.

7. COVID-19 Infection Status

8. Discontinuation of CoV-Risk Infection Status
   a. Discontinuation of the CoV-Risk Infection Status requires approval from local Infection Control/Biothreats leadership.
   b. In the setting of high clinical suspicion for COVID-19 despite negative test result(s), CoV-Risk will be maintained through hospitalization.
   c. If clinical suspicion for COVID19 is low then the CoV-Risk Infection Status can be discontinued after a single negative COVID-19 test if an alternative, non-infectious diagnosis has been established (e.g., pulmonary embolism, bacterial pneumonia without concern for viral prodrome or superinfection)
   d. Otherwise, CoV-Risk Infection Status can be discontinued in the following circumstances
      i. Two negative nasopharyngeal swabs taken >24 hours apart (sensitivity of single negative NP = 70%), or
      ii. One negative nasopharyngeal swab and one negative lower respiratory sample (endotracheal aspirate or bronchoalveolar lavage). These may be drawn within a 24-hour period. Note that an expectorated sputum sample does NOT count.

9. Discontinuing Contact + Droplet Isolation, for patients previously CoV-Risk
   a. Discontinuation of the Contact + Droplet Isolation requires approval from local Infection Control/Biothreats leadership.
b. The following are required:
   i. Patient has met criteria above for discontinuation of CoV-Risk
   ii. All respiratory viral illness tests ordered are negative (flu/rsv, other viral respiratory tests).
   iii. Team no longer suspects a respiratory viral illness because an alternative, non-infectious diagnosis is established (e.g., pulmonary embolism, bacterial pneumonia without concern for viral prodrome or superinfection)

10. Discontinuing Contact + Droplet Isolation, for patients never considered for CoV-Risk
   a. Discontinuation of the Contact + Droplet Isolation requires approval from local Infection Control/Biothreats leadership.
   b. The following are required:
      i. All respiratory virus tests ordered are negative (influenza & RSV as well as any additional respiratory viruses ordered) and one or more of the following criteria are met:
         1) CT chest without parenchymal infiltrates (sensitivity of infiltrates on chest radiograph = 59%, CT chest = 86%) or
         2) Procalcitonin >0.5ng/ml (sensitivity of PCT ≤0.5 = 94%) or
         3) Team no longer suspects a respiratory viral illness because an alternative, non-infectious diagnosis is established (e.g., pulmonary embolism, bacterial pneumonia without concern for viral superinfection)

11. Discontinuation of Strict Isolation requires approval from local Infection Control/Biothreats leadership.

12. Individuals who are not providing direct patient care or entering the rooms of patients with suspected respiratory viral infections need only wear a mask as per Partners universal mask policy.

III. Ambulatory (including Urgent Care)

1. Identification of Patients with Suspected Viral Respiratory Illness
   a. Screen patients telephonically for fever, subjective or documented, or new sore throat or new cough or new runny nose or nasal congestion or new muscle aches or new shortness of breath or new anosmia before arrival, and 2) contact with person with confirmed COVID-19 within the preceding 14 days.
      i. If screen positive, defer in-person visits and manage remotely if clinically appropriate
   b. If symptomatic and in-person evaluation required for person with respiratory symptoms, ask patient to put on a mask upon arrival to facility.

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c. Patients with suspected or confirmed COVID-19 should be evaluated per facility in dedicated evaluation areas.

2. Protecting front desk personnel. Any of the following 3 options should provide adequate protection:
   a. Erect a transparent barrier between patients and front desk personnel, or
   b. Place physical barriers (e.g., table) to keep patients at least 6 feet apart from front desk personnel, or
   c. Develop a workflow wherein patients will spend no more than 2 minutes face-to-face with front desk personnel.

3. Immediate steps for patients identified with symptoms consistent with a Viral Respiratory Illness.
   a. Have the patient don a mask immediately if not already wearing one
   b. Ensure that patient remains masked while in the clinic.
   c. Limit the number of clinic staff in contact with patient
   d. Room immediately and keep the door closed. If not possible to room immediately, seat patients at least 6 feet apart, with physical barriers between patients if possible.

4. Provider Personal Protective Equipment.
   a. For patients identified with viral respiratory illness, implement Contact + Droplet Isolation (including eye protection). This includes gown, gloves, a surgical mask, and eye protection.
   b. Patient must keep mask on throughout the encounter as much as feasible
   c. Negative pressure not required.

5. Limitations on use of Nebulizers
   a. Nebulization is an aerosolizing procedure and is strongly discouraged.
   b. Consider inhalers or spacers instead of nebulizers
   c. If nebulizer treatment is needed, preferentially perform in an Airborne Infection Isolation Room (AIIR, “negative pressure”). AIIR is required for COVID positive patients.
      i. If an AAIR is not available and the patient does not have proven COVID, discuss with Infection Control/Biothreats. If consensus is to proceed perform in room with the door closed. Providers must wear gown, gloves, N95 or PAPR, and eye protection.
   d. Wipe down all high touch surfaces immediately after the procedure.
   e. Door to remain closed during and for one hour following completion of the procedure if non AAIR; if AAIR duration of closure depends on number of air exchanges per hour.

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6. Limitations on influenza testing and throat swabs in the ambulatory setting.
   a. It is not possible to differentiate between influenza and COVID19 on the basis of symptoms alone. We therefore recommend treating all patients with respiratory viral syndromes as if they might have COVID19.
   b. Obtaining NP or OP swabs in this context requires a higher level of PPE (fit-tested N95 mask or PAPR, eye protection, gloves, and gown; negative pressure not required) as well as rigorous training on the safe removal of PPE.
   c. We therefore recommend against obtaining NP and OP swabs in the outpatient setting unless a formal system is in place for safe testing (appropriate PPE, training, and monitoring as above).
   d. Empiric treatment recommendations
      i. We recommend treating influenza empirically in vulnerable patients or referring patients for combined influenza/COVID19 testing to centralized testing facilities.
      ii. We recommend treating group A strep empirically in patients who meet the Centor Criteria.

7. CoV-Risk Infection Status
   a. Applied to patient record when patient is undergoing testing for COVID-19.
   b. This Infection Status will remain in place for 14 days from when applied, unless resolved manually by Infection Control staff. Please note that this Infection Status may appear at the same time as COVID-19 in the interim between when a test results positive for COVID-19 and when CoV-Risk Infection Status is resolved.

8. COVID-19 Infection Status

9. Individuals who are not providing direct patient care or entering the rooms of patients with suspected respiratory viral infections need only wear a mask as per Partners’ universal mask policy.

IV. Peri-Procedural Areas

1. Identification of Patients with Suspected Viral Respiratory Illness
   a. Screen patients telephonically before appointment for 1) fever, subjective or documented, or new sore throat or new cough or new runny nose or nasal congestion or new muscle aches or new shortness of breath or new anosmia and 2) contact with a person with confirmed COVID-19 within the preceding 14 days.
      i. Defer all non-urgent procedures for at least 14 days
   b. If symptomatic and procedure cannot be deferred ask patient to put on a mask upon arrival to facility.

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c. Patients with suspected or confirmed COVID-19 should be evaluated per facility in dedicated evaluation areas.

2. Protecting front desk personnel. Any of the following 3 options should provide adequate protection:
   a. Erect a transparent barrier between patients and front desk personnel, or
   b. Place physical barriers (e.g., table) to keep patients at least 6 feet apart from front desk personnel, or
   c. Develop a workflow wherein patients will spend no more than 2 minutes face-to-face with front desk personnel.

3. Immediate steps for patients identified with symptoms consistent with a Viral Respiratory Illness.
   a. Have the patient don a mask immediately if not already wearing one.
   b. Ensure that patient remains masked while in the practice.
   c. Limit the number of clinic staff in contact with patient.
   d. Room immediately and keep the door closed. If not possible to room immediately, place patients at least 6 feet apart, with physical barriers between patients if possible.

4. Periprocedural respiratory protection
   a. Please see Partners Infection Control Guidance on Peri-Procedural Respiratory Protection during Aerosol Generating Procedures. (see Procedures in Policy Central under Covid-19 Domain)

5. Isolation and Patient Placement
   a. For patients in whom an aerosol-generating procedure is needed:
      i. Strict Isolation (Airborne + Contact + Eye protection). This includes an N95 respirator or PAPR in addition to gown, gloves, and eye protection, and placement in an Airborne Infection Isolation Room (AIIR, “negative pressure room.”)
      ii. Aerosol-generating procedures are defined by the Partners Infection Control List of Aerosol Generating Procedures (see Procedures in Policy Central in Covid-19 Domain)
   b. In the setting of limited availability of AIIR, discuss decision making with Infection Control/Biothreats:
      i. Priority will be the following order:
         1) Confirmed COVID-19 patients
         2) Suspect COVID-19 patients (test pending)
         3) Patients with need for AIIR (Confirmed tuberculosis, measles, disseminated zoster)
4) All other patients, including those with diagnosed respiratory viruses (i.e., influenza, RSV)
   iii. If an AAIR is not available and the consensus is to proceed, procedures must be performed in room with the door closed. Providers must wear, N95 or PAPR, gown, gloves, and eye protection.
   iv. Wipe down all high touch surfaces immediately after the procedure.
   v. Door to remain closed during and for one hour following completion of the procedure if non AAIR; if AAIR duration of closure depends on number of air exchanges per hour.

c. Limitations on use of Nebulizers
   i. Nebulization is an aerosolizing procedure and is strongly discouraged.
   ii. Consider inhalers or spacers instead of nebulizers.

d. If aerosolizing procedure is not required
   i. Contact + Droplet (including Eye protection). Negative pressure room and N95 respirator not required.

6. CoV-Risk Infection Status
   a. Applied to patient record when patient is undergoing testing for COVID-19.
   b. This Infection Status will remain in place for 14 days from when applied, unless resolved manually by Infection Control staff. Please note that this Infection Status may appear at the same time as COVID-19 in the interim between when a test results positive for COVID-19 and when CoV-Risk Infection Status is resolved.

7. COVID-19 Infection Status

8. Notification of Infection Control/Biothreats
   a. For patients with suspected COVID-19 or confirmed COVID-19, alert local contacts for Biothreats/Infection Control if not done so already.

9. Individuals who are not providing direct patient care or entering the rooms of patients with suspected respiratory viral infections do not need to wear any personal protective equipment other than a mask as per Partners’ universal mask policy.