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MASSACHUSETTS GENERAL HOSPITAL

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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

This document supersedes all prior guidance.

Summary of April 10, 2020 changes:

- Addition of new "Enhanced Respiratory Isolation" category of isolation
- Updated criteria for use of N95 or PAPR for patients with Viral Respiratory Illness as part of Enhanced Respiratory Isolation
- Updated prioritization of Airborne Infection Isolation Rooms (AIIRs) for aerosol-generating procedures (AGPs)

Background:

The following provides 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

Enhanced Respiratory Isolation

Enhanced Respiratory Isolation is a new isolation category used for patients with viral respiratory illness and is defined as follows:

1. Patient placement
    a. Private room with the door closed; cohorting of confirmed COVID-19 patients is permitted so long as there are no other infection status mismatches (e.g. MRSA, C. difficile, etc.).
    b. Placement in an Airborne Infection Isolation Room (AIIR) is preferred if aerosol-generating procedures (AGPs) are anticipated; AIIRs should be prioritized when there is a shortage of AIIR rooms and there is a need for AGPs. Prioritization of AIIRs in these situations is based on patient risk of COVID 19 infection:

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1st priority: COVID-19
2nd priority: CoV-Risk
3rd priority: CoV-Exposed
4th priority: Other viral respiratory illness

2. Personal Protective Equipment (PPE): gowns, gloves, eye protection, and N95 respirator or powered air-purifying respirator (PAPR)
3. Some institutions may continue to use the Strict Isolation category to designate use of AIIR.

Locations of Care:

I. Emergency Department

1. All patients will be provided with a surgical or procedural mask upon arrival to the facility and instructed to wear the mask throughout their visit.

2. Protection of Triage and registration personnel
   The following two options are recommended:
   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
   If neither of the above are possible, instruct triage personnel to wear a surgical mask and eye protection.

3. Identification of Patients with Suspected Viral Respiratory Illness.
   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.

4. Immediate steps for patients identified with suspected Viral Respiratory Illness.
   a. Ensure that patient is wearing the surgical or procedural mask provided at entry to the facility 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.

5. Personal Protective Equipment
    a. N95 respirator or PAPR will be used by:
        i. HCWs who provide direct patient care in an enclosed space within 6 feet of the patient for ≥ 10 minutes (e.g., patient room, exam room, procedure room, etc.)
        ii. HCWs who do not provide direct patient care but work in an enclosed space (e.g., patient room, exam room, procedure room, etc.) within 6 feet of the patient for ≥ 10 minutes or who must enter the enclosed space after an aerosol-generating procedure during the airing period.
        iii. HCWs who do not provide direct patient care but may regularly be in an enclosed space (e.g., patient room, exam room, procedure room, etc.) within 6 feet of a patient for cumulatively ≥ 10 minutes (e.g., transport in elevators or HCWs visiting multiple patients for short periods of time)
    b. Gowns, gloves, and eye protection will be used by HCWs who have direct contact with the patient or patient's environment.
    c. Gowns, gloves, and N95 respirator or PAPR are not required for HCWs passing by or being in brief proximity (within 6 feet for < 10 minutes) of a patient. A surgical or procedural mask should be worn by all HCWs per Partners' universal mask plan.

6. Isolation and Patient Placement.
    a. Enhanced Respiratory Isolation
        i. Private room with the door closed; cohorting of confirmed COVID-19 patients is permitted so long as there are no other infection status mismatches (e.g. MRSA, C. difficile, etc.).
        ii. Placement in an Airborne Infection Isolation Room (AIIR) is preferred if aerosol-generating procedures (AGPs) are anticipated; AIIRs should be prioritized when there is a shortage of AIIR rooms and there is a need for AGPs. Prioritization of AIIRs in these situations is based on patient risk of COVID 19 infection:
            1st priority: COVID-19
            2nd priority: CoV-Risk
            3rd priority: CoV-Exposed
            4th priority: Other viral respiratory illness
        iii. If an AIIR is not available and the consensus is to proceed, procedures must be performed in room with the door closed.
            1) Wipe down all high touch surfaces immediately after the procedure.
            2) Door to remain closed during and for one hour following completion of the procedure if non-AIIR (standard room); if AIIR duration of closure depends on number of air exchanges per hour for the specific room.
    b. Strict Isolation may be used to designate use of AIIR.

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7. Limitations on use of Nebulizers
    a. Nebulization is an aerosolizing procedure and is strongly discourages.
    b. Consider inhalers or spacers instead of nebulizers.

8. Testing for COVID-19
    a. Approved indications for testing for COVID-19 are updated frequently and are posted on Partners Pulse.
    b. COVID-19 Testing Approval:
        i. Please see your facility-specific instructions regarding approval requirements for testing.
    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.

9. Infection Statuses associated with SARS-CoV-2.
    a. Please see Partners Guidance on Infection Statuses and Resolution: COVID-19, CoV-Risk, and CoV-Exposed.

10. 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.

II. Inpatient

1. All patients will be provided a surgical or procedural mask to be used for the duration of their encounter as long as not soiled or damaged.
    a. The mask must be worn anytime the patient is outside their room (i.e., during transport). The mask may also be used during prolonged face-to-face encounters with providers in their room per clinician discretion.

2. 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.

3. 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
c. If COVID-19 suspected, initiate testing per institutional protocol.

4. Personal Protective Equipment
    a. N95 respirator or PAPR will be used by:
        i. HCWs who provide direct patient care in an enclosed space within 6 feet of the patient for ≥ 10 minutes (i.e., patient room, exam room, procedure room)
        ii. HCWs who do not provide direct patient care but work in an enclosed space within 6 feet of the patient for ≥ 10 minutes (i.e., patient room, exam room, procedure room)
        iii. HCWs who do not provide direct patient care but may regularly be in an enclosed space within 6 feet of a patient for cumulatively ≥ 10 minutes (i.e., transport in elevators or clinicians who visit multiple patients for a short period of time)
    b. Gowns, gloves, and eye protection will be used by HCWs who have direct contact with the patient or patient's environment.
    c. Gowns, gloves, and N95 respirator or PAPR are not required for HCWs passing by or being in brief proximity (within 6 feet for < 10 minutes) of a patient. A surgical or procedural mask should be worn by all HCWs per Partners' universal mask plan.

5. Isolation and Patient Placement
    a. Enhanced Respiratory Isolation
        i. Private room with the door closed; cohorting of confirmed COVID-19 patients is permitted so long as there are no other infection status mismatches (e.g. MRSA, C. difficile, etc.).
        ii. Placement in an Airborne Infection Isolation Room (AIIR) is preferred if aerosol-generating procedures (AGPs) are anticipated; AIIRs should be prioritized when there is a shortage of AIIR rooms and there is a need for AGPs. Prioritization of AIIRs in these situations is based on patient risk of COVID 19 infection:
            1st priority: COVID-19
            2nd priority: CoV-Risk
            3rd priority: CoV-Exposed
            4th priority: Other viral respiratory illness

        iii. If an AIIR is not available and the consensus is to proceed, procedures must be performed in room with the door closed.

1. Wipe down all high touch surfaces immediately after the procedure.
2. Door to remain closed during and for one hour following completion of the procedure if non-AIIR (standard room); if AIIR duration of closure depends on number of air exchanges per hour for the specific room.

b. Strict Isolation may be used to designate use of AIIR

6. Limitations on use of Nebulizers
   a. Nebulization is an aerosolizing procedure and is strongly discouraged.
   b. Consider inhalers or spacers instead of nebulizers.

7. Cohorting Suspect and Confirmed COVID-19 patients:
   a. Suspect COVID-19 patients (CoV- Risk): not permitted.
   b. Confirmed COVID-19 patients (COVID-19): permissible so long as there are no other infection status mismatches (e.g. MRSA, C. difficile, etc.)
   c. CoV-Exposed: not permitted

8. Testing for COVID-19
   a. Approved indications for testing for COVID-19 are updated frequently and are posted on Partners Pulse.
   b. COVID-19 Testing Approval:
      i. Please see your facility-specific instructions regarding approval requirements for testing.
   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.

9. 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.

10. Infection Statuses associated with SARS-CoV-2. Please see Partners Guidance on Infection Statuses and Resolution: COVID-19, CoV-Risk, AND CoV-Exposed

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

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III. Ambulatory (including Urgent Care)

1. All patients will be provided a surgical or procedural mask upon arrival to the facility and instructed to wear the mask throughout their visit.

2. Identification of Patients with Suspected Viral Respiratory Illness
    a. Screen patients telephonically 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. If screen positive, defer in-person visits and manage remotely if clinically appropriate.
    c. If symptomatic and in-person evaluation required for person with respiratory symptoms, determine appropriate clinical location for evaluation.
    d. Patients with suspected or confirmed COVID-19 should be evaluated per facility in dedicated evaluation areas.

3. Protecting front desk personnel. The following 3 options are recommended:
    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 10 minutes face-to-face with front desk personnel.

4. 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.

5. Personal Protective Equipment
    a. N95 respirator or PAPR will be used by:
        i. HCWs who provide direct patient care in an enclosed space within 6 feet of the patient for ≥ 10 minutes (i.e., patient room, exam room, procedure room)

ii. HCWs who do not provide direct patient care but work in an enclosed space within 6 feet of the patient for ≥ 10 minutes (i.e., patient room, exam room, procedure room)
iii. HCWs who do not provide direct patient care but may regularly be in an enclosed space within 6 feet of a patient for cumulatively ≥ 10 minutes (i.e., transport in elevators or clinicians who visit multiple patients for a short period of time)

b. Gowns, gloves, and eye protection will be used by HCWs who have direct contact with the patient or patient's environment.
c. Gowns, gloves, and N95 respirator or PAPR are not required for HCWs passing by or being in brief proximity (within 6 feet for < 10 minutes) of a patient. A surgical or procedural mask should be worn by all HCWs per Partners' universal mask plan.

6. Limitations on use of Nebulizers
    a. Nebulization is an aerosolizing procedure and is strongly discouraged.
    b. Consider inhalers or spacers instead of nebulizers
    c. Placement in an Airborne Infection Isolation Room (AIIR) is preferred if aerosol-generating procedures (AGPs) are anticipated; AIIRs should be prioritized when there is a shortage of AIIR rooms and there is a need for AGPs. Prioritization of AIIRs in these situations is based on patient risk of COVID 19 infection:
        1st priority: COVID-19
        2nd priority: CoV-Risk
        3rd priority: CoV-Exposed
        4th priority: Other viral respiratory illness
    d. If an AIIR is not available and the consensus is to proceed, procedures must be performed in room with the door closed.
        i. Wipe down all high touch surfaces immediately after the procedure.
        ii. Door to remain closed during and for one hour following completion of the procedure if non-AIIR (standard room); if AIIR duration of closure depends on number of air exchanges per hour for the specific room.

7. 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. NP and OP swabs should only be obtained in the outpatient when a formal system is in place for safe testing.
    c. Empiric treatment recommendations
        i. We recommend treating influenza empirically in vulnerable patients or referring patients for combined influenza/COVID19 testing to centralized

testing facilities. ***Note that at this time, there is minimal influenza circulating.***

ii. We recommend treating group A strep empirically in patients who meet the Centor Criteria.

8. Infection Statuses associated with SARS-CoV-2. Please see Partners Guidance on Infection Statuses and Resolution: COVID-19, CoV-Risk, AND CoV-Exposed isk Infection Status.

IV. Peri-Procedural Areas

1. Identification of Patients with Suspected Viral Respiratory Illness
    a. Screen patients telephonically 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. If screen positive, defer in-person visits and manage remotely if clinically appropriate
    c. If symptomatic and in-person evaluation required for person with respiratory symptoms, determine appropriate clinical location for evaluation.
    d. Patients with suspected or confirmed COVID-19 should be evaluated per facility in dedicated evaluation areas.

2. All patients will be provided a surgical or procedural mask upon arrival to the facility and instructed to wear the mask throughout their visit.
3. Protecting front desk personnel. The following 3 options are recommended:
    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 10 minutes face-to-face with front desk personnel.

4. 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. <u>Ensure that patient remains masked while in the practice.</u>
    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.

5. Personal Protective Equipment
    a. N95 respirator or PAPR will be used by:
        i. HCWs who provide direct patient care in an enclosed space within 6 feet of the patient for ≥ 10 minutes (i.e., patient room, exam room, procedure room)
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    b. Gowns, gloves, and eye protection will be used by HCWs who have direct contact with the patient or patient's environment.
    c. Gowns, gloves, and N95 respirator or PAPR are not required for HCWs passing by or being in brief proximity (within 6 feet for < 10 minutes) of a patient. A surgical or procedural mask should be worn by all HCWs per Partners' universal mask plan.
6. Isolation and Patient Placement
    a. Enhanced Respiratory Isolation
        i. Private room with the door closed; cohorting of confirmed COVID-19 patients is permitted so long as there are no other infection status mismatches (e.g. MRSA, C. difficile, etc.).
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            2nd priority: CoV-Risk
            3rd priority: CoV-Exposed
            4th priority: Other viral respiratory illness

        iii. If an AIIR is not available and the consensus is to proceed, procedures must be performed in room with the door closed.
            1) Wipe down all high touch surfaces immediately after the procedure.
            2) Door to remain closed during and for one hour following completion of the procedure if non-AIIR (standard room); if AIIR duration of closure depends on number of air exchanges per hour for the specific room.
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    a. For patients with suspected COVID-19 or confirmed COVID-19, alert local contacts for Biothreats/Infection Control if not done so already.