Due to COVID-19, special precautions are needed to keep our patients, visitors and associates safe. These guidelines outline necessary interventions to reduce the risk of COVID-19 transmission while promoting an environment of health and safety at Montefiore.

The guidelines are based on our current understanding of how the virus that causes COVID-19 is transmitted and who is able to communicate the disease to others. As we learn more, these recommendations may be subject to revision.
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Transmission and Infectivity of COVID-19

COVID-19 is spread principally by droplet and contact. Airborne transmission may occur during aerosol-generating events/procedures (abbreviated “AGPs”). Such procedures include active endotracheal intubation or extubation, BiPAP/CPAP, high-flow nasal cannula (HFNC), bag valve mask ventilation, cardiopulmonary resuscitation (CPR), bronchoscopy, sputum induction, nebulizer therapy, surgical tracheostomy and ongoing endotracheal ventilation in non-closed respiratory circuits. Servo ventilators are closed and are NOT considered aerosol generating. The extent of aerosol generation during oral, airway and sinus surgery, and when a patient is breathing heavily and not consistently wearing a face mask, is unknown but presumed to occur.

When caring for the suspected or confirmed COVID-19 patient, the type of infection-control practices we employ depends on whether the patient is infectious (i.e., has replication-competent virus) and whether the care being considered will increase the transmission of infectious particles.

Based on the current data and public health guidelines:

- **Infectious droplets and aerosols are generated from the respiratory tract.** Urine is not considered infectious. Feces could potentially be infectious in the significantly ill patient.

- **Patients without immunosuppression** are considered no longer infectious when at least 14 days have passed since symptom onset and the patient has been afebrile for at least 72 hours with significantly improving respiratory symptoms.

- **Patients with immunosuppression** are considered no longer infectious when at least 14 days have passed since symptom onset, and the patient has been afebrile for at least 72 hours with significantly improving respiratory symptoms and has had two negative PCR tests from nasopharyngeal (NP) swab samples separated by at least 24 hours.

**Immunosuppression is defined as:**

1. Receiving chemotherapy
2. History of organ or stem cell transplant
3. HIV CD4 count <200 c/mm³ (12–15%)
4. Inherited immunodeficiency
5. Receiving medication such as the equivalent of prednisone >3 mg/kg or 20 mg/day for greater than or equal to 2 weeks, cyclosporine, azathioprine or monoclonal antibodies (Ab).

Given what is currently known about COVID-19 and its transmissibility, ensuring a safe workplace environment depends upon three fundamental principles: what we wear when at work, how we act while at work, and what we do to identify and isolate those who might be infectious with the COVID-19 virus.
The guidelines with respect to the proper use of PPE depend upon the location where clinical care is being delivered and the type of activity being undertaken by the provider.

**COVID-19 PPE GUIDELINES**

**For non-clinical areas:**

In accordance with current public health guidance, all associates, students and volunteers, visitors, and vendors (referred to as “individuals”) must wear a face mask at all times while on Montefiore property or when performing duties as an employee of Montefiore irrespective of whether the location is designated as research, administrative, clinical, education, non-clinical or public space.

- **Face masks** are the primary tool to prevent COVID-19 transmission and must fully cover the mouth and nose at all times (with the exception of individuals who are alone in a private office with the door closed).

- **Medical-grade masks, filtering facepiece respirators or approved N95 equivalents** must be used by Montefiore associates (see below for clinical areas). Cloth masks are not permitted for associates, visitors or patients at Montefiore.

- Visitors and patients may use clean, intact cloth masks that fully cover the mouth and nose to enter the facility but should be given a medical mask to wear upon arrival.

- A mask is not required:
  - When an individual is alone in a private office
  - During breaks or mealtimes; however, associates should maintain social distancing by not sitting closer than 6 feet from one another during these times

**For operating and procedure rooms:**

Please refer to perioperative guidelines for PPE in the operating and procedure rooms on the intranet (see “MHS COVID-19 Clinical Evaluation, Management, Infection Prevention”).

**For clinical areas:**

- **A medical face mask** is required for patient care even if the patient does not have suspected or confirmed COVID-19.

- **Face shields, safety glasses or goggles** are required for:
  - Providing direct patient care
  - Individuals at any location where a patient or member of the public may present without a face mask or maintaining 6 feet of separation from patients is not possible
• **Filtering facepiece respirators** or approved N95 equivalents should be used:
  – When providing direct patient care of suspected and confirmed COVID-19 patients within the infectious period (or patients carrying other airborne pathogens)
  – When performing AGPs or surgical procedures, regardless of the patient’s COVID-19 status
  – When performing oral, airway and sinus surgery/procedures
  – During procedures/events when a patient is breathing heavily and not consistently wearing a face mask (e.g., stress test)

• **Glove use** is recommended when providing direct patient care of suspected and confirmed COVID-19 patients. The use of gloves is not a substitute for hand hygiene. Associates should perform hand hygiene before and after patient contact, and frequently throughout the day. The same pair of gloves should never be used for multiple patients.

• **Tyvek or other full-body suits** are not required or necessary for the care of patients with known or suspected COVID-19. If Tyvek or other full-body suits are purchased by individuals and worn in the workplace, they should be covered by a gown when providing care for any patient where splashing/spraying is anticipated, when contact with body fluids or wounds is anticipated, and when attending to any patient on isolation for COVID-19 or other pathogens requiring barrier protection. Suits must be cleaned thoroughly with disinfectant wipes (PDI or equivalent) or another approved disinfection process upon removal and at the end of each shift.

• **Isolation gowns** are recommended only for exposure to body fluid splashes or close contact with a patient on isolation, including suspected or confirmed COVID-19 patients, within the infectious period per Infection Prevention and Control (IPC). Close contact is defined as the patient’s body coming in contact with the healthcare worker’s body during care.
  – Gowns should not be reused between patients unless directed in specific circumstances by IPC in the setting of a severe shortage.
  – Gowns and gloves are not to be worn in non-patient-care areas, including nurses stations, common areas of the hospital, etc., unless explicitly permitted by IPC.

• **For Aerosol Generating Procedures (APGs)** or when obtaining NP swabs for SARS-CoV-2 testing, wear gloves, gown, **filtering facepiece respirators** or approved N95 equivalents and eye protection.
  – AGPs include endotracheal intubation or extubation, electroconvulsive therapy (ECT) patients, BiPAP or bag valve mask ventilation, CPR, bronchoscopy, sputum induction and nebulizer therapy not in closed respiratory circuits.
Certain testing or procedures performed on patients who cannot reliably wear a mask may result in aerosols and respiratory secretions. The use of a face shield, filtering facepiece respirators or approved N95 equivalents and gloves is recommended. These procedures include:

- Pulmonary function testing
- Cardiac stress testing
- Metabolic function testing
- Nasopharyngeal endoscopy
- Gastrointestinal endoscopy
- ECT
- Dental surgery and cleaning involving high-speed drills or other devices/interventions that may generate aerosols
- Rehabilitation medicine therapy that induces coughing or heavy exertion (e.g., cardiac rehabilitation and swallow evaluations)

**Careful removal of PPE is important.**

See the PPE safe use videos on the intranet to learn more about how to safely remove PPE.

**Conservation of PPE is critical to ensure an adequate supply of these items in the future.** Recommendations on the use of PPE may change based on recommendations of IPC. Please refer to the current guidance for reuse and conservation of PPE on the intranet.
Behaviors That Keep Us Safe at Work

In addition to wearing PPE, there are actions that we take while at work that are equally important in keeping our environment sanitary and in keeping ourselves and our patients secure from infection.

Hand hygiene is one of the key behaviors we use to interrupt transmission of COVID-19.

All individuals must wash hands frequently while present at Montefiore using alcohol-based hand rub or soap and water and should avoid touching their faces.

- For associates, diligent hand hygiene must be performed while working, including (but not limited to) the Centers for Disease Control and Prevention’s (CDC’s) recommended moments for hand hygiene:
  - Immediately before touching a patient
  - When hands are visibly soiled
  - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
  - After caring for a person with known or suspected infectious diarrhea
  - Before moving from work on a soiled body site to a clean body site on the same patient
  - After known or suspected exposure to spores (e.g., *B. anthracis*, *C. difficile* outbreaks)
  - After touching a patient or the patient’s immediate environment
  - After contact with blood, body fluids or contaminated surfaces
  - Immediately after glove removal

- Visitors and others should be encouraged to also practice vigorous and frequent hand hygiene while at Montefiore.

Appropriate social distancing also helps maintain a sanitary environment.

- Work areas and meeting rooms should have seats spread to 6 feet of separation whenever possible. Removal of chairs should be considered.

- Floor markings and other visual cues should be utilized to maintain distance in common areas and when waiting in line for food, etc.

- Large gatherings are strongly discouraged, and alternative technological solutions should be leveraged.

- Associates should maintain 6 feet of separation during breaks, meals and any other time mask use is not possible.

- During breaks or meals, tables should be cleaned before and after use.
• **Shared equipment/areas** should be cleaned before and after use.

• **Paper towels should be used** to open doors, flush toilets or turn sinks on/off when possible.

• **There should never be more than 4 people in a large elevator** and 2 people in a small elevator.

• Site managers/leaders should **evaluate all areas of congregation** (including lobbies, cafés, cafeterias, staff and public restrooms, waiting rooms, staff lounges, break rooms, conference rooms, etc.) and implement safe distancing parameters.

• **Flexible work hours** (e.g., rotating or staggering shifts to limit the number of employees in the workplace at the same time) including weekend and night shifts should be considered.

• **Limit and maintain a log of any visitors** including contact information.

**Frequent use of surface disinfection helps to maintain a clean environment.**

• **Any hospital-provided Environmental Protection Agency (EPA)—approved disinfectant** is appropriate.

• **Clean visibly soiled** and frequently touched surfaces as per policy.

• **Standard discharge cleaning** and disinfection process is effective.

• In ambulatory, office and research locations, **daily cleaning and disinfection process should occur** in addition to cleaning of high-touch surfaces as per policy. Please refer to “Ambulatory Care, Faculty Practice and Business Office Guidance for COVID-19 Operations” on the intranet.

• In all locations, **take responsibility for your workspace** and wipe touched surfaces with a disinfectant frequently as you start and end your day.

• **Limit the sharing of objects** and discourage touching of shared surfaces when possible. When contact with shared objects or frequently touched areas occurs, sanitize or wash hands before and after contact and clean shared surfaces before and after use.

• **Post signage where appropriate** to remind personnel to adhere to proper hygiene, social distancing rules, appropriate use of PPE, and cleaning and disinfecting protocols.
Identifying and Isolating Individuals with Potential to Transmit COVID-19

SCREENING ASSOCIATES
All associates working in clinical settings will undergo temperature check and daily COVID-19-related symptom screening prior to start of shift. Associates working in non-clinical areas will be expected to self-monitor for temperature and symptoms before reporting to work.

For associates who screen positive or who have experienced a high-risk exposure:

- Associates who develop any COVID-19 symptoms should not report to work or, if at work, should return home.
- Any suspected or confirmed COVID-19 illness must be disclosed to an associate’s supervisor and Occupational Health and Services (OHS) as soon as possible and testing for COVID-19 (available for scheduling through OHS) is strongly encouraged. Any work-restriction recommendations issued by OHS must be followed.
- Any close contacts of associates with COVID-19 in the workplace (15 minutes or more of contact without recommended PPE) for the 2 days preceding symptom onset must be disclosed to IPC.
- Associates with a COVID-19 exposure outside the workplace (15 minutes or more of contact without recommended PPE) must report the exposure to OHS as soon as possible and must follow any work-restriction recommendations.

SCREENING PATIENTS
All patients and visitors 4 years of age or greater (2 years or greater if tolerated) should be offered a medical mask upon entry into the hospital or ambulatory locations if not currently wearing one. All patients will have their temperatures taken upon entry into a Montefiore clinical facility.

An individual’s screen is considered positive if there is new onset of either fever (as defined as ≥100.0°F) OR one or more of:

- Chills
- Shaking chills
- Cough or shortness of breath
- Muscle pain
- Headache
- Sore throat
- Nausea
- Vomiting
- Unexplained diarrhea
- Loss of taste/smell

Children may also present with new-onset diarrhea, erythematous lesions on distal metacarpals, Kawasaki syndrome or pediatric multisystem inflammatory syndrome.
For ambulatory sites:

- During the pre-visit phone call, associates should screen patients for known COVID-19, symptoms or potential exposure to COVID-19 and instruct them to arrive with a face mask.
- Upon arrival, patients should be screened for COVID-19 symptoms, diagnosis or exposure and, if the screen is positive, they should be isolated.

For emergency department (ED) and inpatient locations:

- At triage or at the time of direct admission, patients should be screened for COVID-19 symptoms, diagnosis or exposure and, if the screen is positive, should be isolated.
- All patients, regardless of COVID-19 infection status, should wear a mask at all times, even when in their room if tolerated.

Patients who screen positive should be isolated and managed according to Montefiore protocols for specific departments and care settings.

SCREENING VISITORS

Visitors to clinical areas will be offered a surgical mask and screened for symptoms and fever by having their temperature taken upon entry to the facility. Visitors who screen positive may not enter the facility and should be instructed to contact their primary physician.

- To minimize opportunities for transmission of COVID-19 within Montefiore facilities, business operations are encouraged to minimize face-to-face interactions with vendors and to conduct as many of these interactions remotely as possible.
- In addition to temperature and symptom screening, visitors to specific clinical areas including Labor and Delivery, oncology, transplant and the NICU will also be required to have a negative PCR test (see below).

TESTING FOR COVID-19

All associates who develop signs or symptoms of COVID-19, or who have a high-risk exposure, should contact OHS as soon as possible and, if appropriate, undergo a test for COVID-19. Testing may also be recommended as part of an infection prevention investigation.

Associates testing positive on SARS-CoV-2 PCR test must follow the current New York State Department of Health (NYS DOH) guidelines to:

- **Isolate at home for 10 days from initial test date** if asymptomatic
- **Isolate at home for 10 days after symptom onset**, 72 hours after fever resolves without the use of fever-reducing medications, and after significant improvement of other symptoms occurs (whichever is longest) if symptomatic

In addition to screening associates, we conduct PCR COVID-19 testing on the following patients based on public health guidance and current testing capacity:
• **All adult hospitalized patients**, upon admission.

• **All patients who are scheduled for elective admission** or those scheduled to undergo procedures and operations performed in a designated endoscopy suite, procedure room or operating room, 2–3 days prior to the procedure.

**NOTE:** Repeat testing is **not required** upon admission for patients undergoing planned procedures or admissions who had a test within 2–3 days of arrival, nor is repeat testing required after a surgical procedure. In addition, patients who had a confirmed COVID-19 infection in the past 90 days (confirmed by PCR) **and** who are at least 14 days past the date of symptom onset **and** who have been afebrile for at least 72 hours **and** whose other symptoms have resolved are presumed to have recovered from their COVID-19 infection and will not need to be retested prior to their procedure. IPC should be consulted to ensure the patient meets the criteria to waive pre-procedure SARS-CoV-2 PCR testing.

• **Prior to certain testing or procedures** in the ambulatory setting that may generate aerosols.

• **In patients who test PCR positive**, if it is possible without entailing undue clinical compromise, surgical and ambulatory procedures will be deferred for 2–4 weeks. Refer to current public health guidelines and Montefiore perioperative guidance documents on the intranet for details (see Appendix A: COVID-19 Screening and Testing for Surgical Procedures and, on the intranet, “MHS COVID-19 Clinical Evaluation, Management, Infection Prevention”).

• **Testing will also be performed on visitors to high-risk areas** including Labor and Delivery, the transplant unit and oncology, including the NICU.

**ISOLATION PRECAUTIONS AND ENVIRONMENTAL CONTROLS FOR PATIENTS WITH SUSPECTED (PUI) OR CONFIRMED COVID-19 INFECTION** (see Appendix B: Infection Prevention Guide to COVID-19 Isolation and Infection Status)

Infection prevention measures are implemented for suspected or confirmed COVID-19 patients within the infectious period.

The infectious period is defined by the patient characteristics as outlined here:

• **Asymptomatic, not immunocompromised:** 14 days after the first positive SARS-CoV-2 PCR test.

• **Symptomatic, not immunocompromised:** 14 days after the onset of symptoms or the patient is afebrile for 72 hours with significantly improving respiratory symptoms, whichever is longer.

• **Immunocompromised:** 14 days from the first positive PCR test or symptom onset until the patient is afebrile for 72 hours with significantly improving respiratory symptoms, whichever is longer, plus two negative PCR tests, at least 24 hours apart. The infectious period in immunocompromised patients is expected to be prolonged.
Symptoms include:
- Fever
- Chills
- Shaking chills
- Cough or shortness of breath
- Muscle pain
- Headache
- Sore throat
- Nausea
- Vomiting
- Unexplained or new diarrhea
- Loss of taste/smell

Children may also present with new-onset diarrhea, erythematous lesions on distal metacarpals, Kawasaki syndrome or pediatric multisystem inflammatory syndrome.

Immunocompromised is defined as:
- Receiving chemotherapy
- History of organ or stem cell transplant
- HIV CD4 count <200 c/mm³ (12–15%)
- Inherited immunodeficiency
- Receiving medication such as the equivalent of prednisone >3 mg/kg or 20 mg/day for at least 2 weeks, cyclosporine, azathioprine or monoclonal antibodies

ED and hospital locations:

- **Implement Special Pathogen Precautions** and order COVID-19-positive or COVID-like illness (CLI) flag

- **Place the suspected or confirmed COVID-19 patient in:**
  - **A negative pressure room when an AGP is anticipated**, including active endotracheal intubation or extubation, BiPAP/CPAP, HFNC, bag valve mask ventilation, CPR, bronchoscopy, sputum induction, nebulizer therapy and ongoing endotracheal ventilation in non-closed respiratory circuits. Servo ventilators are closed and are NOT considered aerosol generating. A private room (or room shared with another COVID-19 patient) with HEPA filters should be used if a negative pressure room is unavailable.
  - All other suspected or confirmed COVID-19 patients are placed on **Contact+Droplet+ Eye protection isolation precautions** and do not require negative pressure rooms.
  - **COVID-19-positive or COVID-like illness (CLI) flags, Special Pathogen Precautions and patient movement to COVID-19-negative areas** should not occur without approval from Infection Prevention/Hospital Epidemiology.
Ambulatory locations:

- Patients should be tested for SARS-CoV-2 by PCR 2–3 days prior to the following testing or procedures performed on un-masked patients that may result in aerosols and respiratory secretions:
  - Pulmonary function testing
  - Cardiac stress testing
  - Metabolic function testing
  - Nasopharyngeal endoscopy
  - Dental surgery and cleaning involving high-speed drills or other devices that may generate aerosols
  - Rehabilitation medicine therapy that induces coughing or heavy exertion (e.g., cardiac rehabilitation and swallow evaluations)

  **NOTE:** These tests or procedures do not require negative pressure rooms.

- Supplemental HEPA filtration and/or increased air changes per hour (ACH) should be considered for the above procedures if testing prior to the procedure is not possible.

- The removal of airborne SARS-CoV-2 particles depends on the ACH within the space. Use the table below to determine how long a room should remain empty after a patient with suspect or confirmed COVID-19 within the infectious period undergoes a procedure or test that may cause aerosols and the patient was not masked. The room does not typically need to remain empty if the patient was wearing a mask (source control).

<table>
<thead>
<tr>
<th>Room Type</th>
<th>Exchange</th>
<th>Time in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Room – Surgery</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Delivery Room – Surgery</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>X-ray (Cardiac Cath) – Ancillary</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Endoscopy Room – Hutch</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>Endoscopy Room – MMC</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>Newborn Nursery – Suite – Nursing</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>Recovery Room – Surgery</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>Critical / Intensive Care – Surgery</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>Intermediate Care – Surgery</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>Treatment Room / Pulmonary Function Testing Room</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>Newborn Intensive Care - Surgery</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>Iso Room – Protective Environ – Nursing – Positive Pr Room</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>Iso Room – Infectious Airborne – Nursing – Negative Pr Room</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>Iso Room – Ante Room - Nursing</td>
<td>10</td>
<td>41</td>
</tr>
</tbody>
</table>
PLACEMENT OF HOSPITALIZED SUSPECTED (PUI) AND CONFIRMED COVID-19 PATIENTS

The following patients are admitted to designated COVID-19 inpatient units or treated in a COVID-19-appropriate bed:

- **Patients with positive SARS-CoV-2 testing** who are within the infectious period as outlined above. These patients must have a COVID-19-positive flag in Epic in addition to a Special Pathogen Precaution isolation order.

- **Patients with suspected COVID-19 infection** due to typical signs, symptoms and laboratory findings but negative SARS-CoV-2 testing. These patients are designated as having COVID-like illness (CLI). These patients must have a CLI flag in Epic in addition to a Special Pathogen Precaution isolation order.

If a patient on a non-COVID-19 inpatient unit develops findings concerning for COVID-19 infection:

- Obtain appropriate SARS-CoV-2 testing.

- Implement isolation precautions and either move the patient to a single/shared CLI room or transfer the roommate out of the room.

- Flag these patients as CLI in Epic.

- **If the test is positive**, move the patient to a designated COVID-19 inpatient unit or COVID-19-appropriate bed. Notify Infection Prevention and Control for contact tracing immediately and perform SARS-CoV-2 testing of any patient who was a roommate of the COVID-positive patient in the preceding 2 days.

- **If the test is negative**, the patient may remain in a CLI-appropriate bed and testing should be repeated in 24–48 hours.

If a patient is directly transferred from another hospital or directly admitted to an inpatient area:

- Planned admissions should have SARS-CoV-2 PCR performed 2–3 days prior to the admission.
• **Unplanned admissions** should be placed in a private room on Empiric Special Pathogen Precautions upon arrival pending results of SARS-CoV-2 PCR.

• **Transfers** should have SARS-CoV-2 PCR performed within 2–3 days of transfer (if patient is not already known to be positive) and repeated upon arrival. The patient should be placed in a private room on Empiric Special Pathogen Precautions upon arrival pending test result.

**Cohorting:**

• Confirmed patients with positive SARS-CoV-2 testing who are within the infectious period as outlined above may be cohorted with one another.

• As a general rule, do not cohort CLI patients and confirmed COVID-19-positive patients together.

• Do not cohort patients directly admitted or transferred with pending SARS-CoV-2 PCR tests with other patients.

Refer to Obstetrics guidance for Labor and Delivery protocols on the intranet (see “COVID-19 Labor and Delivery Guidance”)

**WHEN TO DISCONTINUE COVID-19 ISOLATION PRECAUTIONS IN THE INPATIENT SETTING**

**A symptom-based strategy is followed for patients without immunosuppression:**

• Discontinue isolation precautions when all of the following criteria are met:
  - 14 days or more after symptom onset AND
  - Afebrile at least 72 hours without antipyretics AND
  - Significantly improved respiratory symptoms

**A test-based strategy is followed for patients with immunosuppression:**

• Discontinue isolation precautions when all of the following criteria are met:
  - 14 days or more after symptom onset AND
  - Afebrile for at least 72 hours without antipyretics AND
  - Significantly improved respiratory symptoms AND
  - Two negative SARS-CoV-2 PCR tests from an NP swab sample separated by at least 24 hours

COVID-19-positive or CLI flags, Special Pathogen Precautions and patient movement to COVID-19-negative areas should not occur without approval from Infection Prevention/Hospital Epidemiology.

When COVID-19 isolation precautions are discontinued, the patient is placed on a non-COVID-19 inpatient unit or room.
## Appendix A: Guide to COVID-19 Testing for Procedures

<table>
<thead>
<tr>
<th>TYPE OF PROCEDURE</th>
<th>PROCEDURE PLANNING</th>
<th>PROCEDURE PLANNING</th>
<th>PROCEDURE PLANNING</th>
<th>DAY OF PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screen #1 – Symptoms and Exposure</td>
<td>Screen #2 – Symptoms and Testing</td>
<td>NP swab SARS-CoV-2 PCR</td>
<td>Screen #3 – Symptoms and Testing*</td>
</tr>
<tr>
<td></td>
<td>1. History of COVID-19 &lt; 4 weeks</td>
<td>2. Suggestive symptoms ≤ 14 days</td>
<td>(2–3 days prior to procedure)</td>
<td>If indicated, NP swab SARS-CoV-2 PCR*</td>
</tr>
<tr>
<td></td>
<td>2. Suggestive symptoms ≤ 14 days</td>
<td>3. Known or suspected exposure ≤14 days</td>
<td></td>
<td>*Testing only if not already done in the preceding 3 days or if high-risk procedure</td>
</tr>
<tr>
<td></td>
<td>3. Known or suspected exposure ≤14 days</td>
<td>4. International travel or domestic travel to a high-risk area ≤14 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergent no delays</td>
<td>N/A</td>
<td>N/A</td>
<td>1. Intraoperative by anesthesia</td>
<td>1. Preoperative and await results</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. EXPEDITED order</td>
<td>2. EXPEDITED order</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Hand deliver to lab</td>
<td>3. Hand deliver to lab</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Proceed with surgery – full PPE</td>
<td>4. If POS, use COVID-19-positive designated areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Recover in the OR if test not back or if test positive or suspected/confirmed COVID-19 disease</td>
<td>* If NEG result but strong clinical suspicion, flag as CLI and proceed in COVID-positive areas</td>
</tr>
<tr>
<td>Emergent few-hour (&lt;4) delay possible</td>
<td>YES</td>
<td>If positive screen, consider CLI even if test is negative</td>
<td>N/A</td>
<td>** For Emergent Inpatient procedures – call COVID-19 Provider Hotline (914-457-4136) to help order EXPEDITED test, collect NP swab and hand deliver to lab.</td>
</tr>
<tr>
<td>Elective</td>
<td>YES</td>
<td>If positive screen, defer/ reschedule</td>
<td>Outpatients: Follow outpatient testing performed 2–3 days prior to procedure to ensure result available at the time of procedure.</td>
<td>NO TESTING REQUIRED ON DAY OF SURGERY UNLESS CLINICAL SUSPICION OF COVID-19 ON DAY OF PROCEDURE:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inpatients: STANDARD virology testing SARS-CoV-2 NP PCR. Deliver to lab by 2:00 pm for same-day results. Testing MUST be performed 2–3 days prior to the procedure to ensure result available at the time of procedure.</td>
<td>1. Review PCR results from 2–3 days prior to surgery to confirm they are negative</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– If positive, defer/ reschedule</td>
<td>2. If positive*, recommend delaying and rescheduling procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– If negative, proceed</td>
<td>*If negative result but strong clinical suspicion, flag as CLI and proceed in COVID-19-positive areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patients who tested positive for or had COVID-19 in the past 90 days and have now recovered (and are &gt;14 days from positive result or onset of symptoms and 72 hours without fever) may not require pre-procedure testing. Please discuss safety recommendations regarding procedure and need for testing with IPC physician.</td>
</tr>
</tbody>
</table>

Patients who tested positive in the past 14 days should remain on isolation and considered COVID-19-positive for procedure purposes; procedure must be performed in COVID-positive designated area.
Appendix B: Infection Prevention Guide to COVID-19
Isolation and Infection Status

- **When to discontinue COVID-19 isolation precautions:**
  - Immunocompetent + asymptomatic: 14 days after first positive SARS-CoV-2 PCR test
  - Immunocompetent with symptoms: 14 days after first positive SARS-CoV-2 PCR **AND**
    72 hours after resolution of fever **AND** improving respiratory symptoms **AND** IPC approval.
  - Immunocompromised with symptoms: 14 days after first positive SARS-CoV-2 PCR **AND**
    72 hours after resolution of fever **AND** improving respiratory symptoms **AND** 2 negative NP SARS-CoV-2 PCR 24 hours apart **AND** IPC approval.

- **COVID-19-positive infection flag** will remain in place for **30 days** from first positive NP swab (can be removed only by IPC physicians; can be removed earlier at the discretion of or as deemed safe by IPC).
- **COVID-like illness (CLI) flag** will remain in place for **14 days** from admission or onset of symptoms.
- **NP PCR retesting** can be repeated can repeat at least **72 hours after last POSITIVE**. (If two negative results are required, they should be performed 24 hours apart.)

<table>
<thead>
<tr>
<th>SARS-CoV-2 PCR*</th>
<th>Reason for testing</th>
<th>Infection flag</th>
<th>Isolation</th>
<th>Cohorting</th>
<th>Repeat testing if needed for discharge or disposition**</th>
<th>Removal of isolation and infection flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Symptoms</td>
<td>COVID-19-positive (Auto-expire at 30 days)</td>
<td>Special Pathogen Precautions (Contact + Droplet or Contact + Airborne if AGP)</td>
<td>COVID-19-positive</td>
<td>≥ 10 days from symptom onset • Symptoms IMPROVING • &gt;72 hours no fever (off antipyretics)</td>
<td>14 days from onset of symptoms or positive PCR test • Afebrile for at least 72 hours • Improvement of respiratory symptoms • Requires approval of IPC Immunocompromised patients – also need 2 negative NP swabs 24 hours apart</td>
</tr>
<tr>
<td>Screening (admit, procedure, OR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>≥ 10 days from symptom onset, or No symptoms</td>
<td></td>
</tr>
</tbody>
</table>

| Negative (obtain COVID-19 Ab testing) | Symptoms | COVID-like illness (CLI) (Auto-expire at 30 days) | CLI | Second test to be done within 24 hours of admission | ≥ 10 days from symptom onset • Symptoms IMPROVING • >72 hours no fever (off antipyretics) | 14 days from onset of symptoms • Afebrile for at least 72 hours • Improvement of respiratory symptoms |

* SARS-CoV-2 PCR: reverse transcriptase polymerase chain reaction for severe acute respiratory syndrome coronavirus 2. ** Discharge or disposition: discharge or discharge from hospital or from outpatient facility. AGP: airway containment equipment.
<table>
<thead>
<tr>
<th>SARS-CoV-2 PCR *</th>
<th>Reason for testing</th>
<th>Infection Flag</th>
<th>Isolation</th>
<th>Cohorting</th>
<th>Repeat testing if needed for discharge or disposition**</th>
<th>Removal of isolation and Infection Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Screening</td>
<td>None</td>
<td>Standard and as needed for other infections</td>
<td>As per IPC isolation guidelines</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| Direct admissions or transfers | New admission (direct admit or transfer) | COVID-19 test in progress or COVID-19 test pending | Full empiric Special Pathogens Contact and Droplet precautions | Private room — cannot cohort while results are pending | • If positive past 14 days, no need to retest  
• Otherwise, repeat testing on admission/transfer  
If not able to do preadmission testing and patient is already admitted, while test result is pending, draw curtains and use full empiric Special Pathogens Contact and Droplet precautions | Determined by symptoms and testing results |

* Nasopharyngeal or stool SARS-CoV-2 PCR.
** Immunocompromised patients may have prolonged viral shedding and repeat testing may need to be delayed.
NP COVID PCR test is ordered
- COVID Symptoms +
- Screening (COVID Symptoms - and unrelated reason for presentation)

Special Pathogen Precautions
(Contact +Droplet, or Contact +Airborne if AGP)

Previously COVID POS result in MMC EMR?

< 14 days since last POSITIVE result
- COVID POS flag

> 14 days since last POSITIVE result
- +/- COVID POS flag (Exp at 30 d)

Infection flag based on ordered lab
- COVID lab pending
- COVID lab in process

Clinical suspicion for COVID?

Can d/c Special Pathogen Precautions, further management as per team?

POS

- Isolation: Special Pathogen Precautions
- Infection flag: COVID-like Illness Infection flag placed by provider (active for 14 days)
- PPE: Mask, face shield, gown, gloves
- Cohorting: With COVID-like illness (CLI) only
  - CLI infection flag remains for 14 days
  - Does not impact discharges
  - Allows cohorting with CLI only (other cohorting if absolutely necessary - in discussion with Infection control)
  - Can be removed by INFECTION CONTROL only

NEG

- Isolation: Special Pathogen Precautions
- Infection flag: Same as per COVID-19
- PPE: Mask, face shield, gown, gloves
- Cohorting: With COVID-19
  - COVID POS infection flag remains for 30 days
  - Does not impact discharges
  - Allows cohorting with COVID POS
  - Can be removed by INFECTION CONTROL only

When can isolation be d/c?

Prolonged hospitalization or readmission

Disposition and Discharge planning

D/c isolation a pt hospitalized for > 14 days since last POS result (same admission or readmission)
1. At least 14 days from first positive NP test
2. Afebrile for at least 72 hours
3. Improved respiratory symptoms.
4. Immunocompromised patients - ALSO 2 neg NP PCR 24 hours apart

Negative result required for d/c disposition and < 14 days since last POS result
1. NP PCR testing as per dispo guidelines
2. COVID POS flag remains for 30 day - can be d/c by Infection control
3. Isolation remains for 14 days from last POS

Retesting and Removal of isolation:
1. Repeat COVID NP PCR within 24 hours after admission to confirm negative
2. Can repeat NP PCR test, and if neg d/c isolation if:
   - > 10 days from onset of symptoms, clinically improving
   - > 72 hours of no fever without antipyretics

COVID related INFECTION FLAG
- COVID POS - active based on test results, Removed by Infection control only, autoexpires at 30 days
- COVID-Like Illness - Activated by physician based on clinical assessment, active for 14 days