POLICY:

To outline management and control measures for facilities to follow in response to the spread of COVID-19.

OVERVIEW:

What is Coronavirus disease 2019 (COVID-19)?
COVID-19 is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

What are the symptoms of COVID-19?
Clinical presentation ranges from asymptomatic to severe illness, and symptoms may vary over time. Symptoms commonly associated with COVID-19 include fever, chills, cough, shortness of breath, fatigue, muscle pain, headache, sore throat, new loss of taste or smell, congestion, runny nose, nausea, vomiting, and diarrhea. Skin manifestations may occur and the most common are a maculopapular rash, discolored lesions of the fingers and toes, and hives. More severe symptoms suggesting the need for a higher level of care may include difficulty breathing, bluish lips or face, persistent pain or pressure in the chest, and new confusion or inability to arouse.

Who is at higher risk for serious illness?
People 65 years or older, people who are overweight BMI > 25 kg/m^2) or obese (BMI ≥ 30 kg/m^2), people who are a current or former smoker, people who are pregnant, and/or people with conditions such as heart disease, high blood pressure, cerebrovascular disease, chronic respiratory disease, chronic kidney disease, liver disease, diabetes, Down Syndrome, dementia or other neurological conditions, substance use disorders, sickle cell disease, cancer, HIV, or a weakened immune system are at a higher risk for getting very sick from COVID-19. Complications include pneumonia, acute respiratory distress syndrome (i.e., ARDS) and even death.

How is COVID-19 transmitted?
The virus is thought to spread mainly through close contact (within 6 feet) from person to person. Vaccinated or unvaccinated people who are infected but do not show symptoms can also spread the virus to others.

Infections occur mainly through exposure to respiratory droplets when a person is in close contact with someone who has COVID-19. Respiratory droplets range in size from large to small and are produced when someone coughs, sneezes, sings, talks, or breathes. Larger droplets fall out of the air due to gravity. Smaller droplets spread apart in the air. Respiratory droplets cause infection when they are inhaled or deposited on mucous membranes, such as those that line the inside of the nose and mouth.
The virus can be spread by exposure to small droplets that can linger in the air for minutes to hours and it may be able to infect people who are further than 6 feet away from the person who is infected or after that person has left the space. This kind of spread is referred to as airborne transmission. It seems that under certain conditions (e.g., enclosed spaces with inadequate ventilation), people with COVID-19 have infected others who were more than 6 feet away. Current data indicates spread is more commonly due to spread through close contact rather than airborne transmission.

Although not a common way of spread, it is believed that a person can become infected with COVID-19 by touching a contaminated surface or object that has the virus on it and then touching their own nose, eyes, or mouth.

**What is the difference between confirmed COVID-19 case vs. suspected COVID-19 case?**
A confirmed case has received a positive result from a COVID-19 laboratory test, with or without symptoms. A suspected case shows symptoms of COVID-19 but either has not been tested or is awaiting test results. If test results are positive, a suspected case becomes a confirmed case.

**DEFINITIONS:**

**Cloth Face Covering** – A cloth face covering is a covering that is usually made of tightly woven cotton material or textile that is designed to fit on the face to cover the nose and mouth. A cloth face covering is not considered personal protective equipment. Use of a face covering is one strategy that might help slow the spread of COVID-19 if worn by asymptomatic people who have the virus and do not know it in settings where physical distancing measures are difficult to maintain or in areas of significant community-based transmission. They are worn to protect others, not the wearer. If everyone wears a cloth face covering in congregate settings, the risk of exposure can be reduced.

**Close Contact** – A close contact is someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period (e.g., three 5-minute exposures) starting from 2 days before illness onset or 2 days prior to test collection date for exposure to an asymptomatic COVID-19 case until the time the patient is isolated.

**Cohorting** – Cohorting refers to the practice of housing multiple COVID-19 cases together as a group under medical isolation or housing close contacts of a particular case together as a group under medical restriction. Cohorting is used when there is inadequate space to place individuals in single cells for medical restriction or medical isolation.

**Community Transmission**: Community transmission occurs when individuals are exposed to the virus through contact with someone in their local community, rather than through travel to an affected location. It is a measure of the presence and spread of COVID-19. Once community transmission is identified in a particular area, correctional facilities are more
likely to start seeing infections inside their facilities. Transmission is described as **minimal to moderate** when there is sustained community transmission with high likelihood or confirmed exposure within communal settings (e.g., workplaces, schools) and potential for rapid increase in cases. It is described as **substantial** when there is large scale transmission including communal settings.

**COVID-19 Community Levels** – Community levels are a measure of the impact and healthcare system strain of COVID-19. Community levels of COVID-19 are used to inform the use of prevention strategies. Levels are categorized as low, medium, or high and are based on the number of new COVID-19 cases, hospital admissions due to COVID-19, and the percent of inpatient beds occupied by patients with COVID-19.

**COVID-19 Prevention Strategies** – COVID-19 prevention strategies are separated into two groups. Operations should shift between the strategies based on COVID-19 community levels and facility-level factors (e.g., vaccination coverage, transmission in the facility, risk of severe health outcomes, and facility structural characteristics). In addition, when enhanced prevention strategies are applied, risk of transmission and use of strategies should be weighed against impact on facility operations, mental health, and availability of services and programming for inmates.

- **Strategies for everyday operations**: Strategies that should be kept in place at all times, even when community levels are low.
- **Enhanced COVID-19 prevention strategies**: Additional strategies that should be used when community levels are medium to high or when facility-level factors indicate increased risk.

**Crisis Operations** - When conventional operations can no longer be maintained despite efforts to mitigate staffing shortages and/or if there is insufficient space for medical restriction and isolation, alternative management strategies may be employed to ensure continuum of care and operations in consultation with University Leadership, Health Services, and/or Emergency Management. This includes, but is not limited to, allowing critical staff with high-risk exposure or infection with COVID-19 to return to work before the full conventional operations return to work criteria have been met. Alternative management strategies will be continued temporarily when best practices are not possible.

**Illness severity** – Severity of illness is based on symptoms. Individuals have **mild illness** if they have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging. Individuals have **moderate illness** if they have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) >94% on room air at sea level. Individuals have **severe illness** if they have any of the following: respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%. Individuals have **critical illness** if they have respiratory failure, septic shock, and/or multiple
organ dysfunction.

Medical Isolation – Isolation is for persons who are sick and contagious. Isolation is used to separate ill persons who have a communicable disease from those who are healthy. Isolation restricts the movement of ill persons to help stop the spread of disease.

Medical Restriction – Medical restriction is used to separate and restrict the movement of well persons who may have been exposed to a communicable disease to see if they become ill. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms. Medical restriction can help limit the spread of disease.

N95 Respirator – An N95 respirator is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. The 'N95' designation means that when subjected to careful testing, the respirator blocks at least 95 percent of very small (0.3 micron) test particles.

Precautionary Lockdown - A precautionary lockdown is a temporary suspension of ordinary and routine activities. As a general rule, inmates are confined to their cell or dormitory. The warden in consultation with the medical department may consider implementing precautionary lockdown once a COVID-19 case occurs on a facility. Precautionary lockdown is generally continued for 10 days after the last reported positive test.

Routine Observation Periods:

- **Routine Intake Observation** – Routine intake observation is used to separate and restrict the movement of well persons who have no known exposure to a communicable disease to see if they become ill. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms. During routine intake observation, newly incarcerated persons are housed separately or as a group before being integrated into general housing. Routine intake observation can help limit the spread of disease.

- **Routine Release Observation** - Routine release observation is used to separate and restrict the movement of well persons who have no known exposure to a communicable disease to see if they become ill. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms. During routine release observation, persons who are waiting to be released are housed separately or as a group before being released into the community. Routine release observation may help limit the spread of disease.

Severely Immunocompromised - Patients with certain conditions that may cause a higher degree of immunocompromise are considered to be severely immunocompromised when informing decisions regarding the duration of medical isolation. This includes being on chemotherapy for cancer, being within one year from receiving a hematopoietic stem cell or
solid organ transplant, untreated HIV infection with CD4 count < 200, combined primary immunodeficiency disorder, and receipt of prednisone > 20mg per day for more than 14 days.

Physical Distancing – Physical distancing is the practice of increasing the space between individuals (ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic) and decreasing the frequency of contact to reduce the risk of spreading a disease. Physical distancing strategies can be applied on an individual level (e.g., avoiding physical contact and staying 6 feet apart), a group level (e.g., canceling group activities), and an operational level (e.g., rearranging chairs in clinics to increase distance between them).

Surgical Facemask – A surgical facemask is a disposable device that creates a physical barrier between the mouth and nose of the wearer and potential contaminants in the immediate environment. It is meant to help block large-particle droplets, splashes, sprays, or splatter that may contain germs (viruses and bacteria), keeping it from reaching your mouth and nose. Surgical facemasks may also help reduce exposure of your saliva and respiratory secretions to others. Surgical facemasks may also be referred to as isolation, dental or medical procedure masks.

Vaccination:
- **Fully Vaccinated** - Individuals are considered fully vaccinated when the primary vaccine series is completed which is two weeks after the second dose of a two-dose series vaccine or two weeks after the single-dose vaccine. However, fully vaccinated is not the same as having the best protection. Individuals are best protected when they are up to date on their vaccination which includes booster doses when eligible.
- **Up to Date Vaccination** - Individuals are up to date with COVID-19 vaccines when they have received all doses in the primary series and all boosters recommended, when eligible

**PROCEDURES:**

**I. INFECTION CONTROL**

A. Implement flexible prevention strategies based on COVID-19 community levels and facility-level factors such as vaccination coverage, transmission in the facility, risk of severe health outcomes, and facility structural and operational characteristics.

1. Facilities should apply strategies for everyday operations at all times during a COVID-19 outbreak.
2. Enhanced prevention strategies should be applied when community levels are medium or high or when facility-level factors indicate increased risk.
3. When enhanced prevention strategies are applied, risk of transmission and use of strategies should be weighed against impact on facility operations, mental health, and availability of services and programming
for inmates. Facilities may not be able to apply all enhanced prevention strategies due to local resources, facility and population characteristics, and other factors, but they should add as many as feasible.

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B. In preparation, staff should ensure there is sufficient stock on hand of hygiene supplies, cleaning supplies, personal protective equipment (PPE), medication, and medical supplies. This includes, but is not limited to, liquid soap, hand sanitizer, viral test kits and nasal swabs, surgical facemasks, N95 respirators, eye protection (goggles or face shields), gloves, and gowns.

C. During the COVID-19 outbreak, all units should follow standard infection control strategies:
1. Medical staff should educate inmates and staff on how COVID-19 is transmitted, signs and symptoms of COVID-19, treatment, and prevention of transmission (Attachment A).
2. Remind staff and inmates on the methods used to prevent the spread of any respiratory virus.
   a. Encourage handwashing with soap and water for at least 20 seconds (Attachment B). If soap and water is unavailable, hand
D. Cleaning and Disinfection
1. Detailed cleaning recommendations can be found in Infection Control Policy B-14.26 (Attachment D, Housekeeping/Cleaning).
2. Disinfect common areas and surfaces that are often touched with a 10% bleach solution. The bleach solution should be sprayed or wiped on and allowed to air dry for at least 10 minutes. The formula for the 10% bleach solution is:
   a. 8 oz. of powdered bleach to 1 gallon of water
   b. 12.8 oz. of liquid bleach to 1 gallon of water
3. Thoroughly clean and disinfect all areas where suspected or confirmed COVID-19 cases spent time. Staff and inmates performing cleaning should wear gloves and a gown.
4. Equipment
   a. Dedicated medical equipment should be used when caring for patients with suspected or confirmed COVID-19. Equipment should be cleaned and disinfected according to manufacturer’s recommendations.
   b. Non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer’s recommendations between each use.

E. Laundry
1. Launder items using the warmest appropriate water setting for the items and dry items completely if permissible according to the manufacturer’s instructions.
2. Laundry from medical isolation and medical restriction areas may be washed with other laundry.
F. Evaluate the need to expand the number of medications allowed to be distributed keep on person to minimize movement and reduce contact between different areas of the facility to prevent transmission.

G. Consider suspending co-pays for medical evaluations so inmates will not be hesitant to report symptoms of COVID-19 or seek medical care due to co-pay requirements. If suspended, inform inmates.

H. If the facility has the capacity & resources, consider implementing routine intake observation for all new intakes for 7 days before they enter the facility’s general population as a general rule not because they were exposed to COVID-19. Inmates that are close contacts of suspected or confirmed COVID-19 cases should be placed in medical restriction.
   1. Do not cohort individuals in medical restriction with individuals undergoing routine intake observation.
   2. The 7-day observation period begins on the day the last inmate is added to the observation group. All cohort members should begin the observation period on the same day when feasible.
   3. Asymptomatic individuals under routine intake observation, with no known exposure to a COVID-19 case, do not need to wear surgical facemasks while under observation.
   4. Staff supervising asymptomatic persons under routine intake observation, with no known exposure to a COVID-19 case, do not need to wear PPE.

I. Implement physical distancing strategies when enhanced prevention strategies are indicated and when feasible.
   1. Minimize contact with the community. Consider the impact of prolonged restrictions on the mental health and well-being of inmates when determining the length of the restrictions.
      a. Suspend contact visitation.
      b. Cancel group healthcare activities (e.g., group therapy) and other group activities (e.g., school and church).
      c. Restrict non-essential vendors, volunteers, and tours from entering the facility.
   2. Staff should avoid gatherings and meetings. Meet by teleconference or videoconference when feasible.
   3. Consider setting up a separate waiting area for inmates with suspected or confirmed COVID-19. At a minimum, ensure that inmates wear cloth face coverings or surgical facemasks and sit at least 6 feet from other inmates while waiting to be seen by healthcare staff.
   4. Schedule healthcare appointments to limit the number of inmates in waiting rooms.
   5. If possible and if space and resources permit, designate an area near
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housing units for healthcare staff to evaluate symptomatic individuals and individuals in medical restriction or isolation, rather than having individuals walk through the facility to be evaluated in the medical department.

6. Encourage increased space (6 feet apart) between individuals in lines (e.g., pill window).
7. Rearrange scheduled movements to minimize mixing of individuals from different housing areas (e.g., feed and shower inmates in cohorts by housing area).
8. Consider providing meals inside housing units or cells during precautionary lockdown.
9. Consider population reduction strategies such as suspension of intake.

J. Offer cloth face coverings and/or masks to inmates during a COVID-19 outbreak as part of the facility’s everyday prevention strategies. Cloth face coverings and/or masks should be used indoors in public spaces and medical areas when enhanced prevention strategies are indicated.

1. Face coverings should be worn at all times unless it restricts breathing or interferes with activities of daily living.
2. Face coverings are not a replacement for physical distancing, cleaning of frequently touched items, good hand hygiene, or proper use of PPE (e.g., N95 respirator or surgical facemask) when indicated or as recommended in policy.
3. Hands should be thoroughly washed before and after putting on a face covering.
4. Face coverings should fit snugly but comfortably against the side of the face and completely cover the nose and mouth.
5. Face covering should be removed by the elastics or straps from behind the ears. The eyes, nose and mouth should not be touched when removing a face covering.
6. Face coverings should be laundered when visibly soiled or at least daily. Machine wash and dry is preferred.

K. Minimize inmate movement and contact across housing units when enhanced prevention strategies are indicated.

1. Consider limiting transfers to other facilities unless necessary for healthcare evaluation and treatment, medical isolation, medical restriction, extenuating security concerns, release, or to prevent overcrowding. If a transfer is necessary, inmates should be screened for symptoms of COVID-19 before allowing them on transport vehicles.
2. Minimize intra-unit transfers unless necessary for healthcare evaluation and treatment, medical isolation, medical restriction, extenuating security concerns, or to prevent overcrowding.
3. Consider implementing a precautionary lockdown once a case occurs on
a facility to minimize inmate movement. Precautionary lockdown should be continued for 10 days after the last reported positive test.
4. Inmates should not be allowed to use dayrooms in housing areas unless all inmates using the day room are suspected or confirmed COVID-19 cases.
5. Inmates may go to the dining hall, work, commissary, recreation, etc., if they do not mingle with inmates from other housing areas during the process. They must be escorted when leaving the housing area.
6. Advise unit food captains to eliminate self-serve foods in dining halls.
7. When possible, limit entrance to essential staff only. If possible, staff should be assigned to a single facility, with limited assignments to other facilities only when necessary to provide essential safety, security, and services.
8. Once there are individuals with COVID-19 and when possible, staff should be given a duty assignment in the same area of the facility throughout the entire work shift to prevent transmission to other areas within the facility.
9. Once there are individuals with COVID-19 and when possible, consider postponing elective procedures, elective surgeries, and non-urgent specialty and outpatient visits.

L. Minimize transportation when enhanced prevention strategies are indicated.
1. In general, inmate transportation must be curtailed, except for movement that is absolutely required, such as for release, bench warrant, medical emergencies, etc.
2. If transport is necessary and unavoidable, inmates should be screened for symptoms of COVID-19 before allowing them on transport vehicles.
3. When inmates are transported during these conditions, they must be seated at least 3 feet apart.
4. An inmate who is in medical restriction or who is in isolation for COVID-19 (suspected or confirmed COVID-19 case) must wear a cloth face covering or surgical facemask outside of restricted and isolation areas including movement from isolation to transport, during transport, and until the final destination is reached at the receiving facility. These inmates must be transported by ambulance or van.
5. Multiple inmates who are under COVID-19 medical isolation may be transported in the same vehicle, but no non-isolated inmates (including inmates under medical restriction) may travel with them.
6. Multiple inmates from the same cohort who are under medical restriction may be transported in the same vehicle.
7. Staff or inmate attendants must wear surgical facemasks and gloves during transport unless the inmate area has separate ventilation from the staff area. Gowns and eye protection should be worn if direct or very close contact is expected. After all inmates have disembarked from the
transport vehicle, the seats and hand contact areas such as handrails must be cleaned and disinfected.

M. All newly arriving inmates including extraditions and those returning from bench warrant or reprieve into TDCJ, including private facilities or intermediate sanction facilities, must be screened by medical staff for symptoms consistent with COVID-19 infection (Attachment F).
   1. Inmates who are medically cleared upon provider evaluation will be released to continue the intake process.
   2. Inmates who have been exposed to COVID-19 but who are not yet ill (i.e., close contacts), will be placed under medical restriction for a minimum of 10 days.
   3. Inmates with positive screening findings will be referred to a provider for further evaluation.
   4. Inmates with confirmed or suspected COVID-19 shall immediately have a cloth face covering or surgical facemask placed and will be instructed to wash his or her hands. The inmate will be placed in medical isolation.
   5. Medical staff will notify the TDCJ intake security supervisor of all inmates placed under medical restriction or isolation, who will then notify the facility Warden and Classification Department.

N. Enhance ventilation in facilities when enhanced prevention strategies are indicated to help reduce viral particle concentration and risk of transmission. The combination of strategies used will vary based on facility-level characteristics, existing building ventilation systems, and resources.
   1. Open outdoor air dampers beyond minimum settings to reduce or eliminate HVAC air recirculation
   2. Open windows and doors, when weather conditions allow, to increase outdoor air flow.
   3. Use fans to increase air flow.
   4. Ensure ventilation systems are operating properly.
   5. Improve air filtration and make sure air filters are properly sized and replaced as needed.
   6. In buildings where the HVAC fan operation can be controlled, set the fan to the “on” position instead of “auto,” which will operate the fan continuously.
   7. Inspect and maintain exhaust ventilation systems in areas such as kitchens. These systems should be used when these spaces are occupied.
   8. Use portable high-efficiency particulate air (HEPA) fan/ filtration systems in higher risk areas such as a medical departments or areas frequently inhabited by people with a higher likelihood of having COVID-19 and/or an increased risk of getting COVID-19.
10. In non-residential settings, run the HVAC system at maximum outside airflow for 2 hours before and after the building is occupied.

O. Incorporate questions about new onset of COVID-19 symptoms into assessments of all patients seen by medical staff.

P. Consider screening patients in infirmaries for COVID-19 daily during precautionary lockdown.

Q. Units with inmates with COVID-19 should
   1. Institute droplet and contact precautions for inmates with COVID-19.
   2. Ensure that sick inmates do not expose other inmates without COVID-19 while in waiting rooms.
      a. Consider setting up a separate waiting area for inmates with COVID-19.
      b. Ensure that inmates with COVID-19 wear surgical facemasks and sit at least 6 feet from other inmates if possible while waiting to be seen by medical.
   3. Implement daily active surveillance for symptoms of COVID-19 among inmates and health care personnel until at least 2 weeks after the last confirmed case occurred.

R. TDCJ leadership, in coordination with the medical department, will identify an appropriate housing area to assign/cohort all inmates placed on medical restriction and/or isolation.

S. Inmates complaining of symptoms consistent with COVID-19 should be triaged as soon as possible. (Attachment E)
   1. Ensure surgical facemasks are available at triage for patients presenting with COVID-19 symptoms.
   2. If possible, symptomatic patients should be kept > 6 feet apart from asymptomatic patients.
   3. If inmates with an undiagnosed respiratory infection do not meet the criteria for suspected COVID-19, refer to recommendations in Infection Control Policy B-14-51 (Influenza-Like Illness) and do not house them with individuals with suspected COVID-19.

T. Inmates with suspected or confirmed COVID-19 as determined by medical should be placed in medical isolation.

U. Medical isolation
   1. All staff working in medically isolated areas and inmates who are placed in medical isolation, will be educated about early recognition of warning signs and rapid triage of patients with
worsening symptoms.

2. Isolation is for inmates with suspected or confirmed COVID-19 and are considered infectious.

3. Isolated inmates must be under droplet and contact isolation precautions.

4. Inmates should be single-celled (isolated) or may be cohorted (i.e., co-housed) with other inmates with COVID-19 if they cannot be single celled. If possible, suspected and confirmed COVID-19 cases should be kept separate.

5. If cohorted, each inmate’s isolation period is independent, so an inmate may be released from the isolation area even if other inmates in the area are still under isolation.

6. Inmates in medical isolation should be assigned to a dedicated bathroom when possible.

7. Symptomatic Inmates:
   a. Inmates should be kept in medical isolation until at least 24 hours have passed since last fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath) and at least 10 days have passed since symptoms first appeared.
   b. Isolated inmates under symptomatic medical isolation must be observed by medical personnel as often as clinically indicated to detect worsening illness or complications, but in any case, must be observed at least twice per day. Monitoring consists of a temperature check and verbal questioning of symptoms (e.g., cough and shortness of breath). Monitoring forms may be found on the CMCWEB (CMC WEB > TDCJ > SOPs > COVID-19 SOPs).

8. Asymptomatic Inmates:
   a. If inmates are found to have a positive COVID-19 surveillance test results and are otherwise asymptomatic, they should be placed in medical isolation.
   b. They should be single-celled (isolated) or may be cohorted (i.e., co-housed) with other asymptomatic, COVID-19 positive inmates if they cannot be single celled. They should be kept separate from symptomatic inmates if possible.
   c. They may be released from medical isolation after 10 days have passed since the collection date of the positive test.
   d. They must be monitored by medical personnel at least once per day including a temperature check and verbal questioning of symptoms (e.g., cough and shortness of breath). Monitoring forms may be found on the CMCWEB (CMC WEB > TDCJ > SOPs > COVID-19 SOPs).
   e. If they become ill or have symptoms, they should be made to
wear a surgical facemask and be kept at least 6 feet from others until moved to a designated housing or cohort group designated for symptomatic medical isolation. They must also be evaluated by medical staff as soon as practical.

9. Inmates in medical isolation should not be transferred from the facility during the isolation period, unless released from custody or a transfer is necessary for health care (e.g., medical or behavioral health), infection control, lack of quarantine space, or extenuating security concerns.

10. Inmates under isolation must wear a cloth face covering or surgical facemask if they are required to leave the isolation area.

11. Correctional and medical staff entering an isolation housing area must wear a surgical facemask and gloves. Gowns and/or face protection should also be worn if they anticipate direct or very close contact with ill inmates. Personal protective equipment must be removed when leaving the area and hands washed after removal.

12. Inmates in isolation must be fed with disposable trays and utensils. No items will be returned to the kitchen for cleaning or re-use.

V. Contact investigations will be conducted for close contacts of suspected or confirmed COVID-19 cases.

1. Investigations start from 2 days before illness onset for symptomatic patients or 2 days prior to positive test collection date until the time the case is placed in medical isolation.

2. Retesting and medical restriction is not recommended for asymptomatic close contacts who were previously diagnosed with COVID-19 within the last 90 days by either a positive test or a healthcare provider diagnosis based on symptoms.

3. Asymptomatic close contacts who were not tested should be placed in medical restriction for 10 days.

4. Symptomatic close contacts should be placed in medical isolation.

5. If traditional contact investigations are not feasible, TDCJ Health Services may choose to identify person as a close contact based on whether an individual spent time in the same location as an infected person.

W. Medical restriction

1. All staff working in medically restricted areas and inmates who are placed in medical restriction, will be educated about early recognition of symptoms, warning signs, and rapid triage of symptomatic patients.

2. Medical Restriction is used to separate and restrict the movement of well persons who have been exposed to COVID-19.

3. Inmates should be single-celled or may be cohorted (i.e., co-housed) with other inmates if they cannot be single celled. If possible, cohort
groups should be kept separate.
4. Inmates in medical restriction should be assigned to a dedicated bathroom when possible.
5. Inmates may be released from medical restriction if they have not developed symptoms 10 days after the last exposure during the index case’s infectious period.
6. Cohorted inmates should be kept under medical restriction (i.e., quarantine) as a cohort until 10 days after the last exposure to a case for everybody in the cohort.
7. If a group is cohorted due to a suspected case who is subsequently tested for COVID-19 and receives a negative result, the group may be released from medical restriction if they were not housed with another cohorted group.
8. If an individual who is part of a quarantined cohort becomes symptomatic:
   a. The 10-day quarantine clock for the remainder of the cohort must be reset to 0 if the individual is tested for COVID-19 and tests positive.
   b. The 10-day quarantine clock for the individual and the remainder of the cohort does not need to be reset if the individual is tested for COVID-19 and tests negative. This individual can return from medical isolation to the restricted cohort for the remainder of the quarantine period.
   c. The 10-day quarantine clock for the remainder of the cohort must be reset to 0 if the symptomatic individual is not tested for COVID-19.
9. Use of PPE
   a. Correctional and medical staff entering medically restricted housing areas must wear a surgical facemask and gloves. Gowns and/or face protection should also be worn if they anticipate direct or very close contact with ill inmates. Personal protective equipment must be removed when leaving the area and hands washed after removal.
   b. Inmates on medical restriction do not have to wear a surgical facemask (or cloth face covering) unless they must leave their housing area for some reason. They should be questioned about symptoms of COVID-19 before being taken from the housing area and be kept at least 6 feet from inmates from other housing areas as much as possible.
10. Medically restricted inmates may attend outdoor recreation and shower as a group. Areas used by them should be cleaned and disinfected before use by other inmates.
11. Medically restricted inmates may be fed on disposable trays in the housing area or may attend chow hall as a group. If fed in the chow hall,
II. PREVENT OR MINIMIZE COVID-19 INTRODUCTION FROM STAFF

A. Staff should self-screen for COVID-19 symptoms and exposure before reporting to work as a strategy for everyday operations at all times during a COVID-19 outbreak.

B. Security staff will screen all individuals entering the unit when enhanced prevention strategies are indicated.
   1. Before individuals enter a TDCJ location, they will have their temperature taken and will be asked about the presence of symptoms. If a fever is present or answered yes to symptom questions, the screening form will be completed (Attachment G).
   2. If the individual answers yes to fever or symptom questions, they will be sent home and will be required to submit a physician’s note stating they are clear of any symptoms of COVID-19 before being allowed to return to work.
   3. If the individual answers yes to being in contact with anyone who tested positive for COVID-19 or with symptoms of COVID-19, they will be sent home and not allowed to return to work without providing a physician’s note stating they are clear of any COVID-19 symptoms. Notification must also be made to the TDCJ Office of Emergency Management and the TDCJ Deputy Director of Health Services.

areas that may have been touched or otherwise contaminated must be disinfected before use by other inmates. Examples of such areas includes tables, benches, and tray rests.

12. Medically restricted inmates may work only if their job is essential and they will not mingle with non-medically restricted inmates while working or getting to or from the job location and must be screened for symptoms of COVID-19 at each turnout.

13. Medically restricted inmates should not be transferred from the facility during the 10-day restriction period, unless released from custody or a transfer is necessary for health care (e.g., medical or behavioral health), infection control, lack of quarantine space, or extenuating security concerns.

14. Inmates under medical restriction must be observed by medical personnel at least once per day including a temperature check and verbal questions of symptoms (e.g., cough and shortness of breath). Monitoring forms may be found on the CMCWEB (CMC WEB > TDCJ > SOPs > COVID-19 SOPs). If the inmate becomes ill or has symptoms, they should be made to wear a surgical facemask and be kept at least 6 feet from other inmates and staff and must be evaluated by medical staff as soon as practical.
C. Return-to-Work Criteria for Ill Staff
   1. Employees who are sick should stay home and should not report to work.
   2. If employees become sick at work, they should promptly report this to their supervisor and go home.
   3. In general, staff will be allowed to return to work based on a symptom-based strategy or a test-based strategy.
      a. A symptom-based strategy is preferred in most cases, since a test-based strategy may result in prolonged work exclusion of staff who continue to shed detectable virus but are no longer infectious.
         i. University staff should refer to their respective employer’s specific procedure for obtaining clearance to return to work.
         ii. Correctional staff may not return to work until at least 10 days have passed during routine operations or no sooner than 5 days have passed during crisis-level operations since symptoms first appeared and at least 24 hours have passed since last fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath).
      b. If a test-based strategy is used, staff may return to work if they provide a negative COVID-19 test result and a healthcare provider’s note releasing the employee to return to work. A test-based strategy may be considered for staff known to be severely immunocompromised if there are concerns that the individual is infectious for more than 20 days.
   4. To mitigate staff shortages when there is no longer enough staff to provide patient care and/or maintain safe operations, allow critical infrastructure and healthcare staff with suspected or confirmed COVID-19 who are well enough and willing to work but have not met all return-to-work criteria to work.
   5. After returning to work, staff should wear a surgical facemask for source control at all times while in the facility until all symptoms are completely resolved OR until 10 days after illness onset, whichever is longer. Staff should also self-monitor for symptoms and seek re-evaluation if symptoms recur or worsen.

D. Return-to-Work Criteria for Asymptomatic Staff that Tested Positive
   1. In general, staff that are not severely immunocompromised and have tested positive and are considered asymptomatic cases should be excluded from work until 10 days have passed during routine operations or no sooner than 5 days have passed during crisis-level operations since the collection date of the positive test assuming they have not subsequently developed symptoms. If symptoms develop, they should follow the instructions above for ill staff.
   2. In general, staff that are known to be severely immunocompromised and
have tested positive and are considered asymptomatic cases should be excluded from work until at least 10 days and up to 20 days have passed since the collection date of the positive test assuming they have not subsequently developed symptoms. If symptoms develop, they should follow the instructions above for ill staff.

3. Staff should refer to their respective employer’s specific procedure for obtaining clearance to return to work.

4. After returning to work, staff should wear a surgical facemask for source control at all times while in the facility until 10 days after positive test result. Staff should also self-monitor for symptoms and seek re-evaluation if symptoms occur.

E. Management of Exposed Staff

1. Staff that have had close contact with a suspected or confirmed COVID-19 case will be assessed for level of exposure to determine work restrictions.
   a. In general, staff with a high-risk exposure will be restricted from the workplace for 10 days after the last exposure and may return to work if remained asymptomatic.
   b. During crisis operations, asymptomatic staff that have had a high-risk exposure but are not known to be infected may continue to work as long as they remain asymptomatic, must wear a respirator or surgical mask at all times, should get tested at day 0 and 5 after last close contact if testing is available, and must self-monitor for symptoms of COVID-19 for 10 days following the exposure. If symptoms develop, staff must follow the return-to-work criteria for ill staff.
   c. Staff with exposures that are not considered high-risk will be allowed to continue to work as long as they remain asymptomatic.

2. To ensure continuity of operations of essential functions, critical infrastructure and healthcare staff that have a COVID-19 exposure may be permitted to continue to work provided they remain asymptomatic and additional precautions are implemented for 10 days after last exposure. Staff must wear surgical facemasks at all times while in the workplace and must be monitored for symptoms and temperature.

3. Staff should refer to their respective employer’s specific procedure for risk assessments and obtaining clearance to return to work.
III. RE-ENTRY AND RELEASE PROCEDURES

A. When enhanced prevention strategies are indicated, inmates will be placed in routine release observation for 7 days and tested before an inmate’s release date when possible. They will also be screened for COVID-19 symptoms and have a temperature check prior to release. If they are not cleared by the screening process, they will be placed in medical isolation and evaluated by healthcare staff for clearance.

B. All inmates will be released with a cloth face covering or surgical facemask.

C. The Re-entry and Integration Division will notify the Texas Department of State Health Services (DSHS) officials to ensure they are aware of the individual’s release and anticipated location.

D. Inmates in medical isolation will not be released until medically cleared.

E. Inmates in medical restriction that are leaving on parole will not be released until medically cleared.

F. Inmates in medical restriction that are state jail or flat discharges will be released. The Re-entry and Integration Division will ensure the individual receives a packet with instructions to self-quarantine and self-management.

G. Inmates awaiting results of facility-wide testing that are leaving on parole will not be released until medically cleared.

H. Inmates awaiting results of facility-wide testing that are state jail or flat discharges will be released. The Re-entry and Integration Division will ensure the individual receives a packet with instructions to self-quarantine and self-

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<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Exposure Category</th>
<th>Work Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff not wearing a N95 respirator or surgical facemask</td>
<td>High</td>
<td>Conventional Operations: Exclude from work for 10 days after last exposure and instruct staff to self-monitor for symptoms of COVID-19.</td>
</tr>
<tr>
<td>Staff not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or surgical facemask</td>
<td>High</td>
<td>Crisis Operations: No work restriction. Asymptomatic staff may continue to work, must wear a respirator or surgical mask at all times, should get tested at day 0 and 5 after last close contact if testing is available, and must self-monitor for symptoms of COVID-19 for 10 days following exposure.</td>
</tr>
<tr>
<td>Staff not wearing PPE (gown, gloves, eye protection, N95 respirator) while performing an aerosol-generating procedure</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

*Adapted from CDC guidance for managing healthcare personnel with exposure
management. The Re-entry and Integration Division will contact the individual and DSHS officials if results are positive.

IV. USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

A. The unit warden in consultation with the medical department should set up designated PPE donning and doffing areas outside spaces where PPE will be used to include trash disposal, hand washing station or access to alcohol-based hand sanitizer, and poster demonstrating the correct sequence for putting on and taking off PPE.

B. An alcohol-based waterless antiseptic hand rub should be carried by staff and used whenever there is concern that hands have become contaminated. The waterless hand rub may be used when handwashing is unavailable.

C. Offer surgical masks and/or N95 masks to staff during a COVID-19 outbreak as part of the facility’s everyday prevention strategies. Surgical masks and/or N-95 respirators should be used indoors in public spaces and medical areas when enhanced prevention strategies are indicated.

D. Inmates who are required to perform duties for which staff would wear PPE should be provided the same PPE for the job, except they must not have access to the waterless hand rub but must wash hands with soap and water instead.

E. Goggles or protective face shields should be worn when there is a likelihood of respiratory droplet spray hitting the eyes. Since these items are re-usable, they should be cleaned and disinfected between uses. Hands should be washed before donning or doffing goggles, to prevent inadvertent contamination of the eyes.

F. Medical and Security Staff should wear surgical facemasks if their responsibilities require them to remain less than 6 feet from a symptomatic individual or patient suspected with suspected COVID-19. Hands should be washed before donning or doffing surgical facemasks, to prevent inadvertent contamination of the nose and mouth.

G. Surgical facemask, gloves, gowns, and eye protection (face shield or goggles) should be worn when examining or providing direct care to inmates with suspected or confirmed COVID-19.

H. Unless contact inmate searches on general population would clearly involve contact with body fluids, gloves are unnecessary and handwashing between each search is adequate.

I. Gloves may be worn for contact inmate searches of medically restricted inmates.
Coronavirus Disease 2019 (COVID-19)

Gloves must be worn and changed between each search for contact searches on isolated inmates. Hands should be washed before donning or doffing gloves to prevent inadvertent contamination.

J. Security and Medical Staff should be educated on the appropriate sequence of putting on PPE (Attachment J). Proper hand washing should be performed prior to putting on PPE, before putting on gloves, before removing eye protection, and immediately after removal of all PPE. Hand hygiene should also be performed between steps if hands become contaminated.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Rooming Procedure in Medical</th>
<th>Staff PPE</th>
<th>Inmate Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td>Normal</td>
<td>• Gloves</td>
<td>At a least a cloth face covering/surgical facemask</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gown</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Eye protection (face shield or goggles)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgical facemask or N-95 respirator (only if surgical facemask is unavailable)²</td>
<td></td>
</tr>
<tr>
<td>Infirmary</td>
<td>Normal</td>
<td>• Gloves</td>
<td>At a least a cloth face covering/surgical facemask during transfer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gown</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Eye protection (face shield or goggles)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgical facemask or N-95 respirator (only if surgical facemask is unavailable)²</td>
<td></td>
</tr>
<tr>
<td>Medical Restriction Area</td>
<td>Normal</td>
<td>• Gloves</td>
<td>At a least a cloth face covering/surgical facemask outside of medical restriction area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgical facemask or N-95 respirator (only if surgical facemask is unavailable)²</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gowns and/or eye protection (face shield or goggles)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>should be worn only if anticipate direct or very close contact with ill inmates (e.g., temperature check)</td>
<td></td>
</tr>
<tr>
<td>Medical Isolation Area</td>
<td>Normal</td>
<td>• Gloves</td>
<td>At least a cloth face covering/surgical facemask outside of medical isolation area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgical facemask or N-95 respirator (only if surgical facemask is unavailable)²</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gowns and/or eye protection (face shield or goggles)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>should be worn only if anticipate direct or very close contact with ill inmates</td>
<td></td>
</tr>
<tr>
<td>Cleaning area of COVID-19 case or individuals in medical isolation or restriction</td>
<td>Not applicable</td>
<td>• Gloves</td>
<td>• Not applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gown</td>
<td></td>
</tr>
<tr>
<td>Transport Van</td>
<td>Not applicable</td>
<td>• Gloves</td>
<td>At least a cloth face covering/surgical facemask during transfer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgical facemask or N-95 respirator (only if surgical facemask is unavailable)²</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gowns and/or eye protection (face shield or goggles)</td>
<td>Not transported on a chain bus or MPV except for medical emergencies</td>
</tr>
</tbody>
</table>
### Table 3. PPE to Use While Caring for Patients with Suspected or Confirmed COVID-19

<table>
<thead>
<tr>
<th>Setting</th>
<th>Rooming Procedure in Medical</th>
<th>Staff PPE</th>
<th>Inmate Requirement</th>
</tr>
</thead>
</table>
| Procedural Setting (e.g., nebulizer high-flow oxygen, ventilation, intubation, CPR)¹ | Negative Pressure Room | • Gloves  
• Gown  
• Eye protection (face shield or goggles)  
• N-95 respirator | At least a cloth face covering/surgical facemask during transfer |

1. When performing procedure or care that may generate respiratory aerosols  
2. Surgical facemasks are being used as an acceptable alternative to N-95 respirator to conserve supplies and to create surge capacity (i.e., the ability to manage a sudden increase in patient volume that could severely challenge or exceed present supplies).

### V. TESTING

A. Testing is considered to be diagnostic when conducted for persons with symptoms consistent with COVID-19 or among asymptomatic individuals with known or suspected recent exposure to COVID-19 to control transmission, or to determine resolution of infection.

B. Testing is considered to be screening when conducted for asymptomatic individuals without known or suspected exposure to COVID-19 to prevent transmission.

C. In general, testing will be considered in the scenarios listed in Table 3.

### Table 4: Recommendations for Testing¹,²,³

<table>
<thead>
<tr>
<th>Testing Strategy</th>
<th>Testing Scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Test</td>
<td>Test persons with symptoms consistent with COVID-19 infection including fever³, cough, shortness of breath, chills, muscle pain, new loss of taste or smell, congestion, runny nose, nausea, vomiting, diarrhea, headache, and/or sore throat</td>
</tr>
<tr>
<td>Diagnostic Test</td>
<td>Test asymptomatic persons who are close contacts of a person with known or suspected COVID-19 (e.g., cellmate) regardless of their vaccination status at least 5 days after last close contact</td>
</tr>
<tr>
<td>Screening Test</td>
<td>Test asymptomatic persons without known or suspected exposure to COVID-19 prior to community visits including elective hospital admissions or procedures when enhanced prevention strategies are indicated</td>
</tr>
<tr>
<td>Screening Test</td>
<td>Test asymptomatic persons before their release date when enhanced prevention strategies are indicated</td>
</tr>
<tr>
<td>Screening Test</td>
<td>Test persons before transfer to a facility that houses inmates more likely to get very sick from COVID-19 when enhanced prevention strategies are indicated</td>
</tr>
</tbody>
</table>
Coronavirus Disease 2019 (COVID-19)

Screening Test | Test visitors and volunteers before entry is permitted when enhanced prevention strategies are indicated.
---|---
Screening Test | Test asymptomatic persons without known or suspected exposure who are prioritized by the TDCJ Office of Public Health, DSHS, or the Universities for any reason, including but not limited to, public health surveillance, when there is ongoing transmission, or when enhanced prevention strategies are indicated.

1. Adapted from CDC criteria for testing in correctional and detention facilities.
2. Retesting is not recommended if asymptomatic and tested positive within the last 90 days, since RNA may be detectable after risk of transmission has passed.
3. Fever may be subjective or confirmed.

D. Receipt of a COVID-19 vaccine will not affect the results of SARS-CoV-2 viral test.

E. Providers must indicate if the test is being ordered for a symptomatic or asymptomatic patient by ordering the appropriate test in the electronic health record:
   1. ASYMPTOMATIC SARS-COV-2-PCR/NAAT (COVID)
   2. SYMPTOMATIC SARS-COV-2-PCR/NAAT (COVID)

F. Diagnostic tests may be ordered per standing delegated order for public health monitoring (e.g., surveillance testing) or employee testing.

G. All positive and negative COVID-19 tests performed by TDCJ staff will be reported to facility medical staff for review and appropriate action.

VI. REPORTING

A. Daily reporting of COVID-19 to the TDCJ Office of Public Health by email or fax (936-437-3572) is required.

B. Each unit must complete a report (Attachment I).
   1. The daily COVID-19 log should be sent by 9:00 AM. The list is only for the 24-hour period ending at 6AM that morning. Units may submit logs over the weekend or may submit three logs on Monday morning.
   2. Reporting should continue until 2 weeks has lapsed since the last case.
   3. The subject line of the email should include, “[Unit] Name, COVID-19 Log, and the Date Sent (MM/DD/YYYY).”

VII. CLINICAL MANAGEMENT

A. Record proper diagnosis in the electronic health record for suspected COVID-19.
B. Vaccination remains the most effective way of preventing COVID-19 infection. COVID-19 vaccine that has received FDA approval or Emergency Use Authorization (EUA) should be offered per the recommendations from the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

C. Consider the use of oral COVID-19 therapies for eligible individuals. If logistical or supply constraints make it impossible to offer therapies to all eligible individuals, therapy should be prioritized for individuals at highest risk for progression to severe COVID-19. The groups listed below are listed in descending order of priority.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Risk Group</th>
</tr>
</thead>
</table>
| 1    | - Immunocompromised individuals regardless of vaccine status  
      |  - Unvaccinated individuals ≥ 75 years  
      |  - Unvaccinated individuals ≥ 65 years with additional risk factors |
| 2    |  - Unvaccinated individuals ≥ 65 years  
      |  - Unvaccinated individuals< 65 years with risk factors |
| 3    |  - Vaccinated individuals ≥ 75 years  
      |  - Vaccinated individuals ≥ 65 years with additional risk factors |
| 4    |  - Vaccinated individuals ≥ 65 years  
      |  - Vaccinated individuals< 65 years with risk factors |

† Adapted from NIH COVID-19 Treatment Guidelines.

D. Clinicians are encouraged to test for other causes of respiratory illness (e.g., influenza during flu season) if clinically indicated. However, testing should not delay COVID-19 testing since detection of another respiratory pathogen does not rule out COVID-19.

E. Most cases of symptomatic COVID-19 only require usual supportive care with fluids, analgesics, and rest. Acetaminophen (i.e., Tylenol) is the preferred antipyretic for treating fever in non-allergic COVID-19 patients considering its efficacy and safety. Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen may be considered.

F. Signs suggesting the need for a higher level of care include, but are not limited to, difficulty breathing, bluish lips or face, persistent pain or pressure in the chest, new confusion, and inability to wake or stay awake.

G. Inmates who are suspected of having COVID-19 must be placed in medical isolation. Laboratory proof is not required for isolation. The diagnosis of COVID-19 should be made on a clinical basis and testing performed.
H. Adherence to strict infection control measures must always be observed. Cases in an inpatient setting must be under droplet and contact isolation (see Infection Control Policy B-14.21).

I. During influenza season, vaccination against influenza is an important measure to prevent an illness that presents similarly to COVID-19. If there is influenza vaccine available, offer it to unvaccinated staff and inmates. This includes persons under routine intake observation.

1. Influenza vaccination may be deferred under certain circumstances.
   a. For persons in medical restriction, vaccination can be postponed until the quarantine period ends to prevent mild vaccination side effects from being mistaken for COVID-19 symptoms and to prevent potential exposure of COVID-19 to others.
   b. For persons in medical isolation, vaccination can be postponed until the period of isolation ends to prevent potential exposure of COVID-19 to others.

2. Side effects of the influenza vaccination include fever, chills, headache, and body aches, which should resolve within 72 hours of vaccination and should not be mistaken for COVID-19 symptoms. Influenza vaccination does not cause respiratory symptoms common in COVID-19 such as cough or shortness of breath.

VIII. DENTAL MANAGEMENT

A. In general, dental procedures will be prioritized based on urgency during a COVID-19 outbreak and non-emergent and elective visits and procedures will be delayed to prevent spread of disease.

B. Appointments will be scheduled apart to minimize possible contact with other patients in the waiting room when feasible.

C. Patients must be screened for fever and symptoms of COVID-19 prior to receiving dental care.
   1. Emergent dental care may be provided to patients without suspected or confirmed COVID-19 using strict adherence to universal precautions and use of PPE including surgical facemask, gloves, gowns, and eye protection. A N-95 respirator must be used while performing aerosol-generating procedures.
   2. Care should be delayed whenever possible if patients have fever or report symptoms of COVID-19 until the patient has recovered. A patient is considered recovered if at least 24 hours have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and at least 10 days have passed since symptoms
3. Emergent dental care may be provided to patients with suspected or confirmed COVID-19 using strict adherence to enhanced precautions. Do not schedule other patients at the same time and schedule the patient at the end of the day if possible.

D. If patients are not seen individually, dental chairs should be spaced at least 6 feet apart when feasible.

E. Patients should perform a pre-procedure rinse, if medically safe.

F. If aerosol-generating procedures are necessary, use four-handed dentistry and high evacuation suction to minimize droplet spatter and aerosols. Staff present during the procedure should be limited to only those essential for patient care and procedure support.

G. Only clean or sterile supplies and instruments needed for the dental procedure being performed should be accessible. All other supplies and instruments should be put away to prevent potential contamination. Any supplies and equipment that are exposed, but not used during the procedure, should be considered contaminated and should be disposed of or reprocessed properly after completion of the procedure.

H. The cleaning of autoclaves, instruments and other equipment should be performed according to the manufacturer’s instructions for use per routine cleaning, disinfection, and sterilization protocols.

I. Dental operatory must be cleaned and disinfected after each patient. Clean the operatory with a 10% bleach solution or an Environmental Protection Agency-registered, hospital-grade disinfectant. If the bleach solution is used, it should be sprayed or wiped on and allowed to air dry for at least 10 minutes.

**REFERENCES**


Coronavirus Disease 2019 (COVID-19)


For People Living in Prisons and Jails

Protect yourself from getting sick with COVID-19.

This resource contains recommendations for people in prisons and jails. CDC acknowledges it may be difficult to maintain physical distancing and avoid crowds in these settings.

Living in prisons and jails puts you at higher risk for getting COVID-19 because

- There may not be enough space to keep people with COVID-19 away from others.
- You may be sharing space with someone who has the virus and does not know it, because they do not show symptoms.
- Staff or visitors may have the virus and not know it.

About COVID-19

- Many people who have COVID-19 do not feel sick.
- People who feel sick may experience signs and symptoms that include:
  - Fever or chills
  - Cough
  - Shortness of breath or having a hard time breathing
  - Feeling tired
  - Muscle or body aches
  - Headache
  - New loss of taste or smell
  - Sore throat
  - Congestion (stuffy) or runny nose
  - Nausea or vomiting
  - Diarrhea

Take these steps to beat COVID-19

- Get a vaccine.
- Wear a mask.
- Physically distance as much as possible.
- Wash your hands.

Source: [CDC](https://www.cdc.gov/coronavirus)
Stop Germs! Wash Your Hands.

**When?**
- After using the bathroom
- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone at home who is sick with vomiting or diarrhea
- After changing diapers or cleaning up a child who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal feed, or animal waste
- After handling pet food or pet treats
- After touching garbage

**How?**

- Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
- Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails.
- Scrub your hands for at least 20 seconds. Need a timer? Hum the “Happy Birthday” song from beginning to end twice.
- Rinse hands well under clean, running water.
- Dry hands using a clean towel or air dry them.

Keeping hands clean is one of the most important things we can do to stop the spread of germs and stay healthy.

www.cdc.gov/handwashing
STOP THE SPREAD OF GERMS | COVID-19 |

- Get a COVID-19 vaccine.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash and wash your hands.
- Stay at least 6 feet (about 2 arm lengths) from other people.
- When in public, wear a mask over your nose and mouth.
- Do not touch your eyes, nose, and mouth.
- Clean and disinfect frequently touched objects and surfaces.
- Stay home when you are sick, except to get medical care.
- Wash your hands often with soap and water for at least 20 seconds.

cdc.gov/coronavirus
Visitors

WARNING

We are currently having cases of COVID-19 on this facility. This virus can cause severe disease in older adults 65 years and older, people who are obese, people who are a current or former smoker, people who are pregnant, and people with medical issues such as heart disease, chronic respiratory disease, chronic kidney disease, liver disease, diabetes, Down Syndrome, dementia, substance use disorders, high blood pressure, sickle cell disease, cancer, HIV, or weakened immune systems. If you are a member of one of these high-risk groups, you may not want to enter the unit at this time. If you do choose to enter the unit, you should observe the following precautions:

- Try to stay 6 feet away from other people as much as possible.

- Avoid shaking hands, hugging, or touching surfaces that get a lot of hand contact.

- Wash your hands often with soap and water for at least 20 seconds.

- Avoid touching your eyes, nose, or mouth without washing your hands before and afterward.

- Cover your cough or sneeze with a tissue, then throw the tissue in the trash and wash your hands.

- Wear a face covering over your nose and mouth.

- Do not enter and stay home if you are sick.
Patient is screened for symptoms of COVID-19.

Patient reports symptoms consistent with COVID-19?

Yes

1. Put surgical facemask on patient
2. Seat 6 feet from others if possible
3. Nursing wears PPE to assess patient (e.g., surgical facemask, gown, gloves, and eye protection)
4. Nursing triages patient ASAP for fever (≥100°F), cough, and shortness of breath

No

Follow usual triage procedures

Symptoms positive for COVID-19?

Yes

1. Put patient in private room
2. Provider evaluate patient as soon as possible
3. Staff wear PPE (e.g., surgical facemask, gown, gloves, & eye protection)
4. If provider suspects COVID-19, enter order for symptomatic SARS-COV2 PCR/NAAT (COVID)
6. Place in medical isolation and monitor twice a day pending lab results
7. Manage as clinically indicated and provide supportive care

No

Provide usual care

COVID-19 test positive?

Yes

- Manage as clinically indicated and provide supportive care. More severe symptoms suggesting the need for a higher level of care may include difficulty breathing, bluish lips or face, persistent pain or pressure in the chest, and new confusion or inability to arouse.
- Continue medical isolation per criteria in policy.
- Monitor in medical isolation at least twice a day including temperature and worsening respiratory symptoms.

No

Provide usual care based on final diagnosis
CORRECTIONAL MANAGED CARE
COVID-19 Health Screening Intake Form

Date: _____________________

Patient Name: ______________________________________________

DOB: ________________________________________________________

Facility: _____________________________________________________

1. Temperature:

| 100°F or above? | ☐ Yes | ☐ No |

2. Currently have or experienced any of the following symptoms in the last 48 hours: cough, SOB, fever, chills, muscle pain, fatigue, headache, sore throat, new loss of taste or smell, congestion, runny nose, nausea, vomiting, or diarrhea.

| ☐ Yes | ☐ No |

If Yes, document each symptom present:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

3. Had contact with a person known to be infected with COVID-19 or with fever, cough, or shortness of breath in the last 10 days?

| ☐ Yes | ☐ No |

If YES to any question, place a surgical facemask on the patient and separate from the rest of the intake group for additional screening and orders.

Medical Staff Signature ___________________________ Date ___________________________
This health screening form is an important first step to assist staff in maintaining the safety and health of TDCJ employees and inmates and should be used when employees report a positive COVID-19 test or symptoms consistent with COVID-19. Employees no longer need to quarantine when a close contact is identified, however they are required to rapid test on day five of their exposure and MUST wear an N95/KN95 mask for 10 days following exposure.

Clearly PRINT information below:

Name: ____________________________  Birthdate (mm/dd): ____________________________

Does the individual have:

<table>
<thead>
<tr>
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<th>Result</th>
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<tr>
<td>Fever 100°F or above?</td>
<td>□ Yes □ No</td>
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<td></td>
<td>If yes, temperature?</td>
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<tr>
<td>Cough, shortness of breath, feverish, chills, muscle pain, headache, sore throat, new loss of taste or smell, congestion, runny nose, nausea, vomiting, or diarrhea?</td>
<td>□ Yes □ No</td>
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If the individual answers yes to symptom questions regardless of vaccine status, they will be sent home and will be required to quarantine for 5 full days from the date of the positive test, or onset of symptoms. The employee may return to work after the 5-day quarantine, if symptoms are improving, but must wear a N95/KN95 mask for 5 days.

Has the individual:

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<td>*Had close contact with anyone who tested positive for COVID-19 in the last 10 days?</td>
<td>□ Yes □ No</td>
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<td>If yes, when?</td>
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<td>Recovered from COVID-19 infection within the past 90 days?</td>
<td>□ Yes □ No</td>
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<td>If yes, when?</td>
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If an asymptomatic individual answers yes to being in close contact with anyone who tested positive for COVID-19, they may continue to work if they remain symptom free, rapid test on day 5 of exposure, wear an N95/KN95 mask for 10 days following exposure, and self-monitor for symptoms for 10 days following the exposure.

If they become symptomatic or test positive, they will be sent home and will be required to quarantine for 5 full days from the date of the positive test, or onset of symptoms. The employee may return to work after the 5-day quarantine but must wear a N95/KN95 mask for 5 days.

Day 5 post exposure rapid test completed by: ____________________________  Date: ____________________________  Results: □ Positive □ Negative

Tests results must be entered into the CV2 application.

Notification will need to be made to Jennifer Carper, Chris Black Edwards, and Shannon Wood.

Staff completing COVID-19 Health Screening Form:

Name: ____________________________  Date: ____________________________

CONTACT INFORMATION:

Jennifer Carper, Dir. Emergency Management  936-437-6038 (Office)  jennifer.carper@tdcj.texas.gov
Chris Black-Edwards, Deputy Director  H5  936-437-4001 (Office)  chris.black-edwards@tdcj.texas.gov
Shannon Wood, Manager Employee Services  936-661-3844 (State Cell)  shannon.wood@tdcj.texas.gov
**Attachment H**

**COVID-19 LOG**

Completed forms should be emailed to the TDCJ Office of Public Health or faxed to 936-437-3572.

Unit Name: ____________________________

Report for new (not cumulative) patients with COVID-19 for 24-hour period beginning 6AM _____/_____/_____ to 6AM _____/_____/_____

Date* sent: _____/_____/_____

<table>
<thead>
<tr>
<th>Inmate Last Name</th>
<th>Inmate First Name</th>
<th>TDCJ Number</th>
<th>Unit of Assignment</th>
<th>Name of Laboratory to which Specimen was Submitted (e.g., Quest)</th>
<th>Collection Date</th>
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* On Monday morning, send 3 logs (one for each 24-hour period ending at 6AM)
Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

- Receive comprehensive training on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- Demonstrate competency in performing appropriate infection control practices and procedures.

Remember:

- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

Preferred PPE – Use N95 or Higher Respirator

- Face shield or goggles
- N95 or higher respirator
- One pair of clean, non-sterile gloves
- Isolation gown

Acceptable Alternative PPE – Use Facemask

- Face shield or goggles
- Facemask
- One pair of clean, non-sterile gloves
- Isolation gown

www.cdc.gov/coronavirus
**Donning (putting on the gear):**
More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. Identify and gather the proper PPE to don. Ensure choice of gown size is correct (based on training).
2. Perform hand hygiene using hand sanitizer.
3. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by another HC.
4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a face mask if a respirator is not available). If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or twisted. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store it in a pocket between patients.
   - Respirator: Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
   - Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. Put on face shield or goggles. When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. Put on gloves. Gloves should cover the cuff (wrist) of gown.
7. ECP may wear multitask patient gown.

**Doffing (taking off the gear):**
More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. Remove gown. Untie all ties (or unclip all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.
3. ECP may wear multitask patient gown.
4. Perform hand hygiene.
5. Remove face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. Remove and discard respirator (or facemask if used instead of respirator). Do not touch the front of the respirator or facemask.
   - Respirator: Remove the bottom strap by reaching only the strap and being careful over head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator. 
   - Facemask: Carefully unties (or unhooked from the face) and pull away from face without touching the front.
7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing re-use.

*Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate these practices.

www.cdc.gov/coronavirus
Respirator On / Respirator Off

When you put on a disposable respirator
Position your respirator correctly and check the seal to protect yourself from COVID-19.

- Cup the respirator in your hand. Hold the respirator under your chin with the nosepiece up. The top strap (on single or double strap respirators) goes over and rests at the top back of your head. The bottom strap is positioned around the neck and below the ears.
- Place your fingertips from both hands at the top of the metal nose clip if present. Slide your fingers down both sides of the metal strip to mold the nose area to the shape of your nose.
- Place both hands over the respirator, take a quick breath in to check the seal, breathe out. If you feel a leak when breathing in or breathing out, there is not a proper seal.
- Select other PPE items that do not interfere with the fit or performance of your respirator.

- Do not use a respirator that appears damaged or deformed, no longer forms an effective seal to the face, becomes wet or visibly dirty, or if breathing becomes difficult.
- Do not allow hair, facial hair, jewelry, glasses, clothing, or anything else to prevent proper placement or to come between your face and the respirator.
- Do not cross the straps.
- Do not wear a respirator that does not have a proper seal. If an leak is in or out, ask for help or try a different respirator model.
- Do not touch the front of the respirator during or after use! It may be contaminated.

When you take off a disposable respirator

- Remove by pulling the bottom strap over back of head. Follow the top strap, without touching the respirator.
- Discard in a waste container.
- Clean your hands with alcohol-based hand sanitizer or soap and water.

Employee must comply with the OSHA Respiratory Protection Standard, 29 CFR 1910.134, which includes medical evaluations, training, and fit testing.

Additional information is available about how to safely put on and remove personal protective equipment, including respirators:

cdc.gov/coronavirus
Facemask Do's and Don'ts

For Healthcare Personnel

When putting on a facemask
Clean your hands and put on your facemask so it fully covers your mouth and nose.

- **DO** secure the elastic bands around your ears.
- **DO** secure the tie at the middle of your head and the base of your head.

When wearing a facemask, don’t do the following:

- **DON’T** wear your facemask under your nose or mouth.
- **DON’T** allow a strap to hang down. **DON’T** cross the straps.
- **DON’T** touch or adjust your facemask while wearing it.
- **DON’T** wear your facemask on your head.
- **DON’T** wear your facemask around your neck.
- **DON’T** wear your facemask around your arm.

When removing a facemask
Clean your hands and remove your facemask touching only the straps or ties.

- **DO** leave the patient care area, then clean your hands with alcohol-based hand sanitizer or soap and water.
- **DO** remove your facemask touching ONLY the straps or ties, throw it away, and clean your hands again.

Additional information is available about how to safely put on and remove personal protective equipment, including facemasks: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppes.html.

cdc.gov/coronavirus

Facemask Do's and Don'ts