

Coronavirus COVID-19: Guidance for Correctional Facilities and Detention Centers

This guidance provides COVID-19 prevention recommendations for correctional facilities and detention centers. The following measures should be taken to reduce the risk of introducing and transmitting COVID-19 among residents, employees, contract and agency staff, and visitors to facilities. DC Health recognizes that facilities can vary widely in size and physical space considerations, staffing resources, population served, medical resources, operations, and other conditions. These recommendations address general best practices in correctional/detention settings.

General Information

Correctional/detention facilities are at higher risk for COVID-19 transmission, and outbreaks in these settings can be difficult to control. Multiple factors can contribute to increased risk in correctional/detention facilities including: large numbers of people living and working in close proximity, high turnover of people, and space constraints (which can impact the ability to effectively quarantine and medically isolate individuals). Conducting accurate contact tracing can also be challenging in correctional settings. Administrators of correctional facilities should take into consideration the measures below to provide a safe workplace and a safe environment for the people served in their facility.

Multiple layered prevention measures should be employed to prevent COVID-19 in correctional/detention facilities. No individual measure is foolproof, but when used together they are very powerful. Even if COVID-19 does get into your facility, the use of these measures can contain the virus. They include:

- **Vaccination**
- **Wearing face masks (or cloth face coverings as appropriate)**
- **Universal eye protection for correctional staff**
- **Social distancing**
- **Hand hygiene**
- **Preventing sick staff or visitors from entering the facility**
- **Contact tracing, quarantine, and medical isolation**
- **Cleaning and disinfection**

How COVID-19 spreads

- The main way COVID-19 spreads is from person-to-person when an infected person breathes out droplets and particles that contain the virus.
 - People can become sick with COVID-19 by breathing in infected air, being splashed or sprayed in their eyes, nose, or mouth with infectious droplets (e.g., from a cough), or touching their eyes, nose or mouth with hands that have the virus on them.
- People who are 6 feet or closer to the infected person are most likely to get sick.
- COVID-19 can sometimes spread between people in the air over longer distances, especially in crowded indoor settings with poor ventilation.
- COVID-19 can also spread from environmental surfaces, but this is uncommon.

COVID-19 PREVENTION FUNDAMENTALS

COVID-19 Vaccination

It is important for staff of correctional facilities and residents get vaccinated against COVID-19. COVID-19 vaccines are safe and effective at keeping people from getting COVID-19. They are also very effective at preventing people from needing to be hospitalized or dying if they do get sick with COVID-19. There is growing evidence that the vaccines also prevent spread of the virus from infected people who are not showing symptoms. People who are unvaccinated remain at higher risk for catching COVID-19 and need to take more precautions than people who are vaccinated. **People are considered fully vaccinated 14**

days after completion of a COVID-19 vaccination series (after the second dose of a 2-dose series, or after one dose of a single-dose vaccine).

Facility administrators should strongly encourage staff and residents to get the vaccine.

- Consider providing creative incentives for staff and residents to get vaccinated.
- Support staff in getting vaccinated by providing leave options for them to get the vaccine and if they experience vaccine side effects.
- For residents who are released from custody before getting the second dose of a 2-dose vaccine series, incorporate linkage to a vaccination site into release planning.
- Find out more about the COVID-19 vaccine at coronavirus.dc.gov/vaccine.

Masks Requirements for Correctional Staff and Residents

- **Staff and residents at correctional facilities/detention centers must continue to wear masks or cloth face coverings, regardless of vaccination status.** This is necessary due to the higher risk nature of correctional settings. Masks protect the wearer and protect other people.

Universal masking for staff

- All staff must wear a face mask while in the facility. Cloth face coverings are an option for staff in non-resident areas (e.g., administrative offices).
- Staff must wear masks at all times unless they are eating, drinking, or alone in a private office. Fully vaccinated¹ staff are not required to wear a mask while outdoors.
- **Staff providing medical care** to residents must follow guidance for **Required Personal Protective Equipment (PPE) for Healthcare Facilities** at coronavirus.dc.gov/healthguidance.
- Staff must be provided with masks, eye protection and any other PPE required for their job duties.

Masks or cloth face coverings for residents

- Residents must wear masks or cloth face coverings.
 - Residents must wear masks at all times unless they are alone in a cell, eating, drinking, bathing, or sleeping.
 - Fully vaccinated residents are not required to wear a mask while outdoors. Unvaccinated residents must wear a mask and maintain social distance indoors and outdoors.
 - Provide masks/cloth face coverings at no cost to residents and launder cloth face coverings routinely.
 - Clearly explain the purpose of masks to residents.
 - Face masks/cloth face coverings must not be placed on anyone unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

Eye Protection for Correctional Staff

- Staff must wear eye protection:
 - While interacting with someone who is:
 - Under medical isolation for suspected or confirmed COVID-19 infection.
 - Under quarantine after COVID-19 exposure or as part of facility intake protocol.
 - During interactions or care activities when there is anticipated splashes, sprays, or splatters (i.e. standard precautions).
 - As required by transmission-based precautions.

Acceptable eye protection consists of goggles or a disposable face shield that fully covers the front and sides of the face and fits snugly from the corners of the eye across the brow

¹ This mask exemption does not apply to fully vaccinated immunocompromised residents, as it is not yet established that the COVID-19 vaccine provides full protection to immunocompromised people.

Social distancing

Social distancing is still recommended as an effective strategy to help mitigate the spread of COVID-19 with the following considerations:

Staff

- Encourage staff to maintain a distance of 6 feet from other staff members and visitors in the correctional/detention facility, particularly when face masks must be removed, like when eating or drinking. Staff should also maintain a distance of 6 feet when interviewing, escorting, or interacting with residents when feasible and consistent with security priorities.
- Modify staff duty assignments to avoid movement between housing units.
 - It is important for staff members to maintain a consistent duty assignment in the same area of the facility across shifts as much as possible, to help prevent transmission of COVID-19 across different facility areas.
 - Where feasible, consider the use of telemedicine to evaluate persons with COVID-19 symptoms² and other health conditions to limit the movement of healthcare staff across housing units.

Residents

- Limit transfers into and out of the facility as much as possible, except as necessary (e.g., medical evaluation, release from custody, if space constraints necessitate transfer for medical isolation or quarantine, to relieve overcrowding, extenuating security concerns).
- Consider suspending work release programs temporarily.
- Consider implementing alternatives to in-person court appearances, as lawful and appropriate.
- Minimize mixing of individuals from different housing units.
- Social distancing strategies will need to be tailored to the available space in the facility and the needs of the population and staff. Examples of social distancing strategies with varying levels of intensity include:
 - Common areas:
 - Enforcing increased space between individuals in holding cells as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area).
 - Recreation and group activities:
 - Choosing recreation spaces (such as outdoor spaces) where individuals can spread out.
 - Restricting recreation space usage to a single housing unit per space (where feasible).
 - Staggering time in recreation spaces.
 - Limiting the size of group activities and increasing space between individuals during group activities.
 - Suspending group programs where participants are likely to be in closer contact than they are in their housing environment.
 - Considering alternatives to existing group activities.
 - **NOTE: Facilities may elect to offer group activity/recreation sessions open only to fully vaccinated residents who are not immunocompromised. During these sessions, residents do not need to social distance. Staff supervising these activities must also be fully vaccinated.**
 - Meals:
 - Staggering meals in the dining hall (one housing unit at a time).

² Symptoms of COVID-19: may include fever (subjective or 100.4 degrees Fahrenheit), chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, or otherwise feeling unwell.

- Rearranging seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table).
- Providing meals inside housing units or cells.
- Housing:
 - If space allows, reassigning bunks to provide more space between individuals, ideally 6 feet or more in all directions. Ensure that bunks are cleaned thoroughly if assigned to a new occupant.
 - Arranging bunks so that individuals sleep head to foot to increase the distance between their faces.
 - Minimizing the number of individuals housed in the same room as much as possible.
 - Rearranging scheduled movements to minimize mixing of individuals from different housing areas.
- Work details:
 - Modifying work detail assignments so that each detail includes only individuals from a single housing unit.
- Medical:
 - If possible, designating a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering individuals' sick call visits.
 - Staggering pill lines, or staging pill lines within individual housing units.

Hygiene

- Encourage frequent hand hygiene with soap and water. If soap and water are not available, use hand sanitizer with at least 60% alcohol.
 - Soap and water should be used whenever hands are visibly dirty and after using the restroom.
- Consider providing alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.
 - Consider allowing staff to carry individual-sized bottles of hand sanitizer to maintain hand hygiene.
 - Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting, where security concerns allow.
- Placing hand sanitizer dispensers at facility entrances/exits and in PPE donning/doffing stations is strongly recommended.
- **It is recommended that residents and staff have no-cost access to:**
 - **Soap.** Liquid or foam soap where possible. If bar soap is used, individuals are not recommended to share bars of soap.
 - **Running water, and hand drying machines or disposable paper towels** for hand washing.
 - **Tissues** and (where possible) no-touch trash receptacles for disposal.
- Reinforce healthy hygiene practices.
 - Provide hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entrances and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms). Restock supplies regularly
 - Communicate that sharing drugs and drug preparation equipment can spread SARS-CoV-2 due to potential contamination of shared items and close contact between individuals.

PREVENT INTRODUCTION OF COVID-19 INTO THE FACILITY

Facility Entry

- **Facilities must perform verbal screening (e.g., symptom questionnaires) and temperature checks of incarcerated persons/residents, staff, volunteers, and visitors**, prior to entering the facility, over the phone or in person. Verbal screening must also be performed for residents who are transferred from another facility before the resident leaves the facility.
 - For Screening Tool Guidance, visit coronavirus.dc.gov/healthguidance.
 - Instruct visitors to postpone their visit if they have COVID-19 symptoms.
 - Inform visitors before they travel to the facility that they should expect to be screened and will be unable to enter the facility if they decline or do not clear the screening process.
- **Staff or visitors who report COVID-19 symptoms or testing positive for COVID-19 must not enter the facility.**
- Consider restricting non-essential vendors and volunteers from entering the facility.
- Facilities must maintain a daily record of those entering the facility for at least 30 days to facilitate contact tracing.
 - Information collected must include name, date and time of visit, phone number, and email (if available).
 - This information must be provided within 24 hours if requested by DC Health if a case of COVID-19 occurs at your facility, in order to assist with contact tracing.

Intake Testing of Residents

Intake testing of incoming residents is an important tool to prevent COVID-19 from being introduced into a facility.

- **Procedures must be in place for COVID-19 intake testing for all incoming residents to the facility, regardless of a previous stay, including residents returning to a facility after more than 24 hours away.**
 - Testing is recommended for all residents arriving to a facility except those who have:
 - recently tested positive for COVID-19 and are completing their medical isolation
 - recently recovered from a confirmed COVID-19 infection within the last 90 days
 - been fully vaccinated
- **Facilities must verify vaccination status/history of COVID-19 before deferring testing.**
 - Acceptable forms of verification include:
 - Documentation in the medical record
 - Documentation from a previous correctional facility
 - Centers for Disease Control and Prevention (CDC) vaccination card
 - **Verbal statement of vaccination must not be accepted.**
- **Either NAAT (nucleic-acid amplification tests)/PCR or antigen tests may be used for intake screening of asymptomatic residents.**
 - Residents who test negative or have pending results must enter intake quarantine
 - Residents who test positive must enter medical isolation (see *Isolation recommendations for individuals with confirmed or suspected COVID-19* below)
 - **If antigen tests are used, positive results must be confirmed with a NAAT/PCR test.** The resident must be treated as a presumptive positive and be placed in a private room in isolation until confirmatory results return.
- **If a resident refuses COVID-19 testing**, facilities must document refusal to test.
- For additional information about COVID-19 testing considerations in correctional/detention facilities, see *Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities* at cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html

Intake quarantine

Intake quarantine is the practice of routinely quarantining asymptomatic **incoming residents** at intake

for 14 days before they enter the facility’s general population, even with no known history of exposure. Intake quarantine is a tool to prevent the introduction of COVID-19 into a new facility.

- **All incoming residents to a facility, regardless of a previous stay, including residents returning to a facility after more than 24 hours away, must be placed on intake quarantine.**
 - Intake quarantine is recommended for all residents arriving to a facility except those who have:
 - recently recovered from a confirmed COVID-19 infection within the last 90 days
 - been fully vaccinated
 - Facilities must verify vaccination status/history of COVID-19 before deferring intake quarantine as outline in *Intake Testing of Residents* section above.
 - Facilities must ensure that residents on intake quarantine keep their movements outside the quarantine space to a minimum, to minimize exposure to other residents.
 - Exclude residents on intake quarantine from all group activities.
 - Residents on intake quarantine should have dedicated bathroom facilities.
 - Serve meals inside the quarantine space, if possible.
 - Consider retesting residents every 3 to 7 days while they are on intake quarantine.
 - Newly arrived residents should be monitored closely for 14 days regardless of test results as a negative result does not guarantee a resident is free from COVID-19.
 - **Do not group residents who are on routine intake quarantine with residents quarantining because of close contact³ exposure to someone with COVID-19**, due to increased risk of transmission of infection from infected to uninfected residents.
 - Residents on intake quarantine should be monitored daily for symptoms of COVID-19.
 - Consider retesting residents every 3 to 7 days while they are on intake quarantine.
- While awaiting intake testing results, residents should be placed in private cells if possible and staff should wear all recommended COVID-19 personal protective equipment (PPE). More details on PPE can be found on pages 12 -14 of this document.
- If a resident refuses COVID-19 testing, the resident should be kept on quarantine for 14 days from date of admission and staff should use the appropriate.
 - Frequently monitor and perform symptom screening for residents who refuse testing. (i.e., at least twice per shift)

MANAGEMENT OF COVID-19 WITHIN THE FACILITY

Isolation recommendations for individuals with confirmed or suspected COVID-19

Residents who test positive must enter medical isolation. Staff who test positive must isolate until they meet criteria for ending home isolation. Facilities should perform contact tracing for any positive residents, staff member, or visitor to determine if individuals in the facility may have been exposed and must quarantine. For more information, see *First Steps for Businesses when an Employee or Patron Tests Positive for COVID-19* at coronavirus.dc.gov/healthguidance.

Staff

- Staff who have confirmed COVID-19 must not return to work until they meet criteria for ending home isolation. For most people, isolation can be discontinued 10 days after onset of symptoms (or 10 days after positive test date for people with asymptomatic infection). For more information see *Guidance for Persons who tested Positive for COVID-19* at coronavirus.dc.gov/healthguidance.

³ A close contact is someone who was within 6 feet of an infected person for at least 15 minutes cumulatively over a 24-hour period, starting from 2 days before illness onset (or for asymptomatic infected people, 2 days prior to positive test collection) until the time the infected person is isolated.

Residents

- As soon as a resident develops symptoms or tests positive, they must be given a mask (if not already wearing one), immediately placed on medical isolation in a single cell (preferably), and medically evaluated.
- Ensure that isolation for possible or confirmed COVID-19 is operationally distinct from punitive solitary confinement. Staff should be instructed to refer to this as “medical isolation” to avoid confusion.
- **Residents on medical isolation should be a priority group for individual cells.**
 - If necessary, facilities may house residents with **confirmed** COVID-19 as a cohort⁴.
 - **Do not** mix residents with confirmed COVID-19 and residents with suspected COVID-19 (in whom the diagnosis is not confirmed), or with residents who are on quarantine.
 - **Do not** cohort residents with suspected COVID-19. They must medically isolate in individual cells. If they subsequently test positive, they may then be moved to a confirmed COVID-19 cohort medical isolation area, if necessary.
 - **Mixing cohorts is not acceptable due to high risk of transmission from infected to uninfected residents.**
 - If cohorting residents with confirmed COVID-19:
 - Use one large well-ventilated space with solid walls and door that closes fully for cohorted medical isolation rather than small spaces.
 - Ensure that all individuals wear a mask whenever anyone else (including staff) enters the medical isolation space.
- Minimize resident movements outside the medical isolation space.
 - Provide medical evaluation to medically isolated residents inside the medical isolation space, unless they need to be transferred to a healthcare facility.
 - Serve meals inside the medical isolation space.
 - Exclude medically isolated residents from all group activities.
 - Ideally, provide private bathrooms for residents on medical isolation. Prioritize private bathrooms for residents with suspected COVID-19. If private bathrooms are not possible, at minimum designate separate bathroom facilities for use by:
 - Residents with confirmed COVID-19
 - Residents with suspected COVID-19
- Clean and disinfect areas used by residents on medical isolation areas frequently.
- Avoid transferring to another facility unless necessary for medical care.
- Staff assignments to medical isolation spaces should remain as consistent as possible, and these staff should limit their movements to other parts of the facility as much as possible. **Avoid the use of unvaccinated staff in medical isolation spaces if possible.**
 - If staff must serve multiple areas of the facility, ensure that they change PPE when leaving the medical isolation space. If a shortage of PPE supplies necessitates reuse, ensure that staff move only from areas of low to high exposure risk while wearing the same PPE, to prevent cross-contamination.
 - Required PPE is addressed on page 12 and 14 of this guidance.
- Provide residents on medical isolation with tissues and, if permissible, a lined no-touch trash receptacle. Instruct them to:
 - Cover their mouth and nose with a tissue when they cough or sneeze.
 - Dispose of used tissues immediately in the lined trash receptacle.
 - Wash hands immediately with soap and water for at least 20 seconds.

⁴ Cohorting refers to the practice of isolating multiple individuals with laboratory-confirmed COVID-19 together or quarantining close contacts of an infected person together as a group due to a limited number of individual cells.

- For most people, medical isolation can be discontinued 10 days after onset of symptoms (or 10 days after positive test date for people with asymptomatic infection). For more information about duration of medical isolation for residents, refer to the following CDC guidances:
 - *Ending Home Isolation for Persons with COVID-19 Not in Healthcare Settings* at [cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html)
 - *Interim Guidance on Ending Isolation and Precautions for Adults with COVID-19* at [cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcommunity%2Fstrategy-discontinue-isolation.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcommunity%2Fstrategy-discontinue-isolation.html)

Quarantine recommendations for close contacts of a confirmed case of COVID-19

Close contact quarantine is the process of separating individuals **who have been exposed to COVID-19** in case they develop symptoms of infection or test positive, for the duration of time that covers the incubation period of COVID-19 (14 days). Close contact quarantine is a tool to prevent the transmission of COVID-19 within a facility.

Staff

- Exposed staff members/volunteers who do not meet quarantine exemption criteria must complete a full 14-day quarantine before returning to work.
 - Testing negative during the quarantine period does not exempt staff from having to complete the full 14-day quarantine (e.g., there is no “testing out of quarantine”).
 - Quarantine is required regardless of whether a staff member is an essential worker.

Residents

- Exposed residents who do not meet quarantine exemption criteria must complete a full 14-day quarantine.
- Facilities should monitor residents on quarantine for COVID-19 symptoms at least daily.
- Avoid the use of unvaccinated staff in quarantine spaces.
- Close contacts may quarantine in individual cells, or if necessary, can be cohorted with other close contacts.
 - **Do not cohort residents who are quarantining because of close contact exposure to COVID-19 with residents on other types of quarantine (e.g., routine intake, transfer, or release quarantine), due to risk of transmission from infected to uninfected residents.**
 - Facilities must ensure that residents on quarantine keep their movements outside the quarantine space to a minimum.
 - Provide medical evaluation to quarantined residents inside the quarantine space, as much as possible
 - Serve meals inside the quarantine space.
 - Exclude quarantined residents from all group activities.
 - Quarantined residents should have dedicated bathroom facilities.
 - **If any cohorted close contacts develop symptoms or test positive for COVID-19 during the quarantine period, they must be immediately removed from the cohort group and placed on medical isolation.**

Quarantine exemption criteria

- **Staff and residents who are fully vaccinated, or who have a history of confirmed COVID-19 and recovery within the past 90 days, are not required to quarantine or be excluded from work after exposure to a person with COVID-19.**
 - Fully vaccinated staff or residents are not required to quarantine but must monitor symptoms for 14 days, and should be tested 3 to 5 days after exposure.
- For more information, please see the following guidances at coronavirus.dc.gov/healthguidance:

- *Guidance for Fully Vaccinated People*
- *Guidance for Quarantine after COVID-19 Exposure*

PREVENTING TRANSMISSION OF COVID-19 FROM THE FACILITY

Routine screening testing and quarantine for residents leaving a facility

- Facilities must perform a verbal screening and temperature check, and are recommended to implement screening testing and when possible 14-day quarantine of asymptomatic residents:
 - **Before transfer to another facility**
 - **Before a visit to the community (e.g., court appearance, external medical trips)**
 - **Before release from custody.**
- **Fully vaccinated residents and residents with a history of COVID-19 and recovery within the last 90 days are exempt from these requirements.**
- When a resident is being released from custody, routine screening testing and quarantine is particularly important when release is to another congregate setting (such as transitional housing or a homeless shelter), or to a household that contains person (s) at increased risk for severe COVID-19.
 - **Transfer quarantine** is the practice of routinely quarantining asymptomatic residents who are **transferring to another correctional/detention facility** for the 14 days preceding the transfer date. Transfer quarantine is a tool to prevent the transmission of COVID-19 between facilities.
 - **Release quarantine** is the practice of routinely quarantining residents who are either being **released from custody or for a visit to the community** (e.g. for a medical trip, for a court appearance), for the 14 days preceding the release date. Release quarantine is a tool to prevent the transmission of COVID-19 between the facility and the community.
- Either NAAT (nucleic-acid amplification tests)/PCR or antigen tests may be used for release/transfer screening testing of asymptomatic residents. If an antigen test is used, positive results must be confirmed with a laboratory based NAAT(PCR) test.
 - Test as close to the transfer/release date as possible.
 - Wait for a negative test result prior to transfer to another facility, or community visit.
 - If a resident must be released from custody prior to a test result, ensure there is a process in place to follow up on test results, and notification for positive test results.
- If a resident refuses COVID-19 testing, facilities must document refusal to test.
 - Frequently monitor and perform symptom screening for residents who refuse testing. (i.e.: At least twice per shift).
- Facilities may cohort residents on transfer or release quarantine, if necessary.
 - Facilities must ensure that residents keep their movements outside the quarantine space to a minimum, to minimize exposure to other residents.
 - Exclude residents from all group activities.
 - Residents should have dedicated bathroom facilities.
 - Serve meals inside the quarantine space, if possible.
 - Do not group residents who are on transfer or release quarantine with residents on intake quarantine or on quarantine because of close contact exposure to someone with COVID-19, due to increased risk of transmission of infection from infected to uninfected residents.

Release or transfer of residents who have not yet completed medical isolation for COVID-19 or quarantine for exposure to a confirmed case of COVID-19

- Except when necessary to provide medical attention, **transfers** to other facilities should be delayed until the resident has completed their medical isolation (for positive COVID-19 result) or close contact quarantine (for exposure to a known COVID-19 positive individual). If transfer is required, receiving facility must be notified prior to departure.

- Residents who are being **released** from custody who have a positive COVID-19 test result or had an exposure to a known individual with COVID-19, and who have not yet completed their medical isolation or quarantine period, should be provided educational materials in a format that is easy to understand (e.g., plain language, primary language) that include at minimum the following:
 - Self-monitoring instructions.
 - Specific information about how long self-isolation or self-quarantine should last.
 - Information on how to self-isolate or self-quarantine.
 - For persons who had an exposure to a known individual with COVID-19, resources and instruction on when to get tested for COVID-19.
 - Further details can be found at coronavirus.dc.gov/healthguidance in the following DC Health guidance:
 - *Guidance for Persons Who Tested Positive for COVID-19,*
 - *Guidance for Close Contacts of a Person Confirmed to have COVID-19,*
 - *Guidelines for Household Members, Intimate Partners, and Caregivers of a Person Confirmed to have COVID-19.*
- **Transportation** for all residents who have a positive COVID-19 test result or had an exposure to a known individual with COVID-19, must be provided by medical transport or other properly equipped private vehicle.
 - Public transportation or ride shares must not be used.
 - For additional information on considerations for vehicle type, air circulation, and cleaning the vehicle after transport, visit cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html.

ADDITIONAL OPERATIONAL CONSIDERATIONS

Staff Considerations

- **Actively encourage staff to stay at home if they are sick.** Staff with symptoms consistent with COVID-19 should be encouraged to talk to their healthcare provider and seek testing.
- **Staff who develop symptoms of COVID-19 while at the facility must be immediately sent home.**
- Implement leave policies that are flexible and non-punitive. Leave policies should account for the following:
 - Staff who report COVID-19 symptoms,
 - Staff who were tested for COVID-19 due to symptoms, exposure, or travel with test results pending,
 - Staff who are isolating due testing positive for COVID-19,
 - Staff who need to quarantine due to close contact exposure to someone who tested positive for COVID-19,
 - Staff who need to stay home with their children if there are school or childcare closures, or to care for sick family members,
 - Staff who need to get the COVID-19 vaccine,
 - Staff who are experiencing side effects from the COVID-19 vaccine
- **Plan for staff absences.**
 - Identify critical job functions and plan for alternative coverage.
 - Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
 - Review CDC guidance on safety practices for critical infrastructure workers (including correctional officers, law enforcement officers, and healthcare workers) who continue to work after an exposure to SARS-CoV-2. cdc.gov/implementing-safety-practices
- Consider offering revised duties to staff who notify their supervisor that they are at increased risk for severe illness from COVID-19.

Considerations for Visitation

- Consider modifying visitation policies as legally permissible.
- Discourage contact visits between unvaccinated persons and promote non-contact visits if either the resident or the visitor is unvaccinated.
- Encourage residents to limit in-person visitors.
- Provide alternatives to in-person visits (e.g., phone or video visits)
 - Consider temporarily decreasing or eliminating the cost of phone calls and increasing phone privileges.
- Ensure any legally required visits are able to occur (e.g., with legal counsel, lawyer, clergy).

Communication:

- Clearly communicate COVID-19 policies with staff, residents, and visitors.
- All communications should be in plain language and in appropriate primary languages for the setting.
- Post signage at entrances stating that no visitors or staff with a fever or symptoms of COVID-19 is permitted to enter the facility.
- Display signage outside visitation entrance explaining the screening process.
- Communicate with the public about any changes to visitation programs.

CLEANING AND DISINFECTION

The virus that causes COVID-19 can land on surfaces. While it is not the primary way of spread, it is possible for people to become infected if they touch those surfaces and then touch their nose, mouth, or eyes. The most reliable way to prevent infection from surfaces is to frequently perform hand hygiene by washing hands or using alcohol-based hand sanitizer. Cleaning and disinfecting surfaces can also reduce the risk of infection. **If no people with confirmed or suspected COVID-19 are known to have been in a space, cleaning high-touch surfaces once a day is usually sufficient to remove virus that may be on surfaces.**

- Correctional/detention facilities must develop a comprehensive plan for increased routine cleaning (and disinfection as needed) of common spaces and frequently-touched surfaces within the facility (e.g., countertops, computer equipment, telephones, handrails, printer/copiers, drinking fountains, door handles, sink handles, workstations, light switches, recreation equipment).
- Correctional/detention facilities must implement the following practices:
 - Train staff on cleaning procedures and monitoring cleaning schedules to ensure compliance.
 - Clean frequently touched surfaces at least daily.
 - Clean any shared objects and equipment frequently, based on level of use (e.g., radios, service weapons, keys, handcuffs).
 - Clean and disinfect restrooms frequently, with special attention to high-touch surfaces (such as faucets, toilets, stall doors, door handles, countertops, and light switches). Adequate supplies of soap and paper towels must always be present.
 - Provide workers with appropriate PPE, such as disposable gloves for cleaning activities and handling trash. Hand hygiene should be performed before and after wearing gloves.
- **If a sick person, or someone with COVID-19, has been in the facility (or in a space within a facility) within the last 24 hours, cleaning and disinfection must be performed.** If it has been more than 24 hours, **cleaning** should take place. If more than 3 days have passed since the person who is sick or diagnosed with COVID-19 has been in the space, no additional cleaning (beyond regular cleaning practices) is necessary.
- **Clean and disinfect areas used by residents with suspected/confirmed COVID-19 on an ongoing basis during medical isolation.**
- Residents on medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and

washed following food safety requirements. Individuals handling used food service items should clean their hands immediately after removing gloves.

- Laundry from individuals with COVID-19 can be washed with other people’s laundry.
 - Individuals handling laundry from those with COVID-19 should wear a mask, disposable gloves, discard gloves after each use, and clean their hands immediately after.
- Consider providing onsite laundry service for staff uniforms.
- **For comprehensive guidance on cleaning and disinfection, including if someone with COVID-19 was or is at the facility**, please see the DC Health *Guidance on Cleaning and Disinfection for Community Facilities* at coronavirus.dc.gov/healthguidance.

Recommended PPE and PPE Training

- Routinely train all staff (healthcare and non-healthcare) and residents who will have contact with potentially infectious materials in their work placements to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with individuals with confirmed and suspected COVID-19.
 - Ensure strict adherence to OSHA PPE requirements.
 - Ensure that staff and residents who require respiratory protection (e.g., N95 respirator) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer’s respiratory protection program. For more information about respiratory protection programs, visit cdc.gov/niosh/nppt/topics/respirators/disp_part/respsource3respirator.html.
- Ensure that all staff are trained to perform hand hygiene after removing PPE.
- Ensure that PPE is readily available where and when needed, and that PPE donning/doffing/disposal stations have been set up as described below.
- Recommended PPE for residents and staff in a correctional facility will vary based on the type of contact they have with someone with COVID-19 and their close contacts.
 - Notes on types of PPE that may be required:
 - **N95 respirator**
 - ❖ **N95 respirators should be prioritized when staff anticipate contact with infectious aerosols or droplets from someone with COVID-19.** See below for guidance on when surgical masks are acceptable alternatives for N95s. Individuals working under conditions that require an N95 respirator should not use a cloth mask when an N95 is indicated.
 - **Surgical/Medical mask**
 - ❖ Protect the wearer from splashes, sprays, and respiratory droplets generated by others. (NOTE: **Surgical masks are distinct from cloth masks, which are not PPE**, but are worn to protect others in the surrounding area from respiratory droplets generated by the wearer. Individuals working under conditions that require a surgical mask should not use a cloth mask when a surgical mask is indicated.)
 - **Eye protection**
 - ❖ Goggles or disposable face shield that fully covers the front and sides of the face and fits snugly from the corners of the eye across the brow.
 - **A single pair of disposable patient examination gloves**
 - ❖ Gloves must be changed if they become torn or heavily contaminated.
 - **Disposable medical isolation gown**
 - ❖ If custody staff are unable to wear a disposable gown because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with an individual with confirmed or suspected COVID-19, and that clothing is changed as soon as possible and laundered. **Clean and disinfect duty belt and gear prior to reuse** using a household cleaning spray or wipe, according to the product label.

- Set up designated PPE donning and doffing areas outside all spaces where PPE will be used. These spaces should include:
 - A dedicated trash can for disposal of used PPE.
 - A hand washing station or access to alcohol-based hand sanitizer.
 - A poster demonstrating correct PPE donning and doffing procedures.
 - For printable signage demonstrating CDC recommended for donning and doffing practices, visit [cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf](https://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf)
 - For donning and doffing training videos, visit [cdc.gov/coronavirus/videos](https://www.cdc.gov/coronavirus/videos).
- If PPE shortages are anticipated during the COVID-19 pandemic, email coronavirus@dc.gov.

REPORTING

- Staff with confirmed COVID-19, or who are being tested for COVID-19, should be encouraged to inform their supervisor immediately.
- ALL positive COVID-19 test results in staff or residents must be reported immediately to DC Health.
 - Facilities must report all positive **staff** cases.
 - Notify DC Health by submitting an online form on the DC Health COVID-19 Reporting Requirements website dchealth.dc.gov/page/covid-19-reporting-requirements
 - ❖ Submit a **Non-Healthcare Facility COVID-19 Consult Form**
 - Healthcare providers reporting positive **resident** cases must follow reporting guidelines outlined in the DC Health Notice *Updated Priorities for COVID-19 Testing, Guidelines for Reporting, and Discontinuation of Home Isolation (8/3/20)* at dchealth.dc.gov/node/1490616.
 - Notify DC Health by submitting an online form on the DC Health COVID-19 Reporting Requirements website dchealth.dc.gov/page/covid-19-reporting-requirements
 - ❖ Complete the **COVID-19 Reporting Form** in the **Healthcare providers or clinical laboratories** section
- **All residents being released from custody while still on medical isolation or quarantine to any setting where there will not be Department of Corrections follow up, must be reported to DC Health.**
 - Notify DC Health by submitting an online form on the DC Health COVID-19 Reporting Requirements website dchealth.dc.gov/page/covid-19-reporting-requirements
 - ❖ Submit a **Non-Healthcare Facility COVID-19 Consult Form**
- An investigator from DC Health will follow up within 24 hours to all appropriately submitted inquiries.

These guidelines will continue to be updated as the situation evolves. Please visit coronavirus.dc.gov regularly for the most current information.

Table 1. Recommended Personal Protective Equipment (PPE) for Residents and Staff in a Correctional or Detention Facility during the COVID-19 Response

Classification of Individual Wearing PPE	Respirator	Surgical Mask	Eye Protection	Gown	Gloves
Residents					
Asymptomatic resident on quarantine and considered to be a close contact of someone confirmed or suspected of having COVID-19.		X*			
Residents who have confirmed or suspected COVID-19, or showing symptoms of COVID-19.		X*			
Residents handling laundry or used food service items from someone with COVID-19 or their close contacts.		X		X	X
Residents cleaning an area where someone with COVID-19 spends time.		X		X	X
Staff					
Staff interacting with residents who are not on quarantine or medical isolation, are not close contacts of someone with COVID-19, and do not have symptoms of COVID-19		X			
Staff having direct contact with asymptomatic residents on quarantine as close contacts of someone with COVID-19		X	X	X	
Staff performing temperature checks on any group of people (staff, visitors, or residents), or providing medical care to asymptomatic quarantined persons		X	X		X
Staff having direct contact with (including transport) or offering medical care to individuals with confirmed or suspected COVID-19	X		X	X	X
Staff present during a procedure on someone with confirmed or suspected COVID-19 that may generate infectious aerosols	X		X	X	X
Staff handling laundry or used food service items from someone with COVID-19 or their close contacts.		X		X	X

* Cloth face coverings are also acceptable in these scenarios