Interim Guidance: Discontinuing Additional Precautions Related to COVID-19 for Admitted Patients in Acute Care and in High-Risk Outpatient Areas

May 21, 2021

This guidance is intended for health-care providers working in acute care settings including infection prevention and control; workplace health and safety and public health teams; direct care providers (e.g., physicians, nurse practitioners, nurses); patient access and flow teams; and unit and site leadership.

Contents

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Scope

This document applies to admitted patients in acute care (e.g., hospitals) and high-risk outpatient areas associated with acute care facilities (e.g., dialysis, oncology, transplant).

For discontinuation guidance for long-term care and assisted living settings, refer to the BCCDC's *infection prevention and control requirements for COVID-19 in long-term care and seniors' assisted living.*[1]

Decision-making about service provision (e.g., rescheduling appointments) is not within the scope of this guidance. Public health determines the isolation requirement and end of isolation period for people in the community. When the patient has had an exposure but does not require self-isolation as deemed by public health, health-care providers should not prevent or delay care. Even when someone is in self-isolation due to COVID-19 exposure or infection, health-care providers should address the patient's medical needs with appropriate mitigation strategies and infection prevention and control (IPC) measures. Concerns about specific, perceived exposure risks should be discussed with local public health or the IPC team as appropriate.

As evidence continues to evolve, this guidance document will be updated as needed.

Purpose

This provincial guidance details how and when to discontinue COVID-19 related additional precautions for patients admitted to acute care and in high-risk outpatient areas associated with acute care facilities.

Patients may require COVID-19 related additional precautions because they are:*

- Confirmed to have COVID-19 or they are suspected to have COVID-19 (e.g., have COVID-19 risks [2]) and require hospitalization due to the severity of their COVID-19 illness;
- Admitted in acute care for reasons unrelated to COVID-19 and the hospitalization occurs during the required timeframe for self-isolation (see appendix A);
- Exposed to COVID-19 during their hospitalization (e.g., as identified through contact tracing).

* Note: These are the primary reasons patients may require additional precautions related to COVID-19. However, this list is not exhaustive.

How to Use This Document

This document should be read in conjunction with local health authority guidance on discontinuing COVID-19 related additional precautions. Decisions about discontinuing COVID-19 related additional precautions require collaborative discussions on a case-by-case basis between IPC teams, medical health officers (MHOs) and the patient care team.

Refer to the BCCDC's *interim guidance for public health management of cases and contacts associated with novel coronavirus (COVID-19) in the community*[3] for information about COVID-19 incubation and communicability period.

Clinical judgement, including an evaluation of patients' symptoms and risk factors for COVID-19 exposure (see BCCDC's COVID-19 *patient screening tool for direct care interactions*[2] and appendix A) remain important in determining their infectiousness and ability to transmit the virus to another person. This assessment subsequently informs the need for additional precautions.

This provincial guidance is divided into the following sections:

A. Patients with laboratory-confirmed COVID-19;
B. Patients suspected of COVID-19 with negative COVID-19 laboratory results;
C. Indeterminate laboratory results;
D. Asymptomatic patients (not tested) with risk factors for COVID-19 exposure; and
E. Multisystem inflammatory syndrome in children (MIS-C).

Even when it is determined that additional precautions can be discontinued from a COVID-19 perspective, patients may need to remain on additional precautions for other reasons according to local heath authority IPC guidelines (e.g., antibiotic resistant organisms, *Clostridium difficile).*

Different strategies (test-based and non-test based), and their relevant criteria for discontinuing additional precautions related to COVID-19, are described in the sections below. Care providers should follow only one strategy for each patient at a time. If the criteria outlined in the most appropriate strategy have not been met, patients should remain on droplet and contact precautions. Additional measures, including the use of a fit-tested N95 respirator, are required when aerosol generating medical procedures (AGMPs) are done for patients with confirmed COVID-19, suspected to have COVID-19 (e.g., have COVID-19 risks[2]) or based on a point-of-care risk assessment (PCRA). Refer to the BCCDC website for provincial guidance on AGMPs[4] and PCRAs.[5]

If patients are medically suitable for discharge from the facility before additional precautions have been discontinued, they will need to self-isolate in the community. Contact the local public health team for guidance in this regard. If a test-based strategy was used during hospitalization based on consultation with the patient's most responsible provider/physician (MRP) and IPC teams, consultation with an MHO as part of discharge planning is recommended.[3]

Considerations for Determining Duration of Additional Precautions

Live viral shedding may occur for longer in those with COVID-19 illness of greater severity and those who are immune compromised (see *definitions of key concepts* section).[3,6] The period of communicability may extend to 20 days or longer after onset of symptoms in these groups.[3,6–9] The severity of COVID-19 illness and the minimum period of additional precautions is determined by the MHO, IPC, medical microbiologist and/or infectious disease specialist, in consultation with the health-care provider most familiar with the patient's medical status.[3,6]

At this time, there is no evidence to suggest that the period of communicability of COVID-19 is significantly different in the pediatric population compared to the adult population.[3]

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Use of a Test-Based Strategy

In general, current evidence[3,6,10] no longer recommends a test-based strategy to guide decision-making about discontinuing additional precautions for COVID-19 patients. In the majority of cases, using a test-based strategy results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.[6]

It is not necessary to retest patients who previously tested positive for COVID-19 and were cleared by public health in the community before their admission or before entering a high-risk outpatient area prior to providing care. Please consult with IPC if there are concerns about COVID-19 reinfection and/or if there are concerns that the patient may still be infectious.[7]

A test-based strategy could be considered in limited scenarios:

- For discontinuing additional precautions earlier than if a symptom-based or time-based strategy was used.[6]

  Re-testing patients with laboratory confirmed COVID-19 for this reason must be done in consultation with IPC teams and MHOs. Despite the use of a test-based strategy, the minimum duration of droplet and contact precautions for any patient with laboratory confirmed COVID-19 is at least 10 days.

- If there are concerns that a patient is infectious for more than 20 days (e.g., if they are severely immune compromised, see the *definitions of key concepts* section).[6]

  Refer to guidance in section A, table 1.

- For patients who are not severely immune compromised and whose symptoms are not improving after 20 days and where the symptoms may be due to an alternative diagnosis.

  Re-testing patients with laboratory confirmed COVID-19 for this reason should be done in consultation with IPC teams and the MRP. Consider consulting an infectious disease specialist.

For some COVID-19 tests, there are values that may suggest the amount of virus RNA present (e.g., cycle threshold values). Since cycle threshold (Ct) values are not equivalent across COVID-19 nucleic acid amplification testing (NAT)[11] platforms, Ct values should not be routinely used to make decisions about a patient's COVID-19 transmission risks or disease severity.[12] However, in some circumstances, they may be helpful. Consult a medical microbiologist for any questions related to Ct values of laboratory specimens.

Definitions of Key Concepts

General

Additional Precautions: The IPC measures put in place (e.g., droplet and contact precautions)[13] when caring for patients while they are in health-care settings, regardless of whether or not they have been cleared by public health.

Clearance: From a public health perspective, when patients are cleared, they no longer require self-isolation in the community.

COVID-19 Illness Severity Criteria

Below are some criteria to help you determine the communicability period and decisions about the duration of additional precautions for pediatric and adult patients:

- **Asymptomatic infection**: A patient who had a laboratory-confirmed positive COVID-19 test and who had no symptoms during the complete course of infection.[10] If they developed compatible symptoms, the patient should be reclassified in one of the appropriate categories based on the severity of their COVID-19 illness.[3]

- **Mild to moderate COVID-19 illness**: A patient who did not reach the threshold for severe to critical illness. If a patient was admitted to the hospital for reasons unrelated to their COVID-19 illness, they should not automatically be considered as having severe or critical COVID-19 illness.

- **Severe to critical COVID-19 illness**: A patient for whom COVID-19 causes any one of the following[3,6,14]:
    - experienced oxygen saturation below 94% on room air;
    - pneumonia;
    - hypoxemic respiratory failure;
    - multi-organ dysfunction or septic shock;
    - hospitalized because of the severity of their COVID-19 illness.

  Please note, patients who have COVID-19 can be hospitalized for reasons other than the severity of their COVID-19 illness (e.g., surgical procedure, another medical condition).

Level of Immune Compromise

A patient's MRP is the best person to determine how immune compromised a patient is and which category identified below (i.e., mildly, moderately or severely immune compromised) a patient belongs in. This decision-making is done in consultation with IPC teams and with medical microbiologists or infectious disease specialists as needed. The information below are examples and considerations to guide decision-making.

Mildly immune compromised: Patients with mild immune compromising conditions and/or factors such as advanced age, diabetes mellitus or end-stage renal disease.[3,6] For the purpose of discontinuing additional precautions, these patients are treated in the same manner as those without immune compromising conditions and/or factors.

Moderately immune compromised: Patients with one or more of the following:[6,15]

- Persons on systemic chemotherapy for solid organ cancer (as determined by the MRP);
- Human immunodeficiency virus (HIV) with a CD4 count of 50 - 200 cells/mm^3 (inclusive);
- Any person taking a biologic/immunomodulatory therapy, prednisone of >20 mg/day (or equivalent dose) for ≥14 days, tacrolimus, sirolimus, mycophenolate, methotrexate or azathioprine.

Based on their clinical judgement, MRPs may determine that there are other diagnoses and/or medications not listed above that support considering patients as moderately immune compromised. Consult an infectious disease specialist as needed.

Severely immune compromised: Decision-making about discontinuing additional precautions for patients who are considered severely immune compromised requires consultation with MRPs and IPC teams. Consult an infectious disease specialist as needed. A test-based strategy is used to discontinue additional precautions for this population.

As per the U.S. Centers for Disease Control (CDC),[7] "detection of sub-genomic SARS-CoV-2 RNA or recovery of replication-competent virus has been reported in severely immunocompromised patients… beyond 20 days, and as long as 143 days after a positive SARS-CoV-2 test result." For example, as the U.S. CDC notes[7], these include "patients with chronic lymphocytic leukemia and acquired hypogammaglobulinemia, lymphoma and immunochemotherapy, hematopoietic stem-cell transplant, chimeric antigen receptor T-cell therapy or AIDS."[16–20]

There may be other diagnoses or a combination of diagnoses and/or medications that support considering patients as severely immune compromised. Examples include but are not limited to: HIV with a CD4 count of < 50 cells/mm^3, solid organ transplant,[21] use of rituximab and primary immunodeficiencies. Current evidence may not have demonstrated prolonged live viral shedding with such diagnoses and/or medications to date. Thus, clinical judgement remains important to determine if these patients should be considered as severely immune compromised for the purpose of determining their communicability period.

Section A: Patients with Laboratory-Confirmed COVID-19

The duration of droplet and contact precautions for patients with laboratory-confirmed COVID-19 depends on the severity of their COVID-19 illness, whether they are immunocompromised and to what degree (see *definitions of key concepts* section). Decision-making regarding patients who are severely immunocompromised require consultation with the IPC team and MRP. See table 1 for criteria that patients must meet prior to discontinuation of additional precautions.[3,6,7,9,15]

Patients with laboratory-confirmed COVID-19 may be hospitalized for different reasons. Examples include but are not limited to:

- Residents living in long-term care facilities may need to be hospitalized for a higher level of care or as per local health authority guidance or process;
- Patients may be diagnosed with COVID-19 while they are hospitalized for non-COVID-19 related reasons;
- Patients with COVID-19 may require hospitalization for non-COVID-19 related reasons.

As such, there may be patients who are hospitalized with COVID-19 who have mild to moderate or severe to critical COVID-19 illness.

Table 1: Criteria for Discontinuing Droplet and Contact Precautions for Patients with Laboratory-Confirmed COVID-19*		
COVID-19 Illness Severity	**Level of Immune Compromise**	**When Droplet and Contact Precautions Can be Discontinued**
Asymptomatic Infection	None / Mildly	**TIME-BASED STRATEGY** Ten days have passed since the date of the first positive COVID-19 test AND symptoms did not develop after the first positive test.
	Moderately	**TIME-BASED STRATEGY** Twenty days have passed since date of the first positive COVID-19 test AND symptoms did not develop after the first positive test.
	Severely (Requires consultation with IPC and MRP)	**TEST-BASED STRATEGY** Twenty days have passed since the date of the first positive COVID-19 test (consider longer period based on consultation with MRP) AND symptoms did not develop after the first positive test. THEN re-test until there have been two consecutive negative nasopharyngeal (NP) specimens collected at least 24 hours apart.
Mild to Moderate Illness	None / Mildly	**TIME-BASED STRATEGY** Ten days have passed since onset of symptoms AND at least 24 hours have passed since last fever without the use of fever-reducing medication AND symptoms (respiratory, gastrointestinal and systemic) have improved.
	Moderately	**TIME-BASED STRATEGY** Twenty days have passed since onset of symptoms AND at least 24 hours have passed since last fever without the use of fever-reducing medication AND symptoms (respiratory, gastrointestinal and systemic) have improved.

	Severely (Requires consultation with IPC and MRP)	**TEST-BASED STRATEGY** Twenty days have passed since onset of symptoms (consider longer period based on consultation with MRP) AND at least 24 hours have passed since last fever without the use of fever-reducing medication AND symptoms (respiratory, gastrointestinal and systemic) have improved. THEN re-test until there have been two consecutive negative nasopharyngeal specimens collected at least 24 hours apart.
Severe to Critical Illness	None / Mildly	**TIME-BASED STRATEGY** Twenty days have passed since onset of symptoms AND at least 24 hours have passed since last fever without the use of fever-reducing medication AND symptoms (respiratory, gastrointestinal and systemic) have improved.
	Moderately	
	Severely (Requires consultation with IPC and MRP)	**TEST-BASED STRATEGY** Twenty days have passed since onset of symptoms (consider longer period based on consultation with MRP) AND at least 24 hours have passed since last fever without the use of fever-reducing medication AND symptoms (respiratory, gastrointestinal and systemic) have improved. THEN re-test until there have been two consecutive negative nasopharyngeal specimens collected at least 24 hours apart.

*Notes:

- Additional precautions can only be discontinued where there are no reasons at all to continue them (e.g., a patient with an antibiotic resistant organism should remain on contact precautions at a minimum).
- In general, it is not recommended to test patients without close-contact exposure who are asymptomatic.[22] However, health authorities may test these patients as part of an outbreak or cluster investigation, or for other reasons, as directed by public health.
- If unable to determine date of symptom onset, use collection date of initial positive laboratory result as the date of symptom onset.

- Symptom improvement does not necessarily apply to pre-existing or chronic respiratory symptoms caused by another health condition. Coughing may persist for several weeks and does not mean the patient is infectious and must remain on additional precautions, providing that the patient is afebrile and other symptoms have improved.[3]
- The 20-day period for patients who are moderately or severely immune compromised may be modified by the MHO and IPC, in consultation with the patient's care team.
- Consult a medical mirobiologist, infectious disease specialist and/or IPC when:
    - A patient refuses repeat testing, or if a NP specimen cannot be collected.
    - The initial specimen that tested positive was not a NP swab to determine what type of specimen is needed for repeat testing.
    - The repeat test result is positive to get guidance on when to re-test again. The patient should remain on additional precautions for COVID-19.
- In patients with persistently positive COVID-19 test results (e.g., patients whose symptoms have resolved, but polymerase chain reaction testing still indicates the presence for virus RNA), consult a medical microbiologist, infectious disease specialist and/or IPC. Based on their organizational risk assessment, health authorities may choose to identify a specific time period for when additional precautions can be discontinued for patients who persistently test positive.
- Ct values of laboratory specimens may also be considered to determine when repeat testing should be done. This should only be done in consultation with a medical microbiologist.

Section B: Patients Suspected of COVID-19 with Negative COVID-19 Laboratory Results

Even with a negative laboratory result, if a patient is still suspected to have COVID-19, they might need to be re-tested and droplet and contact precautions should be maintained. COVID-19 symptoms occur in many other illnesses. Therefore, a slight change in symptoms might warrant repeat testing to ascertain that the changed symptoms are not from COVID-19. Also, if a patient is tested early on in their course of infection or too early after a COVID-19 exposure, they might have minimal symptoms and test negative for COVID-19. Consult IPC or a medical microbiologist for questions about re-testing. If the repeat test result is positive, follow guidance from section A: patients with laboratory-confirmed COVID-19.

Providing there are no other reasons to continue isolation, and the treating team is satisfied that the patient does not have a COVID-19 infection, additional precautions for COVID-19 can be discontinued.

It is essential to consider if patients who tested negative had risk factors for COVID-19 exposure (see appendix A). At a minimum, patients with risk factors for COVID-19 exposure need to be cared for using additional precautions for 14 days from their last exposure. Exposed patients who test negative before the end of their 14-day isolation period should not be taken off additional precautions before 14 days, regardless of if they had symptoms or remained asymptomatic.

Patients Who Are Still Suspected to Have COVID-19 and/or Have COVID-19 Risks

If clinical suspicion of COVID-19 remains and/or there is a risk factor for COVID-19 exposure (see appendix A), then even if the testing result is negative, these patients should be presumptively treated as cases and should remain on droplet and contact precautions. At a minimum, the duration of additional precautions will be determined by time since symptom onset* and the 14-day incubation period if there is a risk factor for COVID-19 exposure, whichever is longer. See examples below.

* Follow the criteria outlined in the time-based strategy for symptomatic patients outlined in table 1

Consult a medical microbiologist, infectious disease specialist and/or IPC to determine if and when the patient should be further tested for COVID-19, and to also consider other pathogens or alternative diagnoses that may be relevant.

For patients who are managed as presumptive COVID-19 cases despite repeatedly negative tests, inform public health as contract tracing may be required.

Example scenario:

A patient's last exposure to COVID-19 (e.g., travel, contact with a confirmed case) was on June 1 and the patient's COVID-19 symptoms started on June 8. The patient was tested on June 8 and results came back negative. See tables 2 and 3 for minimum duration of additional precautions.

Table 2: Discontinuing droplet and contact precautions for patients with risk factors for COVID-19 exposure, who are not immunocompromised and have mild to moderate COVID-19 illness, after testing negative, but clinical suspicion for COVID-19 remains.

June	1*	2	3	4	5	6	7	8**	9	10	11	12	13	14	15	16	17	18	19
14-day incubation period from exposure																			
≥10 days since symptom onset																			
Minimum duration of additional precautions																			

* Last day of exposure
** Symptom onset

Table 3: Discontinuing droplet and contact precautions for patients with risk factors for COVID-19 exposure, who have more severe to critical COVID-19 illness or who are moderately or severely immunocompromised, after testing negative, but clinical suspicion for COVID-19 remains.

June	1*	2	3	4	5	6	7	8 **	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
14-day incubation period from exposure																												
≥20 days since symptom																												

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onset																										
Minimum duration of additional precautions																										
* Last day of exposure ** Symptom onset																										

Patients Who Are No Longer Suspected of Having COVID-19

Additional precautions for COVID-19 can be discontinued for patients who do not have risk factors for COVID-19 exposure (see appendix A), and who do not have an alternative diagnosis that requires additional precautions.

For patients who remain symptomatic and/or if an alternative pathogen has been identified, additional local health authority IPC protocols for droplet and contact precautions will apply (e.g., protocols for acute respiratory infection, protocols for specific respiratory pathogens).

Section C: Indeterminate Laboratory Results

Consult a medical microbiologist, infectious disease specialist and/or IPC to determine next steps. Clinical correlation is required; the results may also indicate poor sample quality. Recollect sample if clinically indicated. Repeat testing for known positive cases is not routinely recommended. In the meantime, the patient should remain on droplet and contact precautions.

Section D: Asymptomatic Patients (Not Tested) with Risk Factors for COVID-19 Exposure

Examples of when this may occur:

1. Patients who are on self-isolation in the community, as per public health instructions and are now admitted in acute care for non-COVID-19 reasons.
2. Patients who have been put on droplet and contact precautions due to known COVID-19 exposure in a health-care facility (e.g., exposure to confirmed COVID-19 roommate and/or health-care worker, transferring out from a COVID-19 outbreak unit/area).

Additional precautions for COVID-19 can be discontinued 14 days after the patients' last known COVID-19 exposure if they remain asymptomatic during this 14-day period.

- If patients develop COVID-19 symptoms, droplet and contact precautions should be maintained, and testing should be performed. Based on the testing results, following guidance from section A: Patients with Laboratory-Confirmed COVID-19 or section B: patients suspected of COVID-19 with negative COVID-19 laboratory results.

- If two or more individuals were self-isolating together in the community and one becomes positive, then additional precautions for those isolating with the newly positive individual should extend to 14 days after the last contact with the positive person.

Section E: Multisystem Inflammatory Syndrome in Children (MIS-C)[15]

All patients with suspected MIS-C should be placed on droplet and contact precautions pending COVID-19 PCR results. See BC Children's Hospital's guidelines[23] and BCCDC[24] for clinical guidance.

If the patient tests positive, then follow guidance outlined in section A: Patients with Laboratory-Confirmed COVID-19

If the patient tests negative and:

- There is no known contact with a case of COVID-19, then use additional precautions per local IPC protocols; OR
- There is known contact with a case of COVID-19, then continue droplet and contact precautions for 14 days from last contact as per section B: patients suspected of COVID-19 with negative COVID-19 laboratory results.

Acknowledgement: This document was developed by the Provincial Infection Control Network (PICNet) of B.C. in consultation with regional health authority IPC and public health stakeholders including the MHO and IPC/WHS Provincial COVID-19 Task Group. We thank the Provincial Health Services Authority's IPC team for their insight and expertise for contributing specific sections of this guidance document.

Appendix A: Risk Factors for COVID-19 Exposure[2]

A patient is considered to have a risk factor for COVID-19 exposure if, in the last 14 days, the patient had at least one of the following:

- Under order to quarantine after travel outside of Canada;
- Been told to self-isolate by public health following a close contact exposure;
- Exposed to COVID-19 during their hospitalization (e.g., as identified through contact tracing).

Please note: As the pandemic evolves, there may be other risk factors that need to be considered.

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