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

September 16, 2022

This guidance is intended for health-care providers working in acute care settings including infection prevention and control (IPC); 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.

This guidance has been updated to align with emerging evidence and best practice guidance. Please see below for a summary of changes.

Version	Summary of major updates
December 8, 2020	• Guidance was first published.
May 21, 2021	• Inclusion of associated high-risk outpatient settings within the scope. • Updated considerations for a test-based strategy. • Definition of key concepts section. • Updated considerations for categorizing immune compromised and severely immune compromised individuals.
September 16, 2022	• The duration of additional precautions for patients with COVID-19 exposure risk[1] has been shortened to 10 days from 14 days. • Increased flexibility has been added for recommendations to allow modifications by health authorities or on a case-by-case basis in consultation with the patient's most responsible physician/provider (MRP), Infection Prevention and Control (IPC) team (infection prevention and control professional, medical microbiologist and/or infectious diseases specialist). • To allow increased flexibility using clinical assessment and judgement, the requirement for a test based strategy to remove additional precautions in severely immune compromised patients with COVID-19 infection, has been modified from a 'requirement' to a 'recommendation' in consultation with MRP, IPC team/infectious diseases specialist. • Added algorithm for duration of COVID-19 related droplet and contact precautions as a quick reference tool.

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Scope

This guidance 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 guidance on discontinuation of droplet and contact precautions in long-term care and assisted living facilities, refer to the following BCCDC resources:

- Infection prevention and control requirements for COVID-19 in long-term care and seniors' assisted living.[2]
- Interim guidance: Public health management of cases and contacts associated with novel coronavirus (COVID-19) in the community.[3]
- COVID-19 outbreak management protocol for long-term care and seniors' assisted living settings.[4]

The need for additional precautions should not prevent or delay the provision of medical services. Health-care providers and facilities should undertake appropriate mitigation strategies and IPC measures. Concerns with specific, perceived exposure risks should be discussed with local IPC and workplace health teams as appropriate.

This guidance will be updated as additional knowledge becomes available.

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. A conservative approach to discontinuing additional precautions in these settings is necessary to protect vulnerable patients from the risk of acquiring SARS-CoV-2 from patients who are still potentially infectious and from higher transmissibility and immune evasion of emerging variants. As such, the recommended duration of additional precautions for these patients might differ from public health's guidance for the public and community settings.

Patients may require COVID-19 related additional precautions because they are confirmed or suspected to have COVID-19 or have an exposure risk for COVID-19.[1] This guidance is intended to be applied in conjunction with local health authority guidance on discontinuing COVID-19 related additional precautions and other COVID-19 infection prevention and control guidance for health-care facilities.[5]

A quick reference algorithm tool has been included as Appendix 1. Refer to the duration of COVID-19 related droplet and contact precautions in acute care and associated high-risk outpatient areas algorithm.

Key Considerations

The duration of COVID-19 related additional precautions is based on several factors including:

- COVID-19 incubation and communicable periods - 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 more information.
    - Note: The communicable period in the pediatric population is considered to be similar to the adult population.[3,6] Therefore, the duration of additional precautions recommendations for pediatric patients is the same as adult patients.
- Potentially longer duration of infectious viral shedding in individuals who are immunocompromised and those who have increased severity of COVID-19 illness (see definitions of key concepts section).[3,7] The period of communicability may extend up to 20 days or longer after symptom onset in some of these individuals.[3,7–9]
- Clinical judgement, including an evaluation of patients' symptoms and exposure risk for COVID-19 (see BCCDC's COVID-19 patient screening tool for direct care interactions[1]), severity of illness, the level of immune compromise and ability to transmit the virus to another person.
- Local health authority guidance.

Decisions about discontinuing COVID-19 related additional precautions in some cases may require collaborative discussions on a case-by-case basis between the patient care team and IPC team (IPC professional, medical microbiologist and/or infectious diseases specialist).

Definitions of Key Concepts

Additional Precautions: The specific IPC measures put in place (e.g., droplet and contact precautions), based on the mode of transmission, when caring for patients who are at risk of transmitting communicable diseases.

COVID-19 Illness Severity*:* COVID-19 infection can range in illness presentation. Replication-competent virus has been recovered between 10 and 20 days after symptom onset in some patients with severe or critical COVID-19 illness.[7–9] The definitions below are intended to assist in determining the duration of addition 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.[7,10] 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.[7]
- *Mild to moderate COVID-19 illness:* A patient who has COVID-19 symptoms[3] and does not require supplemental oxygen support (i.e. have oxygen saturations of ≥ 94% on room air) for COVID-19 illness.[3,7,11] Additionally, the patient did not reach the threshold for severe to critical illness. If a patient

is 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 based on clinical judgement and as determined by MRP:[3,7,11]
    - experienced oxygen saturation below 94% on room air;
    - hypoxemic respiratory failure;
    - multi-organ dysfunction, septic shock or
    - hospitalized because of the severity of their COVID-19 illness.

  Refer to the British Columbia COVID-19 Therapeutics Committee[11] guidance for information on the classification of severe and critical COVID-19 illness on the BCCDC website.

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

The level of immune compromise is a consideration in determining discontinuation of droplet and contact precautions in moderately or severely immune compromised patients as SARS-CoV-2 replication-competent virus or sub-genomic RNA has been reported after 10 days and in some cases beyond 20 days.[7,8] A patient's MRP is the best person to determine how immune compromised a patient is and which category from the list provided below (i.e., mildly, moderately or severely immune compromised) a patient belongs in. This decision-making is done in consultation with the IPC team 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.[3,7] *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:[7,12]
    - Persons on systemic chemotherapy for solid organ cancer;
    - Solid organ transplant who are greater than one year out of transplant, stable on their immunosuppression and overall very stable as determined by the MRP on a case-by-case basis;
    - 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*: Based on their clinical judgement, MRPs may determine that there are diagnoses or a combination of diagnoses and/or medications that support considering a patient as severely immune compromised. 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. Examples may include, but are not limited to, conditions or combinations of the following as determined by the MRP, based upon their assessment of the patient:[3,7,12–16]
    - Bone marrow transplant
    - Solid organ transplant (less than one year from transplant)
    - Chronic lymphocytic leukemia
    - Lymphoma
    - Hypogammaglobulinemia
    - HIV with a CD4 count of <50 cells/mm^3 or AIDS
    - Chimeric antigen receptor T-cell therapy
    - Use of rituximab
    - Primary immunodeficiencies
    - Familial hemophagocytic lymphohistiocytosis
    - Type 1 interferon defects (primary immunodeficiency and acquired autoantibodies to type 1 interferons).
    - Agammaglobulinemia
    - Combined variable immunodeficiency (CVID)
    - Combinations of diagnoses
    - Medications that would confer severe immune compromise

Decision-making about discontinuing additional precautions for patients who are considered severely immune compromised requires consultation with MRPs and IPC team. Consult an infectious disease specialist as needed. A test-based strategy should be considered to discontinue additional precautions for these patients.

Test-based Strategy: The decision to discontinue additional precautions based on having negative test results. Refer to the COVID-19: viral testing guidelines for British Columbia[17] for information on testing.

Duration of Additional Precautions in Patients Confirmed to Have COVID-19

Table 1 provides general guidance for when to discontinue COVID-19 related additional precautions (i.e., droplet and contact precautions) in patients confirmed to have COVID-19 infection. The duration of additional precautions is dependant on the severity of COVID-19 illness and degree of any immune compromising conditions or medications (see definitions of key concepts). Additionally, health authority specific guidelines and processes for discontinuation of additional precautions should be followed.

Table 1: Duration of Droplet and Contact Precautions for Patient Confirmed to have COVID-19 Infection*

COVID-19 Illness Severity	**Level of Immune Compromise**	**When Droplet and Contact Precautions Can be Discontinued** *Important - Modifications to the duration of additional precautions can be made at the health authority level or on a case-by-case basis in consultation with MRP and IPC team.*
Asymptomatic Infection	None / Mildly	*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	*Twenty days* have passed since date of the first positive COVID-19 test **AND** symptoms did not develop after the first positive test.
	Severely	*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. Consultation with MRP and IPC team/infectious disease specialist is recommended. After the above conditions have been met, a **test-based strategy** should be considered with re-testing until there are two negative tests collected at least 24 hours apart or according to local IPC recommendations. Refer to the notes section.
Mild to Moderate Illness	None / Mildly	*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.

COVID-19 Illness Severity	**Level of Immune Compromise**	**When Droplet and Contact Precautions Can be Discontinued** *Important - Modifications to the duration of additional precautions can be made at the health authority level or on a case-by-case basis in consultation with MRP and IPC team.*
	Moderately	*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	*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. Consultation with MRP and IPC team/infectious diseases specialist is recommended. After the above conditions have been met, a **test-based strategy** should be considered with re-testing until there are two negative tests collected at least 24 hours apart or according to local IPC recommendations. Refer to the notes section.
Severe to Critical Illness	None / Mildly Moderately	*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	*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. Consultation with MRP and IPC team/infectious diseases specialist is recommended. After the above conditions have been met, a **test-based strategy** should be considered with re-testing until there are two negative tests collected at least 24 hours apart or according to local IPC recommendations. Refer to the notes section.

*Notes:

- Additional precautions should only be discontinued when there are no other remaining infectious diseases or pathogens requiring additional precautions (e.g., a patient with an antibiotic resistant organism infection should remain on contact precautions). Refer to the Public Health Agency of Canada guidance on routine practices and additional precautions for preventing the transmission of infection in health-care settings.[18]
- In general, it is not recommended to test patients who are asymptomatic.[19] However, health authorities may test these patients as part of an outbreak or cluster investigation, or for other reasons, as directed by the IPC team or public health/medical health officer.
- If unable to determine the date of symptom onset, use the 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. Additionally, coughing from COVID-19 illness 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 IPC or the medical health officer, in consultation with the patient's care team and MRP.
- A **test-based strategy** may be considered in specific circumstances and should be done in consultation with MRP and IPC team/infectious diseases specialist. Circumstances may include the following:
    - For discontinuing additional precautions earlier than the recommended duration[7] outlined in Table 1.
    - If there are concerns that a patient who has severe or critical illness and/or is moderately immune compromised is infectious for more than 20 days.[7]
    - 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.
- Consult an IPC team when:
    - A patient refuses repeat testing, or if a specimen cannot be collected.
    - 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 the interim.
- In patients with persistently positive COVID-19 test results (e.g., patients whose symptoms have resolved, but polymerase chain reaction testing or rapid antigen test still indicates the presence for virus RNA or antigen, respectively), consult the IPC team/infectious diseases specialist. 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.
- In consultation with a medical microbiologist, cycle threshold (Ct) values of laboratory specimens may also be considered to determine when repeat testing should be done.

Duration of Additional Precautions in Patients with COVID-19 Exposure Risk

A patient is considered to have an exposure risk for COVID-19 if, within the last 10 days, the patient had any one of the following:

- Exposed to COVID-19 during their hospitalization (e.g., as identified through contact tracing); and
- Identified as having COVID-19 exposure risk using BCCDC's COVID-19 patient screening tool for direct care interactions.[1]

Note: Local health authority guidance might have additional considerations for exposure risk. Asymptomatic patients who are known to have COVID-19 exposure risk should be placed on empiric droplet and contact precautions. Additional precautions can be discontinued after *10 days* following the exposure (day 0) if they do not develop symptoms.[7] Continue to monitor for the development of symptoms.

Symptomatic Patients with Negative COVID-19 Laboratory Results

The following recommendations are for patients who have or develop COVID-19 symptoms[20] and have lab tested negative for COVID-19:

- If clinical suspicion for COVID-19 illness remains, additional precautions should be maintained. Consult with MRP, IPC and medical microbiologist for retesting guidance.
- Other alternative pathogens or diseases (e.g., other viral respiratory illnesses) should be considered and, when required, local IPC guidance for additional precautions for those diseases should be followed.
- Patients with known COVID-19 exposure risk should continue on additional precautions for 10 days following the exposure (day 0).
- Additional precautions can be discontinued when COVID-19 or other infectious diseases are ruled out by the clinical team and the patient did not have COVID-19 exposure risk.

Indeterminate Laboratory Results

Consult the IPC team 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.

Multisystem Inflammatory Syndrome in Children (MIS-C)

All patients with suspected MIS-C should be placed on droplet and contact precautions pending COVID-19 test results. See BC Children's Hospital's guidelines[21] and BCCDC[22] for clinical guidance.

If the patient tests positive, then follow guidance outlined in Duration of Additional Precautions in Patients Confirmed to Have COVID-19.

If the patient tests negative and:

- There is no known COVID-19 exposure risk, then use routine practices and follow local IPC protocols;[23] OR
- There is known COVID-19 exposure risk factor, then continue droplet and contact precautions for 10 days from last exposure as per Duration of Additional Precautions in Patients with COVID-19 Exposure Risk

Consideration should be given to assess caregivers/household members for symptoms or COVID-19 exposure risk and manage them accordingly.

Procedures for Discontinuation of Additional Precautions

Follow local health authority or facility protocols on discontinuation of additional precautions when patients meet the conditions for discontinuation of additional precautions. Consult with local IPC team as needed.

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Appendix 1: Duration of COVID-19 Related Droplet and Contact Precautions (DCP) in Acute Care and Associated High-Risk Outpatient Areas Algorithm

Scope: Patients placed on DCP based on BCCDC's COVID-19 patient screening tool for direct care interactions.