COVID-19
Isolation & Quarantine Center
Standard Operating Procedures

Updated 10/1/2020

This document is intended for use by King County’s COVID-19 Isolation and Quarantine facilities. It is a living document and will continue to be updated as needed and based upon experience and learnings related to the COVID-19 response.
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Overview and Purpose
The King County administered COVID-19 Isolation and Quarantine (IQ) facilities are individual rooms in motels or modular units created with the goal of mitigating spread of COVID-19 in our community and preserving hospital system capacity. In addition to providing testing for high risk populations, each facility will provide individual isolation or quarantine spaces for individuals awaiting test results and for those who test positive. These facilities will provide food, shelter and basic health care in a compassionate setting. Basic health care includes monitoring COVID-19 illness to determine if further medical evaluation is warranted and assisting with transfer to a higher level of care when indicated; providing basic management of existing chronic conditions, including access to chronic medications; and supporting with basic behavioral health services. King County’s IQ facilities are designated as Alternate Care Site (ACS) by the Washington State Department of Health.

Scope of Care

Medical Care
- COVID-19 symptom monitoring and medical management of clients who are clinically stable requiring isolation or quarantine
- Acute medical conditions
  - Uncomplicated acute medical conditions that can be assessed by history and exam without a further workup will be managed to the extent possible.
  - Comprehensive medical evaluations will not be performed due to lack of labs and radiology on-site.
  - Transfer to a higher level of care will be arranged when necessary.
- Chronic medical conditions
  - Management of chronic health conditions will be maintained to the extent possible.
  - Diagnosis of new chronic medical conditions will be limited.
  - Referral to primary care provider or other services will be provided upon discharge.
- Medication management
  - Chronic (home) medications will be maintained to the extent possible. If a client does not have a supply, prescriptions can be sent to a nearby outpatient pharmacy for staff to pick-up and deliver to client.
  - IQ staff will coordinate with primary care provider or discharging hospital if refills or other medications are needed.
  - Consulting physicians can prescribe if client needs refills or other medications based on clinical discretion.
  - Pharmacists will be available on call for consultation.
Behavioral Health Support

- **Mental Health**
  - Mental health specialists and/or licensed mental health professionals will be on duty 24/7.
  - Remote psychiatry consultation will be available for psychiatric assessment and management.

- **Scope of mental health specialists and mental health professionals**
  - Mental health and substance use disorder counseling
  - Therapeutic interventions, emotional/relational supports
  - Crisis response, verbal de-escalation, referral to higher level of care
  - Referral context, client background information
  - Disposition and discharge planning

- **Scope of Psychiatric Consultation (on call/telemedicine)**
  - General, addiction, geriatric, perinatal psychiatry
  - Therapeutic interventions, emotional/relational supports
  - Crisis response, verbal de-escalation, referral to a higher level of care
  - Psychiatric medication management

- **Substance Use Disorder**
  - Treatment of active alcohol or benzodiazepine withdrawal is beyond the scope of IQ. Supportive care and medications to decrease the risk of developing withdrawal in at-risk clients will be provided.
  - Clients on medications to treat opioid use disorder, such as methadone and buprenorphine, can continue these medications while at IQ. Methadone cannot be initiated, but buprenorphine can be initiated at IQ when indicated.
  - Remote addiction medicine consultation by phone or telehealth will be available 24/7.
  - A harm reduction approach will be taken to support clients to successfully complete their isolation or quarantine period.

Staffing

Shift Change and Shift Report

Nurses and MAs:

- I&Q nurses and MAs work 12 hour shifts; 07:00 to 19:30 (day), 10:00 to 20:00 (swing) and 19:00 to 07:30 with a 30 minute unpaid lunch and three 15 minute breaks.
- Nursing shift change occurs promptly at 07:00 and 19:00 daily.
- Integrated huddles are held between the nursing staff and behavioral health staff three times per day, immediately after nursing shift change and mid-day.
- Huddle board:
  - Summary report out on all clients at change of shift
  - Review test results, tiering and discharge plans for each client during shift change.
- Note on-call doctors and ensure names/numbers are posted
- Update on any new processes/practices/guidelines
- Staff sign in/sign out sheet

Behavioral Health Shift Change and Responsibilities:
- Morning (1st) 07:00-15:30
- Swing (2nd) 13:00-21:30
- Graveyard (3rd) 23:00-07:30
- BH passdown will occur at each shift-change to discuss concerns or issues that came up, pending arrivals or upcoming discharges, any pass-off items or tasks to complete by the on-coming shift.
- There is a BH Huddle at 03:00PM for passdown, protocol updates and case consultations as needed.
- Integrated huddles are held between the nursing staff and BH team three times per day, immediately after nursing shift change and mid-day.
- Read the most recent BH and clinical notes in EPIC.
- 1st shift and 2nd shift will conduct a Wellness Check, prepare for discharges or admits for the day, and complete Wellness Plans.
- 4th shift will assist clients and the team as needed, inventory the client charts, compile a list of needed tasks for the next day and organize the files. Clearly document any issue that occurred overnight.

### Staffing Model/Ratios

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Day Team</th>
<th>Night Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Off-Site Staff and Services:</strong> Available 24/7 via on-call or remote access</td>
<td>Up to 40 beds</td>
<td>Up to 40 Beds</td>
</tr>
<tr>
<td>Physician</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric Clinicians</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>On-Site Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Operations Manager (Area Manager)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Nursing Supervisor (PHSS)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Assistant Nursing Supervisor (APHSS)</td>
<td>1</td>
<td>1 (on call)</td>
</tr>
<tr>
<td>Behavioral Health Supervisor</td>
<td>1</td>
<td>1 (on call)</td>
</tr>
<tr>
<td>Facility Manager</td>
<td>1</td>
<td>1 (on call)</td>
</tr>
<tr>
<td><strong>On-Site Client Care Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>5 + 1 swing</td>
<td>5</td>
</tr>
<tr>
<td>MA</td>
<td>2 + 1 swing</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Professional (licensed) &amp; Specialist (non-licensed)</td>
<td>2</td>
<td>1</td>
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Admission Criteria

IQ Intake Prioritization
Priority 1: Confirmed COVID-19 positive with illness
Priority 2: New COVID-19-like illness (CLI), known exposure
Priority 3: New COVID-19-like illness (CLI), unknown exposure
Priority 4: No illness (asymptomatic) but had exposure

(Priority groups 2 & 4 include Public Health HEART Team referral or residents from a congregate setting known to have an outbreak.)

Admission Eligibility Criteria (7.14.2020)

Functional
- Able to independently perform mobilize, transfer and perform Activities of Daily Living (ADL), such as eating, dressing, bathing, etc.
- Able to follow directions when provided appropriate language or other facilitation

Behavioral Health
- Does not pose an imminent threat to self or others that warrants a higher level of care
- Does not have behavioral health issues identified; or has mild or moderate behavioral health issues identified; or other complex behavioral health need, such as withdrawals/delusions, with a plan to manage
- Is not in active alcohol withdrawal

General
- Confirmed COVID-19 positive, COVID-19-like illness (CLI), and/or exposure to COVID-19 and in need of testing.
  - COVID-19-like illness (CLI) may be defined as any of the following: fever or 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
  - Testing is available at all sites.
- Needs isolation or quarantine, i.e. not beyond the recommended time period for isolation or quarantine based on 1) date of symptom onset, 2) last fever, 3) date of positive COVID test, and/or 4) date of known exposure to COVID.
  - See COVID-19 Isolation & Quarantine Discharge Guidance and review with on-call physician as needed.

Exclusions from Admission
- Client is unable to manage activities of daily living independently, or follow directions despite appropriate language or other facilitation
Client poses an imminent threat to safety of self, staff or clients, (i.e. recent documented violence, arson, or predatory behavior)

Medical problems need monitoring or treatment adjustment beyond the level that can typically be provided in outpatient care, including:
  o Client requiring supplemental oxygen by nasal cannula
    ▪  *Exception: Individuals prescribed supplemental oxygen for treatment of a chronic medical condition at 4L per minute or less and in possession of all necessary equipment.*
  o Client requires IV medications
  o Client in active alcohol withdrawal

*Clients who do not meet the above admission inclusion criteria will be assessed on a case-by-case basis with clinician.*

**Minors ages 14-17**

- Youth currently unaccompanied/experiencing homelessness and age 14+ are **eligible** for referral to an IQ facility.
  - Per RCW 43.330.702 “unaccompanied” means a youth or young adult experiencing homelessness while not in the physical custody of a parent or guardian.
- Youth currently housed and under the custody of parents/family members/other legal guardians: **eligible** but will need to be accompanied to IQ by an adult caregiver.
- Youth under the custody of the Office of Refugee Resettlement (ORR) or Division of Unaccompanied Children’s Services (DUCS): **may be eligible** for a referral. Contact IQ Health Administrator.
- Youth under the custody of the Department of Youth, Children, and Family Services (DCYF) or the Foster Care system: **not eligible** for a referral to IQ

**Special Circumstances**
- Partners or families can be co-housed.
- Certified service and emotional support animals can be accommodated with CDC pet guidance provided. Arrangements have been made with King County Animal Shelter to transport and care for other client pets while in the facility.
- Clients who are not living homeless but who cannot safely isolate or quarantine in their own homes are permitted with triage to assess need.

**Intake Process**

**Referral via Public Information Call Center**

All new referrals should be directed to the COVID-19 Public Information Call Center (PICC) for initial triage. Referrals may be made by homeless service providers, case workers, local area emergency departments and hospitals, and community clinics or by self-referral. The referring entity should provide as much triage information and medical record information as possible.
IQ Triage Team

Referrals who meet initial criteria (unable to isolate at home and are confirmed or presumed COVID-19 positive; or unable to quarantine at home and have had close contact with a confirmed case) will be referred by the PICC to Isolation & Quarantine (IQ) Triage Team who will call the referring provider back to complete intake assessment and obtain any discharge or medical records available. The behavioral health intake team will simultaneously look up the clients’ behavioral health records and assess appropriate placement. The IQ Triage Team looks up and/or pre-registers the client in EPIC (Electronic Health Record), inputs intake results, and cross checks available test results in EPIC or the Washington Disease Reporting System (WDRS). The IQ Triage Team will determine the appropriate facility based on the intake assessment. Once the client has been deemed eligible and the appropriate facility determined, all intake information – including records as available – will be shared with the onsite team through EPIC. Bed assignment will be made by the onsite team upon arrival.

Report Client Arrival to Facility Staff

IQ Triage Team will call house supervisor/charge nurse located at the assigned IQ facility. The IQ Triage Team will report the basic following information:

- Basic medical and mental health information
- Mobility
- ETOH, opioid, or other possible withdrawal concerns
- Estimated arrival time
- Current COVID-19 Status (Exposure date, test date/location/result if applicable)
- House Supervisor/Charge Nurse will notify RN/BH team of ETA

Transportation to Facility

The IQ Triage Team will arrange pick up and transportation with referring provider. Clients will be transported to the facility utilizing King County Metro vehicles that have been retrofitted with a barrier to separate the driver from the passengers. Clients will be transported in separate COVID-19 positive and presumed positive groups.

Admission to Facility

Room Assignment/Placement

Room assignment/placement will be made by the onsite team, with consideration to cluster clients according to care needs. Room assignment should be documented in EPIC in the Facility Care Encounter. Consider the following should a room assignment need to be changed: clients...
over 60 years old, with underlying health conditions or risk factors for severe COVID-19 illness should be closer to the nursing station.

**Client Arrival and Rooming**
- A nurse, MA, and behavioral health team are assigned for client admission
- Room assignment is determined before client arrives
- Before arrival RN will don full PPE, BH only needs mask (See Personal Protective Equipment Procedures below)
- BH will scribe for RN, staying at least 6 feet from guest at all times
- RN and BH will greet guest outside using AIDET skills and discuss:
  - Welcome to IQ
  - Smoking/vaping policy
  - Weapons policy
  - Mask policy
- Escort to their room
- Client is provided with hygiene kit and cleaning supplies
- Nurse obtains consent to treat and provides:
  - Notice of privacy practices
  - Public Health Officer Order
- Obtain vital signs and symptom check
- Perform COVID-19 testing as indicated in COVID Testing Protocol (Appendix 20)
- Ensure guest has telephone in room. If assessment will continue over the phone, inform guest RN and BH will be calling shortly to finish intake

**Completion of Admission and Medical Intake**
Nurse follows up by phone to complete the medical intake and admission. This is performed within one hour after rooming client.
- Bring client up in EPIC under Client Lists (See Epic IQ Nursing Intake Job Aid)
- If not already in EPIC, complete registration (See Epic IQ Registration Job Aid)
- Call client on phone within one hour of arrival to complete admission
- Review Client Information handout with client:
  - Client Code of Conduct
  - Rounding/Wellness and method of contact
  - Meal/snack schedule
  - How to request items such as snacks, toilet paper, clean linens, or toiletries
  - Reinforce smoking/vaping policy
  - How to contact the front desk/care team
  - Procedure for going outside
  - WIFI information
  - Interacting with other guests
  - Other site-specific information
Complete medical intake and EPIC intake
  - Admission: enter admission date and time and bed number
  - Isolation Status:
    - Patient Infection Status: COVID-19 or COVID-19 (rule out)
    - Patient Isolation Status: Droplet Precautions
  - Problem List:
    - Add COVID (exposure, rule out, or other appropriate option)
    - In Overview use the following dot phrase: .KINGIQPROBLEMLIST
  - Allergies: enter documented or client reported allergies
  - Medications:
    - Record documented or client reported medication in Epic
    - Coordinate medications that client needs but does not have with on-call provider (See Medication Management below)
  - Homeless Status: enter homeless status
  - Medical History:
    - Enter patient-reported problems
  - Social History
    - Enter SUD information (BH will take lead asking these questions)
  - Quick Questions: enter interpreter needs if relevant
  - Progress Note: Use the following dot phase: .KINGIQINTAKE

Tier client to Level 1, Level 2 or Level 3 (See Client Tiering below)

Client Tiering

Tier Level 1 (if any of the following apply):
  - Abnormal vital signs
  - Temperature of 100.4° F (38° C) or higher
  - Blood pressure systolic <90 mmHg or diastolic <60 mmHg
  - Heart rate <60 BPM or >100 BPM
  - Respiratory rate <12 or >24/min
  - Oxygen saturation (O2 sat) <94% on room air (or <88% if known history of COPD)
  - At risk of withdrawal from substance use disorder (See General Medical and Behavioral Health Conditions/Substance Use Disorder below)
  - Clinical discretion based on underlying health condition or concerning clinical signs and symptoms
  - Consult with clinician regarding Level 1 clients as needed

Tier Level 2:
  - Vital signs within normal limits, AND
  - Medical problems are stable, and client is able to self-manage, AND
  - Behavioral health conditions are stable, and client can self-manage
Tier Level 3:
- Must meet all Level 2 criteria, AND
- Asymptomatic, OR
- Mild COVID symptoms and is NOT at increased risk for severe illness from COVID-19*

*Individuals at increased risk for severe illness from COVID-19¹ include:
- Individuals age 60 years or older
- Persons who are pregnant
- People of any age with the following underlying medical conditions:
  - Chronic kidney disease
  - COPD (chronic obstructive pulmonary disease)
  - Immunocompromised state (weakened immune system) from solid organ transplant
  - Obesity (body mass index [BMI] of 30 or higher)
  - Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
  - Sickle cell disease
  - Type 2 diabetes mellitus

Consult with clinician if client presents with:
- Blood pressure: systolic <90 or >160 or diastolic <60 or >90 after repeat measurement (Refer to Elevated BP Guideline)
- Shortness of breath or respiratory distress
- Hypoxemia with oxygen saturation <94% on room air
- Any other acute medical or behavioral health problems or nurse-identified concern

Rounding & Client Monitoring

Tier Level 1:
- In-person assessment at least once per shift by nurse for:
  - Temperature, pulse, respiratory rate, oxygen saturation, and symptom check
  - Other vital signs, such as blood pressure, per nurse assessment or clinician order
  - Alertness and orientation to person, place, time and situation
- More frequent checks may be determined by clinician at time of tiering or at any time based on clinical status
- Behavioral health team rounds regularly with medical team to assess any needs
- Downgrade to Level 2 if client is clinically stable and vital signs are within normal limits for at least 48 hours

Tier Level 2:
- Temperature, wellness and symptom checks by phone or in person at each shift by nurse
- Behavioral health team rounds regularly with medical team to assess any needs
- Escalate to Level 1 for abnormal vital signs, worsening symptoms or clinical concerns

Tier Level 3:
- When a decision is made to downgrade a client to Level 3, document in EPIC about tiering rationale and education provided to client regarding procedures to contact care team as needed; Level 3 status should be noted on census board
- CNA/MA team will perform and chart BID symptom checks and temperatures Any fever (temperature of 100.4° F (38° C) or higher), new/worsening symptom, or any other health complaints are promptly reported to the House Supervisor or Charge Nurse for nursing assessment.
  - Symptoms of COVID-19 are defined as any of the following
    - Fever or 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
- Perform nursing triage for Tier 3 guests as needed

Other Client Care and Wellness Checks:
- The goal for Wellness Checks is for the care team to set a plan for the day for any medical and/or behavioral health needs.
- Nursing staff and behavioral health staff assigned to work together will complete the rounding and client assessment as a care team whenever possible.
- RN may dispense and administer standing order medications from the on-site stock dispensary per procedure and based on appropriate clinical judgment. May consult clinician for any questions regarding standing orders.
- Meals are dropped off outside of client rooms at mealtimes. MA/CNA/LPN delivers meal via knock and drop.
- Clients may call the care team for additional assistance when needed.
- Use the following dot phrase: .KINGIQPQGNOTE

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Behavioral Health

- Once the RN completes the nursing assessment and after the client has settled in, Behavioral Health Staff conduct the behavioral health assessment and complete the Behavioral Health Wellness Plan (see Appendix 19).
  - Review the client’s chart in EPIC for any known medical/behavioral health history at screening.
  - Check-in with the client by phone and complete the Behavioral Health Wellness Plan.
  - The Plan should be completed ideally in the first 24 hours and can be updated as needed.
  - Enter the Wellness Plan into EPIC and send a message to the BHRD Care Coordination Team. The Wellness Plan is under its own tab in EPIC and called the BH Service Plan. Refer to the EPIC Behavioral Health Job Aid document for instructions on how to enter progress notes using the dotphrases.
  - The assigned BHRD Care Coordinator will check all other relevant databases for any additional information, then enter this information into EPIC under the BH Service Plan (aka Wellness Plan) Tab.

- For clients already enrolled with an agency
  - Care Coordinator will contact the outpatient provider and initiate clinical support during stay.

- For clients not enrolled with an agency
  - If a client wants to connect with outpatient services, BH staff will contact Crisis Connections (206-461-3222) to schedule a Next Day Appointment (NDA) to connect the client with an outpatient provider.
  - This intake appointment will take place over the phone. There are four NDA providers: Navos, Harborview, Valley Cities and Sound.
  - When calling Crisis Connections, please have information about the client prepared ahead of time.

- Outpatient provider clinicians will contact the client via phone to develop an individual service plan (ISP) for their IQ stay. If the client is not enrolled, the NDA provider will begin with a behavioral health assessment to identify need for ongoing services and support.

- The outpatient provider clinician will reach out to the client via phone at least once per day for the duration of the IQ stay, more if agreed per the ISP. The clinician will also collaborate and coordinate care with IQ team as needed.

- Peer supports are available based on the client preferences.

Medical Management & Care Coordination

- Medical problems related to COVID-19 can be managed by standing order or consultation with the on-call provider as needed
Non-COVID-19 related acute medical conditions can be triaged and managed on a case by case basis with help from the on-call provider as needed.

Guests should be managing their chronic health conditions; IQ scope includes care coordination, reminders, and education.
  
  - Utilize *Telephone Triage for Nurses* by Julie K Briggs.
  - Use the following dot phrase to cite the book: KINGIQTRIAGECITATION

Tele-health visits: Consultations with an on-call provider can be coordinated and the guest be issued a phone

**Medication Management**

Clients will be responsible for managing their own medications.

- Clients arrives with home medications:
  - Record medications in EPIC at intake
  - Clients will self-manage regular medications during stay

- Clients without prescribed medications upon arrival:
  - Ask client if anyone can locate and deliver medications to site
  - Coordinate with client’s PCP or call stated pharmacy to request refills
  - If refills available: IQ staff will arrange to have prescriptions picked up at pharmacy and delivered to client’s room
    - Copays can be paid for out of site petty-cash if the patient does not have means to pay for it
  - If no refills available: call clinician to request refill

- Clients who need a medication but do not have a current prescription and are unable to get a prescription from their PCP:
  - Review medication need with clinician (obtain records if possible)
  - Clinician will determine whether to fill medication, not to fill medication, or find an alternative
  - Nurse coordinates obtaining prescribed medication with site manager and communication with client

- Use the pharmacy at the Downtown Public Health Center for clients who do not have insurance coverage. Courier can be used for medication transport. Can only fill scripts written by Public Health providers.

- Methadone doses should be kept in the central lock box/pharmacy and administered daily to the client with appropriate documentation and following the courtesy dosing protocol (see Methadone Administration Appendix 17).

- Clients taking buprenorphine can keep their medication with them or can have it stored in the central lock box and administered daily by the RN with appropriate documentation.

- Any medications requiring daily observed dosing will be administered by the RN.

- Adjustment to routine medications will be determined and ordered by a prescribing provider using EPIC.
RN can dispense and administer standing order medications from the on-site stock dispensary as instructed and based on appropriate clinical judgment. May consult prescribing clinician for any questions regarding standing orders.

**When to Call Clinician**
- Systolic blood pressure <90 mmHg or >160 mmHg (refer to Elevated BP Guideline)
- Heart rate <50 or >110 beats per minute
- Respiratory rate <12 or >30 breaths per minute
- Oxygen saturation <94% on room air (or <88% if known history of COPD)
- Point of care glucose >300 or <70
- Shortness of breath or respiratory distress with inability to speak full sentences
- Chest pain or chest pressure
- Intractable vomiting and inability to tolerate oral intake
- Severe headache
- Signs of active withdrawal from substance use disorder
- Change in mental status or confusion
- If a client becomes significantly distressed, agitated or violent
  - Behavioral health team to evaluate urgently
  - Security on stand-by as warranted
- Any other clinical concern

**Contacting the On-Call Physician**
- Use EPIC Staff Message to send Non-Urgent matters or FYI notifications to the IQ Provider Pool for review
  - The IQ Provider Pool is for non-urgent issues only, and typically monitored intermittently from 0800 to 1600 Monday through Friday, excluding holidays
- For urgent matters:
  - Call the on-call provider - if no answer, leave a voicemail. If no response, try again. Allow 20 minutes for a return phone call.
  - If you cannot get in contact with the on-call provider, Lead Physician is the back-up, follow the same process.
  - If you cannot get in contact with either the on-call provider or Lead Physician, the final backup is the Medical Director.
- Phone numbers for these providers are in ScheduleAnywhere and should be posted for the shift on the white board.

**When to Transfer to Higher Level of Care**
- Clinical instability or uncontrollable symptoms despite interventions
- Acute mental health condition not resolved by standard interventions
- Signs of hypoxemia or hemodynamic instability
- Clinical condition requiring
- Vital signs monitoring more frequently than every 4-6 hours
- Supplemental oxygen greater than 4L/min
- IV fluid administration
- Inability to perform ADLs independently

**COVID-19-Related Signs and Symptoms**

- **Fever:** acetaminophen as needed.
- **Pain:** acetaminophen as needed. NSAIDs only as second line if needed. No narcotics.
- **Cough:** Robitussin and cough lozenges as needed.
- **Diarrhea:** if no suspicion for other infectious etiology, loperamide AD as needed (2 tabs after first episode, then 1 tab after each loose stool, max 6 tabs/day)
- **Shortness of breath:** should always be assessed by RN and consulted with clinician. Albuterol MDI as needed. For oxygen saturation <94% (or <88% if known history of COPD), begin supplemental oxygen by nasal cannula at 2L/min, titrating to maintain O2 sat >94% (or >88% if known history of COPD).
  - If client demonstrates persistent hypoxemia or increased work of breathing requiring supplemental oxygen, transfer to a higher level of care for further evaluation and management.

**Supplemental Oxygen**

- Clients with supplemental oxygen needs should be arriving with their own equipment.
- A limited number of oxygen concentrators are available at each site for initiating supplemental oxygen. Concentrators can provide up to 5L/min of continuous supply of concentrated oxygen from ambient air.
- The concentrator has a motor and slight noise and therefore should be placed away from the client’s bed (ideally in the bathroom), with enough tubing to reach the client anywhere in the room.
- Portable oxygen cylinders are available for emergent oxygen supply for unstable client requiring more than 4L/min, while awaiting transfer to the hospital.

**General Medical and Behavioral Health Conditions**

- **Asthma, COPD:**
  - Continue routine medications if symptoms are well controlled. Albuterol MDI as needed for shortness of breath. Consider transferring to a higher level of care if condition is not controlled despite intervention.

- **Congestive heart failure:**
  - Monitor for clinical symptoms, such as shortness of breath when lying flat, waking up at night short of breath, or worsening leg swelling. If these symptoms develop, consult on-call physician, check vital signs including oxygen saturation, and monitor daily weight.
**Diabetes on oral medication or diet controlled:**
- For clients with controlled diabetes and not requiring insulin, daily blood sugar checks are not required.
- If the client requests a blood sugar check, MA/RN can provide the check.
- If the client has symptoms of hypoglycemia, MA/RN should test blood sugar.
- Clean glucometer per infection control protocols.

**Diabetes requiring insulin:**
- Understand and follow client’s usual regimen via client history and review of medical record.
- See Insulin Conversion Chart in Appendix 3 if needed.
- Consider giving the client their own glucometer if they don’t have one. (Medicaid should cover for Medicaid clients.)
- If the client has symptoms of hypoglycemia or hyperglycemia, RN/MA should test blood sugar.
- Juice or oral glucose should be available if needed for hypoglycemia.
- Clean glucometer per infection control protocols.

**Hypertension:**
- For elevated blood pressure (BP) readings, consider potential underlying causes, have client rest for 5 minutes with cuff in place, and repeat BP measurement; if reasonably controlled (under 140/90) and regularly taking medications, continue current management; consult with clinician if BP is uncontrolled or if medication adjustment or initiation is needed.

**Lice or scabies:**
- Oral ivermectin one-time dose of 12mg; and/or
- Permethrin 5% cream: apply from neck to toes including all creases in skin; leave on for 8-14 hours, then wash thoroughly; may repeat in 10-14 days if needed.
- Permethrin 1% lotion/shampoo: apply to towel-dried hair, saturate hair/scalp, wash off after 10 minutes. If client has a hair piece or wig, special cleaning may be required.
- Heat treat or launder any clothing/belongings. Items that cannot be laundered or heat treated can be placed in a sealed plastic bag for two weeks.
- Additional guidelines pages 13-16 of PHSKC’s Sanitation and Hygiene Guide for Homeless Service Providers, which can be found online.

**Agitation or Anxiety**
- Assess for underlying cause of fear, such as hypoxemia, infection, overdose, a reminder of previous trauma, withdrawal, intoxication, etc.
- Engage with behavioral health staff
- Address the underlying cause
- Consider non-pharmacologic interventions: brief problem solving, offer comfort such as food/drink, relaxation and distraction strategies
  - Consider pharmacologic interventions (See Rapid Response section below).

**Insomnia**
- Consider environmental measures (lights, earplugs, etc.) as able.
- Melatonin or diphenhydramine as needed (caution in clients >65 years old).
- Mirtazapine 15mg as needed, assess for drug interactions.

**Substance Use Disorder**
- **Nicotine:** If a client reports regular use of cigarettes, chewing tobacco, vaping, etc.,
  - Offer nicotine replacement therapy with a daily patch and gum as needed per standing order.
  - For harm reduction strategy, see Nicotine Use Guidelines (Appendix 10).
- **Alcohol:** Clients consuming >4 drinks/day for the past 5 days OR any alcohol use in past 7 days with a history of withdrawal symptoms in the past are considered at risk for withdrawal.
  - Offer alcohol withdrawal management according to the Alcohol Withdrawal Prevention Guidelines (Appendix 11).
  - For harm reduction strategy, see Managed Alcohol Use Guidelines (Appendix 12).
  - Clients with active alcohol withdrawal or a history of hospitalization for alcohol withdrawal, seizures, delirium tremens or other contraindications listed in the guidelines are not appropriate for I&Q facilities.
- **Benzodiazepines:** If a client reports regular daily use of prescribed or illicit benzodiazepines, follow Benzodiazepine Withdrawal Guidelines (Appendix 13).
  - Clients with active benzodiazepine withdrawal or a history of severe benzodiazepine withdrawal, seizures or delirium from withdrawal, or who report daily use of >40 mg/day diazepam equivalents for >2 months are not appropriate for I&Q facilities.
- **Stimulants:** If a client reports recent use of stimulants such as cocaine, crack, or methamphetamine, follow the Stimulant Use and Withdrawal Guidelines (Appendix 14) for providing appropriate supportive care.
  - Clients using methamphetamine may benefit from beginning mirtazapine (Remeron) 15-30 mg PO nightly.
- **Opioids:** If a client reports illicit opioid use, follow the Opioid Withdrawal and Buprenorphine Guidelines (See Appendix 15).
- Ask about amount and type of opioid used, time last used, as well as about concurrent alcohol or benzodiazepine use.
- Ask about symptoms of opioid withdrawal. Signs and symptoms of withdrawal include restlessness, muscle/bone/joint pain, congestion/tearing, gooseflesh, yawning, anxiety, tremor, stomach cramps, nausea/vomiting, diarrhea, pupillary dilation.
- The on-call physician is available to discuss medications to treat symptoms of opioid withdrawal.
- Addiction medicine may be consulted for complicated cases and for guests who are pregnant.
- Offer buprenorphine/naloxone (Suboxone) and/or withdrawal medications if needed. See Buprenorphine Prescribing Steps (Appendix 16).
  - If on buprenorphine: prescribing provider should continue Rx.
  - If not on buprenorphine or cannot contact provider: consult with waivered clinician on-call.
- All clients currently receiving methadone will be admitted to the Aurora IQ facility. See Methadone Administration Process (Appendix 17).
- Naloxone (Narcan) should be prescribed to all clients with opioid use disorder. See Naloxone Prescribing Guidelines (Appendix 18).

Rapid Response and Emergencies

Medical Emergency
If a client decompensates medically or becomes unconscious/unarousable:
- Perform basic life support (BLS) if indicated.
- Assess vital signs including blood pressure, heart rate, respiratory rate, oxygen saturation, and temperature.
- Check finger stick glucose, and if <70 mg/dL, administer dextrose 50% (D50).
- Perform focused physical exam and check for mental status and orientation.
- Assess for conditions including respiratory failure.
- If opioid overdose is suspected, administer naloxone and call 911.
- Consider administering oxygen or albuterol per protocol if indicated.
- Review medical history to determine other possible risks.
- If client is stable and an appropriate intervention is identified, consult clinician for further guidance.
- If client is unstable (unstable vital signs, acutely worsening clinical condition, or uncontrollable symptoms) or if interventions are ineffective, call 911 and transfer the client to a higher level of care.

Behavioral Health Emergency
If a client becomes significantly distressed, agitated or violent:
- Behavioral health team to evaluate urgently.
- Security on stand-by as warranted, with attention to safety of client, staff and milieu.
Review and administer medications if clinically indicated and client is willing.
  o  Zydis (Olanzapine) 10mg PO x 1 (do not give to older adults with dementia)
  o  Consider consultation to on-call psychiatrist and transfer to higher level of care.

Client Electing to Leave Against Medical Advice

Clients are at the facility voluntarily; we cannot force them to stay and security will not enforce a client to remain on-site.

Speak with the client about what is concerning them or motivating them to want to leave. Look for a way to problem-solve what it will take to keep them at the facility for the remainder of their stay.

Utilize de-escalation and empathy during this process. If a client elects to leave the facility despite counseling, attempt to develop a quick discharge plan or get a sense of where the client will be going.

During daily rounds, focus on assessment of warning signs, early intervention and anticipating concerns that may come up to motivate a client to leave. Note that if a person tries to leave, we will not restrain or force a person to stay on-site.

Knowing the client’s COVID-19 status (positive/negative), exposure history, and how many days remain before their scheduled discharge is important to know during conversations with each client.

If the individual walks off, security may follow at a distance while contacting a law enforcement officer. At that point, a court order could be obtained at the discretion of Public Health. However, in most cases if a client insists on leaving, we will attempt to learn where they plan to self-isolate and assist with transportation.

Ensure the client is offered a facemask upon their departure and provide education regarding the importance of mask wearing, hand hygiene, and physical distancing.

If Priority 4 and negative, provide Priority Four discharge letter (KINGIQPRIORITYFOURDISCHARGE)

Immediately notify the behavioral health lead of any client who leaves AMA.

Public Health Emergency Code Policy and Procedures

<table>
<thead>
<tr>
<th>CODE NAME</th>
<th>CODE MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Smoke and/or fire</td>
</tr>
<tr>
<td>Blue</td>
<td>Cardiac arrest and/or respiratory failure</td>
</tr>
<tr>
<td>Orange</td>
<td>Hazardous material spill</td>
</tr>
<tr>
<td>Gray</td>
<td>Combative person needing de-escalation</td>
</tr>
<tr>
<td>Silver</td>
<td>Person with a weapon</td>
</tr>
<tr>
<td>Amber</td>
<td>Missing infant or child</td>
</tr>
<tr>
<td>[Code Name] Clear</td>
<td>Indicated code situation is resolved</td>
</tr>
</tbody>
</table>

See Appendix 4 Standardized Emergency Code for more detail.
## COVID-19 Isolation & Quarantine Discharge Guidance by Bed Prioritization Group

<table>
<thead>
<tr>
<th>Isolation &amp; Quarantine Bed Prioritization Groups</th>
<th>COVID Test Result</th>
<th>Discharge Criteria (For Clients with Mild or Moderate Illness) ¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority 1.</strong> Confirmed COVID-19 positive with illness</td>
<td>Positive</td>
<td>≥10 days since symptom onset, AND ≥24 hours after resolution of fever, AND improvement in symptoms</td>
</tr>
<tr>
<td><strong>Priority 2.</strong> New COVID-19-like illness (CLI)², known exposure ³</td>
<td>Positive</td>
<td>Same criteria as COVID+ (Priority Group 1)</td>
</tr>
<tr>
<td></td>
<td>Negative or not tested</td>
<td>Same criteria as COVID+ (Priority Group 1)</td>
</tr>
<tr>
<td><strong>Priority 3.</strong> New COVID-19-like illness (CLI)², unknown exposure</td>
<td>Positive or not tested</td>
<td>Same criteria as COVID+ (Priority Group 1)</td>
</tr>
<tr>
<td></td>
<td>Negative or not tested</td>
<td>≥24 hours after resolution of fever, AND improvement in symptoms ⁵</td>
</tr>
<tr>
<td><strong>Priority 4.</strong> Asymptomatic but had known exposure ³</td>
<td>Positive</td>
<td>10 days since the date of the first positive test (if no subsequent symptoms)</td>
</tr>
<tr>
<td></td>
<td>Negative or Not Tested</td>
<td>14 days after the last day of close contact or exposure ⁶</td>
</tr>
</tbody>
</table>

¹ These criteria apply to patients with mild to moderate illness who are not severely immunocompromised. Patients with severe illness or who are severely immunocompromised may discontinue isolation after at least 20 days have passed since symptom onset, AND at least 24 hours have passed since last fever without the use of fever-reducing medications AND improvement in symptoms. Discuss with a physician for additional recommendations and see CDC guidance: [https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html).

² Consider alternative diagnoses and evaluate for other causes for CLI when testing for COVID-19.

³ Includes HEART referral or residents from a congregate setting known to have an outbreak.

⁴ Retest if symptoms worsen or new symptoms develop.

⁵ Can be considered on a case-by-case basis and discussed with physician (e.g., persons with risk factors for severe COVID-19 illness may stay longer).

⁶ Fourteen-day quarantine period recommended. Offer continued stay to client, dependent on current resources.
COVID-19 Illness Severity Criteria
(adapted from CDC and the NIH COVID-19 Treatment Guidelines)

**Mild Illness:** Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

**Moderate Illness:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

**Severe Illness:** Individuals who have respiratory rate >30 breaths per minute, SpO2 <94% on room air at sea level (or, for clients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

**Critical Illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

**Severely Immunocompromised Condition:** Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of transmission-based precautions.

*(Note: In pediatric clients, normal values for respiratory rate vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.)*

**Test-Based Strategy or Repeat Testing After a Period of Isolation**

Questions have been raised about repeat testing for people with a positive COVID-19 test who have finished the appropriate isolation period. In some cases, individuals discharged from Isolation & Quarantine get tested again in the community and test positive. Providers are confused and unsure what this test result means. While we are still learning about COVID-19, the information below provides currently available scientific evidence and guidance from CDC and WHO to help determine what to do in these situations:

1. After people with COVID-19 have completed the recommended isolation period, they have a low risk of transmitting the virus to others.
2. The COVID-19 test often continues to be positive for a few days to weeks after recovery. Most people will have a negative test by about 3 weeks, but the test can be positive for up to 12 weeks. After isolation and recovery, a positive PCR test is not likely to indicate the presence of infectious virus.
3. People who have a repeat positive test after completing an appropriate isolation period do not need to be isolated again. Anyone who develops new symptoms consistent with COVID-19 should be evaluated by a medical provider.

A test-based strategy is no longer recommended (except as noted below*) because, in the majority of cases, it results in prolonged isolation of clients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

*In some instances, a test-based strategy could be considered for discontinuing transmission-based precautions earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some clients (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the client being infectious for more than 20 days.

Discharge Planning by RN and BH

Discharge planning by RN and BH should begin at admission and includes the following:

- Develop a list of issues which must be resolved before discharge
  - Symptom resolution, isolation/quarantine duration, other concerns
- Tentative plan for housing on discharge
  - Home, temporary housing, shelter, other
- Mental health or substance use disorder follow-up if needed
- Any specific needs/barriers delaying or complicating discharge
  - Medication needs, wound care, etc.

Safety Criteria for Discharge

- Non-infectious per Public Health or CDC guidelines
- No oxygen needs unless on oxygen at baseline
- Stable on current medications
- Safe discharge plan available
- Discharge readiness should be assessed by RN or BH every 1-2 days

Discharge options for clients without available housing:

- Temporary housing (if available and meets criteria)
- Shelter: if no symptoms, low risk (under 60, no chronic medical conditions)

Discharge process:

- Coordinate with Behavioral Health Team to determine discharge disposition
- Complete discharge in EPIC, use the following dot phrase: .KINGIQDISCHARGE
- If discharging to a homeless service agency, 24 notice is preferred.
- On the day of discharge, the RN will lead the discharge and facilitate the process. The nurse will provide a letter (via EPIC to print) stating the person is safe to discharge.
- RN confirms discharge date by above criteria
- Notify site manager guest has left
- Discharge meds: 14-30-day supply through pharmacy if needed
BH evaluation if appropriate
- Documentation of discharge in record with notification to PCP
- Referral for PCP if client does not have existing PCP
- Follow up with mental health if needed
- Follow up with primary care 1 week or sooner if needed
- Provide information about when/how to seek care if symptoms recur or worsen
- Destination identified by the client
- Transportation to desired destination provided

Provide client with appropriate list of provider referrals
- Medical Clinics and Providers
- Dental Clinics
- Behavioral Health Providers (including referrals to substance use disorder treatment if needed)
- Pharmacies

Safety, Infection Control, and Environmental Health

Staff Safety
- Staff are not permitted to go to client rooms alone at any time.
- Staff must provide all client care in pairs.

Food Safety
- Staff are not permitted to consume any food or drinks inside the hot or warm zones (see PPE Zones below.)
- Designate an MA to monitor food safety, and ensure all perishable items are either refrigerated or discarded four hours after delivery.
- Monitor refrigerator ambient air temperature by checking the thermometer inside the unit daily. Ideal air temperature should be between 38 – 39°F, and less than 41°F.
- When you place perishable foods into refrigerator, provide adequate spacing to allow proper cold air circulation.
- Maintain the food storage areas in a clean, sanitary condition and free of insects/rodents.

Facility Behavioral Expectations & Rules for Clients
Facility rules should be reviewed with each client upon admission and are included in the Client Information handout:
- No weapons of any kind on the premises.
- No alcohol is allowed in client rooms without behavioral health plan and care team approval.
- No smoking or vaping is allowed in client rooms or any indoor area.
- There is a designated smoking area. Please discuss the smoking procedure with your care team.
- Please answer calls from the care team and return their calls.
❑ Don’t wait to ask for things you might need to be comfortable. Let the care team know so they have time to get you what you need.
❑ Be respectful of others recovering or awaiting results by respecting people’s privacy, maintaining a low volume of sound that cannot be heard outside your unit, and keeping a 6-foot distance from other clients.
❑ Visitors are not allowed on-site. If you need support for safety and housing of your family, please notify your care team.
❑ Only service animals and emotional support animals are allowed on-site. No other pets are permitted. If your pets need care or housing, please notify your care team.
❑ If required to make close contact with you, your care team will be fully protected with gowns, masks, face shields, and gloves.
❑ Please wear a mask if a care team member needs to come into your room or speak with you in-person.

**Role of Security Personnel**
- Keep the perimeter safe for clients and staff, ensuring no one without authorization enters the facility.
- Report any unusual activity or observations to operations staff and ask whether and how to best address.
- Limit interactions with clients unless staff or client are facing an imminent threat or unless requested by staff. Clinical staff should be the only staff interacting with clients.
- Resolve imminent threat to client or staff safety following protocols.
- Ensure client privacy by not discussing client medical status or requesting information about client medical status with/from clinical staff.
- Follow clients leaving the facility unless instructed not to follow by operations staff.
- Continue to follow clients leaving the facility (by car and with your radio) until asked to stand down by your chain of command.
- Stay alert and awake throughout the entirety of shift.
- Treat clients courteously and politely.
- Confirm permission to enter when a client or anyone else is seeking to enter the facility.

**Infection Prevention and Control**

**Employee Symptom Screening and Tracking**
All facility staff (clinical and operations) are screened for a fever and the presence of any symptoms upon arrival. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with one or more of these symptoms may have COVID-19:
- Fever or 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

*(NOTE: The list of COVID-19 symptoms continues to evolve. For the most up-to-date list of symptoms, refer to [CDC web site](https://www.cdc.gov).*

Each facility and shift should have a designated person to screen all employees entering the site. The screener is responsible for:

- Reading the list of symptoms above and/or refer the individual to a posted list of symptoms.
- Ask the individual if they are experiencing any of the listed COVID-19 symptoms and receive verbal confirmation from them (“yes” or “no”).
  - “No” response:
    - Ask to take their temperature with a no-contact forehead thermometer.
    - If the temperature is 100.4°F or above, then follow the “yes” response protocol below.
  - “Yes” response, or temperature 100.4°F or above:
    - Instruct to immediately self-isolate and physically distance at least 6 feet away from others
    - Provide a facemask to the person if not already wearing, with instructions on proper donning
    - Contact the (nursing) supervisor on-site or on-call

The supervisor will make the determination if the person should be sent home and share information about where to get medical help or testing. If consultation or help with decision-making is needed for symptomatic employees, consultation is advised with PHSKC Employee Health or the lead physician associated with the site.

Asymptomatic essential employees who have been exposed or potentially exposed to COVID-19 may still come to work with appropriate precautions while monitoring symptoms. They should wear a mask throughout the day and take other precautions to reduce the potential for viral transmission, including physical distancing from clients and other staff, whenever possible.

**Personal Protective Equipment Procedures**

**Disbursement/PPE Requirements**

- All scrubs and PPE will be disbursed at the beginning of shift and as needed.
- Staff must be fit tested before donning an N95 respirator for client care. Each model of N95 must be separately fit tested.
Donning

- **Identify and gather the proper PPE to don.** Ensure choice of gown size is correct (based on training).
- **Perform hand hygiene using hand sanitizer.**
- **Put on isolation gown.** Secure on the gown. Assistance may be needed by other healthcare personnel. See instructions specific to gown type.
- **Put on a surgical mask with droplet protection (or NIOSH-approved N95 filtering facepiece respirator or higher for aerosolizing procedures).** If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or帐篷ed. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between clients.
  - **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
  - **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
- **Put on face shield or goggles.** When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes.
- **Put on gloves.** Gloves should cover the cuff (wrist) of gown.
- **Healthcare personnel may now enter warm zone** (see below for zone descriptions).

Doffing

- **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
- **Remove gown.** Untie all ties (or unsnap all buttons/unzip). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle or laundry bin if reusable.
- **Healthcare personnel may now exit warm zone.**
- **Perform hand hygiene.**
- **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
- **Remove and discard respirator (or facemask if used instead of respirator).** Do not touch the front of the respirator or facemask.
- **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.

- **Facemask:** Carefully untie (or unhook from the ears) and pull away from face without touching the front.

- **Perform hand hygiene after removing the respirator/facemask and before putting it on again if practicing reuse.**

**PPE Zones**

In order to standardize operating procedures and limit exposure risks it is recommended to identify areas of different contamination risk. These areas are clearly labeled with posted signs and information on PPE required in each area.

- **Clean Zone**
  - Any area of the site where client access is restricted, and where any staff have fully doffed any PPE, except facemask. Generally, this is any operations office space and clean storage.

- **Warm Zone**
  - All areas of the site outside of client rooms/care areas, where clients and staff both have access.
  - Clients in warm zones should wear masks at all times, except when smoking.
  - Clinical staff in *indoor* warm zones should don the same PPE as required for hot zones.
  - Clinical staff in *outdoor* warm zones for purposes other than client care, and operations staff, should don a face mask and gloves and maintain 6’ of separation from clients. Cloth (non-medical) face coverings will suffice.
  - Proper hand hygiene procedure should be observed when entering and exiting the warm zone.

- **Hot Zone**
  - For IQ facilities, hot zones are all rooms that are occupied by clients, or have been recently occupied and yet to be cleaned/disinfected. All staff in this area must wear full PPE including: scrubs, surgical facemask, face shields, gloves, and gowns. Booties and bonnets are optional.
  - Movement of medical equipment in and out of the hot zone should be minimized by providing dedicated equipment that is intended to remain in each hot zone for the duration of the IQ facility use. Medical disposables should be discarded when removed from the hot zone, whether product was opened/used or not.

**General PPE Guidelines**

- **Change out of dirty scrubs before leaving the site.** See Scrubs Policy (Appendix 23).
- **Donning and doffing should occur in designated and clearly marked areas.**
- **Posters with donning and doffing instructions should be posted on the wall, and visible from at least 6’.** (see [CDC Donning and Doffing posters](https://www.cdc.gov/).)
Support each other. If you see something of concern about PPE, say something. We are all responsible for keeping ourselves and each other protected.

Minimize direct client contact to only times that are medically necessary.

All staff must wear procedure masks, face shields, gloves and gowns inside the hot zone at all times.

If remaining 6 feet away from a client, changing PPE is not required.

All client deliveries should be placed outside the client’s door when possible (drop and knock).

N95 use should be reserved for aerosol-generating procedures, such as for people assisting with the administration of nebulized medication or entering clients rooms within 2 hours of CPAP/BiPAP use. If possible, use of metered-dose inhaler (MDI) with a spacer should be encouraged in place of nebulizer use to minimize aerosol generation. Note: Providing low-flow supplemental oxygen to clients is not considered an aerosol-generating procedure.

If client is not able to use an MDI, nebulizer treatment should be done outside with person assisting using airborne precautions: face shield, N95 mask, gown and gloves.

Surgical masks should be worn for the duration of the shift unless soiled, damaged or hard to breathe through. Care should be taken not to touch the facemask. If adjustments are necessary, the provider should perform hand hygiene immediately after touching the mask. Providers should leave the client care area before removing their mask.

Gowns should be worn for the duration of the shift unless soiled or damaged.

Gloves should be changed after every client encounter followed by hand hygiene after the gloves are removed.

An additional PPE supply will be available in the facility for changes of soiled items.

Doffing will occur before leaving the hot zone in the designated area.

Place face shields in the receptacle for sanitizing and restocking.

Clients arrive wearing a mask during check-in and are required to wear a mask when outdoors at all times except when smoking.

Client will notify staff if they need to smoke and will wear mask when going outside of the facility.

Room Turnover Procedures

Site Manager to call BioClean biohazard contractor for cleaning of COVID positive rooms.

Infectious and Other Waste Disposal Procedures

Disposable PPE and other materials that come into contact with COVID-positive individuals generally not are not considered biomedical waste and should be discarded in the regular garbage. Common Healthcare Wastes That Are Not Biomedical Waste:

- Personal protective equipment (PPE) of health care workers e.g. disposable gloves, gown, and respiratory protection
- Spent dust filters
- Textile wastes e.g. bedding, towels, and clothing
Blood and blood products that are absorbed by materials such as bandages, napkins or commercial absorbents

- All sharps waste must be placed in provided sharps containers.
- If sharps are found on the floor:
  - Place an open sharps container next to the item.
  - With gloved hands, use tongs to pick up the sharp and place in the sharps container.
- Full sharps containers and non-sharp biomedical waste are placed in the biomedical waste containers (lined with red bags).
- Biomedical waste containers should be placed in designated areas that are inaccessible to clients.
- Materials that are heavily soiled, including clothing and cleanup materials with feces, vomit, and urine, should be bagged before placing in a garbage receptacle away from the client’s bed.
- Clients should secure and place full garbage bags outside of their room doors, and call to notify staff if possible. Since staff in these areas should be wearing “warm zone” PPE, no additional PPE is required to transport the garbage bag to the facility dumpster.

**Cleaning and Sanitation**

FMD provides the following:
- Routine janitorial services
- Sanitize high touch surfaces, and check/refill wall-mounted sanitizer dispensers
- As needed/on request: clean up bodily fluids, remove full biomedical waste containers
- Clean floors
- Following discharge: cleanup of non-COVID client rooms

MAs provide the following:
- Removing bedding from client rooms after discharge
- Removing any laundry from outside client rooms to the laundry bin

Site staff provide the following:
- Collect trash from outside client rooms and brings to central trash
- Hotbox of client belongings if available

BioClean hazmat contractor provides the following:
- Full decontamination of client space after discharge

**Laundry**

- Provide fresh bedding and towels once a week, per client. More often if items become soiled.
- Ask clients to bag their used bedding and towels in garbage bags, to leave outside their room doors for pick up.
  - Discard bags after transferring dirty laundry for laundry pick up. Use clean, unused garbage bags for storing and/or transporting clean laundry.
Bed Bugs/Lice/Scabies

Pest (bed bugs) control & prevention must be an integral part of running a successful shelter, congregate living setting, or IQ facilities. These facilities are at a greater risk because of high turn-over rates of clients and their belongings.

Client assessment for bed bugs, lice, and scabies

- **Lice, Scabies & Bed Bugs should be screened for and treated during the client intake process to be considered the most effective.**
  - Nurses provide lice and scabies treatment so clients can self-treat in their rooms.
- Encourage clients to treat their personal belongings in a heat treatment box to eliminate bed bugs, lice, and scabies, if available.
- Let clients know that initial screening and treatment of personal belongings is a routine step to help reduce the risk of site pest infestation. Staff should assure clients that their belongings should remain intact after a heat treatment.
- If client’s privacy is a concern, clients should be able to place their belongings into bags themselves, and they should be sealed by a zip tie or a tamper-proofed seal to honor their owner’s request. Be sure to label client’s bag(s) properly with the client name.
- During bag preparation ensure that flammable materials, pressurized cans, lip balm/lipsticks, batteries, or any items that are sensitive to heat are being kept out of the heat treatment. Most personal belongings, including books and some electronic devices, can be heat treated in the heat box. If possible, all belongings should come out of a suitcase and into a bag for an effective heat treatment. Empty suitcases should be treated with all open zippers.
- Consult the unit’s manufacturer for treatment times and temperatures and how well you keep your heat box from losing heat during the treatment. It is required that these units are used indoors.
- If a heat treatment box is not available, machine wash and dry infested clothing and bedding a 130°F for at least 30 minutes or place items in a sealed plastic bag for two weeks to control lice and scabies. Store bags in a safe and isolated space or room.
  - Bag and discard bed bug infested items that cannot be treated.
- Return the clients belongings to them promptly after heat treatment is performed or place excess items which are not needed during the stay into a remote storage area. Ensure all personal belongings are returned to the client prior to the client being discharged.

Other safety concerns:

- Personal belongings of potentially positive COVID-19 clients should be handled using the facility’s infection control protocols
- If a client brings in a firearm or weapon, please work with your site manager to store it in a safe manner.
- See the Sanitation & Hygiene Guide for the Homeless Service Providers for a recommended to-do checklist.
Treatment of Infected Rooms
- If a client reports a bed bug issue, or bed bugs are discovered by staff during room turn-over cleaning procedures, immediately notify site safety manager.
- The affected room and adjacent rooms may need to be placed out of use for a period of time until effective treatment has been provided to eliminate all bed bugs.
- Contact a certified bed bug extermination company.

Client Records (EPIC)

Client Lists in EPIC – Clients at IQ
- A list of clients who are admitted to IQ is available in client lists:
  - Login Dept – All Admitted
- A list of clients who are awaiting nursing intake at IQ is available in client lists:
  - Triage - Login Dept
- A list of clients with diabetes at the IQ (diabetes on problem list):
  - Login Dept – Diabetes Registry

Provider Teams (services) in EPIC
- Within Epic, clients may be added to provider teams to facilitate care continuity and communication between nursing staff and appropriate provider. Providers will sign in and out of their team in EPIC when they come on and off site.
- Nurses are assigned (or assign themselves) to their clients in EPIC when they come on shift and unassign when they leave. This allows other staff and providers know who is taking care of a client at any given time.
- A clinical user’s assigned list of clients is available in the client list:
  - Login Dept – My Clients

Clinical Users - Communication within EPIC
- Nurses may send a secure chat in EPIC to a client’s provider team members. This will send a notification to all team providers logged on to EPIC at the time, and the available provider may respond.
- Clinical users may use EPIC secure chat regarding a client with other EPIC users.
- In-basket pools have been set up for each site.

Epic Training and Support Materials
- Epic training materials including Videos and Job Aids as well as EPIC reference materials for standard workflows are available on the DPH IQ SharePoint site.

Epic Help Line: 206-263-1212
EHR.HELP@kingcounty.gov  Monday – Friday:  7 AM – 6 PM
Facilities Information
The following information should be determined, documented and made available for staff at each site:
- Facilities and IT primary points of contact
- Facility point of contact for each location
- Plan for building evacuation
- Location of fire extinguishers
- Test all systems in all areas to be occupied
  - Clinical (e.g. oxygen, air, ventilation, labs, etc. as applicable)
  - Non-clinical (e.g. HVAC, phones, etc.)

Critical Contact Information
The following information should be determined and documented for each site, and provided in a separate handout:
- Public Information Officer
- Emergency Management
- Fire / EMS
- System Leadership
- Vendors / Services
- Supplies
- Attorney for health orders
- Meals
- Laundry
- Janitorial

Language and Interpretation Resources
Phone interpretation available through the interpretation line, 206-535-2498

Media Inquiries
All press inquiries should be directed to the Public Health Public Information Officer. IQ staff are not authorized to speak with the media or with governmental officials on behalf of Public Health or DCHS.

Provider Liability
Health care providers who provide care in accordance with the priorities and protocols herein, including care provided outside of their scope of practice or scope of license, will be considered
to have provided care at the level at which the average, prudent provider in a given community would practice.

Any individual client to whom this standard of care is provided should have no basis to assert in a medical malpractice claim against the health care provider that an appropriate level of care was not provided. Moreover, the health care provider, having met this standard of care, should not be held liable in a malpractice action based on the provision of care in accordance with the standards of care herein.

### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AC/RC</td>
<td>Assessment Centers/Recovery Centers</td>
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<tr>
<td>AMA</td>
<td>Against medical advice</td>
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<td>BH</td>
<td>Behavioral health</td>
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<tr>
<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
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<tr>
<td>COVID-19</td>
<td>Coronavirus Disease 2019</td>
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<tr>
<td>DOH</td>
<td>Washington State Department of Health</td>
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<tr>
<td>EOC</td>
<td>Emergency Operations Center</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<td>HMAC</td>
<td>Health and Medical Area Command</td>
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<tr>
<td>IQ</td>
<td>Isolation and Quarantine</td>
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<td>KC</td>
<td>King County</td>
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<td>KCPH</td>
<td>King County Public Health</td>
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<td>KP</td>
<td>Kaiser Permanente</td>
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<td>MA</td>
<td>Medical Assistant</td>
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<td>OTC</td>
<td>Over the counter</td>
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<td>PPE</td>
<td>Personal Protective Equipment</td>
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<td>PHSKC</td>
<td>Public Health – Seattle &amp; King County</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Appendices

1. Medical Supplies
2. Non-Medical Supplies
3. Insulin Conversion Chart
4. Standardized Emergency Code
5. Inventory Form
6. Refrigerator Temperature Chart
7. Pharmaceutical Storage Handling and Dispensing
8. MAR Form
9. Medication List
10. Nicotine Use Guidelines
11. Alcohol Withdrawal Prevention Guidelines
12. Managed Alcohol Use Guidelines
13. Benzodiazepine Withdrawal Guidelines
14. Stimulant Use and Withdrawal Guidelines
15. Opioid Withdrawal and Buprenorphine Guidelines
16. Obtaining Buprenorphine Prescribing Steps
17. Methadone Administration Process
18. Naloxone Prescribing Practice Guidelines
20. COVID-19 Testing Protocol
21. IQ Nursing Process for Minors
22. Unaccompanied Minors Policy
23. Scrubs Policy
24. AIDET Skills
Appendix 1 Medical Supplies

This document is specific to King County, WA. If you have questions or would like more information, please email covidhomelessnessresponse@kingcounty.gov
Appendix 2 Non-Medical Supplies

This document is specific to Public Health – Seattle & King County.
If you have questions or would like more information, please email covidhomelessnessresponse@kingcounty.gov.
Appendix 3 Insulin Information

Insulin Pharmacokinetics – IQ Formulary

<table>
<thead>
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<th></th>
<th>Onset of Action</th>
<th>Peak Effect</th>
<th>Duration of Action</th>
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<tbody>
<tr>
<td>Insulin Glargine (Lantus)</td>
<td>2 hours</td>
<td>None</td>
<td>20 to &gt;24 hours</td>
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<tr>
<td>Insulin Lispro (Humalog)</td>
<td>3-15 minutes</td>
<td>45-75 minutes</td>
<td>2-4 hours</td>
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Converting Home Insulin to IQ Insulin Prescription

<table>
<thead>
<tr>
<th>Home Regimen:</th>
<th>Converting To:</th>
<th>Recommendation:</th>
<th>Notes:</th>
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<tr>
<td>NPH daily</td>
<td>Glargine</td>
<td>Convert unit-to-unit and give once daily.</td>
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<tr>
<td>NPH twice daily</td>
<td>Glargine</td>
<td>Reduce daily NPH dose by 20% and give glargine once daily.</td>
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<tr>
<td>Detemir (Levemir)</td>
<td>Glargine</td>
<td>Convert unit-to-unit and give once daily.</td>
<td>Consider reduction in daily dose.</td>
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<tr>
<td>-Regular/Humulin/Novolin -Glulisine/Apidra -Aspart/Novolog</td>
<td>Lispro</td>
<td>Convert unit-to-unit</td>
<td>Give about 10 minutes before each meal, or with meals. Hold if not planning to eat.</td>
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</table>
Appendix 4 Standardized Emergency Code

This document is specific to Public Health – Seattle & King County. If you have questions or would like more information, please email covidhomelessnessresponse@kingcounty.gov.
Appendix 5 Inventory Form

Perpetual Inventory of Controlled Substance

Public Health – Seattle & King County  

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<th>Medication:</th>
<th>Month:</th>
<th>Balance Forward:</th>
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<td>Prescription Label</td>
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Public Health  
Seattle & King County
Appendix 6 Refrigerator Temperature Chart

**REFRIGERATOR TEMPERATURE CHART**  
Temperature must be in the range of 36F to 46F

**Location:**

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<th>FEB</th>
<th>MAR</th>
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Appendix 7 Pharmaceuticals Storage, Handling and Dispensing at IQ Sites

PURPOSE: To store and dispense drugs in accordance with State, Federal and Local distribution laws and regulations at King County Isolation/Quarantine Sites and Assessment Care and Recovery Center Sites

PERSONNEL: Physicians, Non-Physician Practitioners, Nurses, Medical Assistants, Pharmacists, and Pharmacy Technicians

DEFINITIONS AND ACRONYMS:

❑ **Administration:** The action in which, a single dose of prescribed drug is given to the client.

❑ **Client:** Person using the services of I/Q or AC/RC sites. Also: Client, client

❑ **Drug:** Any chemical compound, remedy or noninfectious biological substance, the action of which is not solely mechanical, which may be administered to clients by any route as an aid for the diagnosis, treatment, or prevention of disease or other abnormal condition, for the relief of pain and suffering, or to control or improve any physiological or pathological condition. Drug

❑ **Drug Dispensing:** The interpretation of an order for a drug, the proper selection, measuring, packaging, labeling and issuance of the drug

STORAGE AND HANDLING:

❑ All drugs will be well organized and stored in specifically designated cupboards, cabinets, closets or drawers. The storage location must be secured where only a limited number of staffs will have access to. The controlled substances will be stored separately, and a daily count of the controls must be completed by more than 1 staff member on site.

  o KCPH-ACRC and IQ sites perpetual inventory form 2020

❑ Drugs will be stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, purity of the drug product is not affected. Room temperature drugs should not be stored above 86°F (30°C).

❑ Prescription, sample, over the counter drugs, prescription pads and hypodermic needles will be securely stored in a lockable space (cabinet or room) within the office/clinic.

❑ Keys to locked storage area will be available only to staff authorized by the physician to have access. (During business hours, the drawer, cabinet or room containing drugs or medication supplies may remain unlocked ONLY if there is no access to the area by unauthorized persons.) Whenever drugs or supplies are unlocked, authorized clinic personnel must remain in the immediate area at all times. At all other times they will be securely locked.

❑ Drugs will be prepared in a clean area, or “designated clean” area if prepared in a multipurpose room.

❑ Drugs for external use in liquid, tablet, capsule or powder form shall be stored separately from medications for internal use.

❑ Drugs and immune biologics requiring refrigeration will be kept in refrigerators that shall always be maintained between 2°C (35°F) and 8°C (46°F), with a desired average temperature of 40°F (5°C).

❑ Drugs and immune-biologics requiring freezing will be kept in freezers that shall be maintained at 5°F or -15°C or lower.

❑ Daily temperature readings of medication refrigerator and medication freezer will be documented. (See Attachment). REFRIGERATOR TEMPERATURE CHART

❑ Items other than medications in refrigerator/freezer will be kept in a secured, separate compartment from drugs.
Drugs must be kept separate from food, lab specimens, and other items that may potentially cause contamination.

Tests reagents, germicides, disinfectants and other household substances shall be stored separately from drugs.

Expiration Date Compliance

The manufacturer’s expiration date must appear on the labeling of all drugs. All prescription drugs not bearing the expiration date are deemed to have expired.

If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unconstituted drug.

Expired drugs will not be distributed or dispensed.

All drugs including stock, vaccine, sample, emergency, controlled, OTC will be checked for expiration monthly and written documentation will be maintained.

Controlled Substances

A dose-by-dose controlled substance distribution log will be maintained, with written records that include, provider’s DEA number, name of medication, original quantity of drug, dose, date, name of client receiving the drug, name of authorized person dispensing drug and number of remaining doses. (See Attached Sample Log).

- KCPH-ACRC and IQ sites perpetual inventory form 2020
- Blank MAR form 2019

Controlled substances will be stored separately from other drugs in a securely locked, substantially constructed cabinet.

Schedule II, III IV, and V controlled substances do not need to be double locked.

Personnel with authorized access to controlled substances include physicians, licensed nurses and pharmacists.

Disposal and Dispensing

Drugs will be disposed of appropriately. Drugs may be returned to the Downtown Pharmacy Warehouse or disposed of in medical waste. (See disposal of controlled substances below).

Drugs will be dispensed only by a physician, pharmacists or other persons (e.g.; NP, CNM, RN, PA) lawfully authorized to dispense medications, upon the order of a licensed prescriber.

Personnel such as medical assistants, office managers, and receptionists will not dispense drugs.

Drugs will not be offered for sale, charged or billed to Medicaid clients.

All drugs that are dispensed will be labeled and will include the following:

- Provider’s name, client’s name, drug name, dose, frequency, route, quantity dispensed, and manufacturer’s name and lot number.
- Dispensing containers will not be cracked, soiled or without secure closures.
- Washington Pharmacy Law does not prohibit furnishing a limited quantity of drugs if dispensed to the client in the package provided by the manufacturer and no charge is made to the client.
- All pre-filled syringes must be individually labeled with date, medication name, and dosage.

All drugs that are administered or dispensed will be recorded in the medical record.

Disposable of Controlled Substances: The DEA requires providers to maintain documentation of disposal of all controlled substances. Provider may return the controlled drugs to the drug manufacturer. Controlled drugs may be sent to a DEA registered disposal firm (reverse
distributor) for destruction. Providers may conduct their own drug destruction if the DEA had previously authorized them to do so. Those authorizations will remain in effect until rescinded, revoked, or procedures are changed.

- **Barcode Dispensary Kiosk System:** (please see attached set-up instructions)

  A brief overview of the process:

  - Every new shipment of medications comes with a document with each med’s barcode on it. Use this form to electronically “receive” the meds with the kiosk system.
  - Every time a med is dispensed to a client, we place that medication barcode sticker on the client’s barcode that prints out when meds are ordered in Epic. At the end of every shift, the responsible dispensary personnel will electronically dispense through the kiosk using the scanner.
  - Write the date on each client barcode form and store these in a binder in a locked cabinet in the dispensary.
  - Perform monthly physical inventory counts (instructions in the attached document).
  - Expired meds need to be electronically “returned” via kiosk.
  - If an error message occurs when electronically receiving new med orders. This is usually because the medication barcode has not yet been entered into the system. Occasionally, logging out and logging back in works, but most of the time it requires an email to Cheryl to have her enter the barcode into the system.

**Ordering Pharmaceuticals:**

- All stocked medications will need approval from Chief of Pharmacy. Please submit the order templates via email. The order will be processed and shipped upon approval. Please allow 48 business hours for all prepackaged medications to arrive at your site.
- Recommend inventory check every 48 hours to ensure adequate supply in the center’s dispensary.
## Medication Administration Record (MAR)

| Medication | Hour | 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 | 29 | 30 | 31 |
|------------|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Start      | Stop |    |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Start      | Stop |    |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Start      | Stop |    |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Start      | Stop |    |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Start      | Stop |    |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Start      | Stop |    |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

Appendix 8 MAR Form
<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies:</td>
<td>Physician Name</td>
<td>A. Put initials in appropriate box when medication is given.</td>
</tr>
<tr>
<td></td>
<td>Phone Number</td>
<td>B. Circle initials when not given.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C. State reason for refusal / omission on back of form.</td>
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<tr>
<td></td>
<td></td>
<td>D. PRN Medications: Reason given and results must be noted on back of form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E. Legend: $S =$ School; $H =$ Home visit; $W =$ Work; $P =$ Program.</td>
</tr>
</tbody>
</table>

| NAME: | Record # | Date of Birth: | Sex: |
| VITAL SIGNS | 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 | 29 | 30 | 31 |
|------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| TEMPERATURE|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| PULSE      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| RESPIRATION|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| WEIGHT     |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

<table>
<thead>
<tr>
<th>PRN AND MEDICATIONS NOT ADMINISTERED</th>
<th>Initials</th>
<th>Staff Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Hour</td>
<td>Initials</td>
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</tbody>
</table>
## Appendix 9 Medication List

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>PAR LEVEL</th>
<th>DIRECTION</th>
<th>ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen 325mg tabs #30/bottle</td>
<td>10 bottles</td>
<td>1-2 tabs po q4-6h prn (NTE 10/day)</td>
<td></td>
</tr>
<tr>
<td>Artificial Tears #15ml/bottle</td>
<td>3 bottles</td>
<td>1 drop to affected eye(s) q4h prn</td>
<td></td>
</tr>
<tr>
<td>Bacitracin ointment pcks (CIN#1612753)</td>
<td>1 box</td>
<td>apply to wound topically BID prn</td>
<td></td>
</tr>
<tr>
<td>Bismuth subsalicylate tab #8 tabs</td>
<td>5 bottles</td>
<td>2 tabs po q 30-60 minutes up to 8 doses/day</td>
<td></td>
</tr>
<tr>
<td>Calcium Carbonate (Tums) 500mg #30/bottle</td>
<td>10 bottles</td>
<td>1-2 tabs po q1h prn gastric pain</td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine 25mg caps #30/bottle</td>
<td>3 bottles</td>
<td>1-2 caps po qhs for sleep or q4h prn itching</td>
<td></td>
</tr>
<tr>
<td>Folic Acid 1mg tabs #14/bottle</td>
<td>3 bottles</td>
<td>1 tab po daily</td>
<td></td>
</tr>
<tr>
<td>Guaifenesin liquid 100mg/5ml (CIN#4476982)</td>
<td>5 bottles</td>
<td>1-2 teaspoonful (5 to 10ml) q4h prn cough</td>
<td></td>
</tr>
<tr>
<td>Guaifenesin w/ DM 100mg/10mg/5ml</td>
<td>5 bottles</td>
<td>1-2 teaspoonful (5 to 10ml) q4h prn cough</td>
<td></td>
</tr>
<tr>
<td>Guaifenesin ER 600mg tablets #14/bottle</td>
<td>4 bottles</td>
<td>1-2 tabs q12h prn cough</td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone 1% cream #1oz</td>
<td>3 units</td>
<td>apply to affected area BID prn itching</td>
<td></td>
</tr>
<tr>
<td>Ibuprofen 200mg tabs #30/bottle</td>
<td>10 bottles</td>
<td>2 tabs po q8h prn (NTE 6 tabs/day)</td>
<td></td>
</tr>
<tr>
<td>Loperamide (Imodium) 2mg cap #10/bottle</td>
<td>5 bottles</td>
<td>2c po at onset of diarrhea, then 1c after each loose stool prn (max 8 caps/24 hours)</td>
<td></td>
</tr>
<tr>
<td>Loratadine 10mg tablet #10</td>
<td>5 bottles</td>
<td>1 tab po daily prn allergies</td>
<td></td>
</tr>
<tr>
<td>Melatonin 1mg #12</td>
<td>5 bottles</td>
<td>1-3 tabs po qhs prn sleep</td>
<td></td>
</tr>
<tr>
<td>Menthol Cough Drops #19/bag</td>
<td>1 bag</td>
<td>1 cough drop q2h prn cough</td>
<td></td>
</tr>
<tr>
<td>Multivitamin #14/bottle</td>
<td>3 bottles</td>
<td>1 tab po daily</td>
<td></td>
</tr>
<tr>
<td>Nicotine Gum 4mg #20/box</td>
<td>2 boxes</td>
<td>chew 1 gum q1-2 hours prn</td>
<td></td>
</tr>
<tr>
<td>Nicotine Patch 14mg #14/box</td>
<td>2 boxes</td>
<td>place 1 patch to skin every 24 hours</td>
<td></td>
</tr>
<tr>
<td>Normal Saline Nasal Spray #44ml bottle</td>
<td>5 bottles</td>
<td>use 1 spray in each nostril q2h prn</td>
<td></td>
</tr>
<tr>
<td>Omeprazole 20mg #14/14/bottle</td>
<td>5 bottles</td>
<td>1 cap po daily prn heartburn (take on empty stomach)</td>
<td></td>
</tr>
<tr>
<td>Permethrin 1% lotion/shampoo</td>
<td>5 bottles</td>
<td>apply to towel-dried hair, saturate hair/scalp, wash off after 10 minutes</td>
<td></td>
</tr>
<tr>
<td>Permethrin 5% cream #60gm tube</td>
<td>4 tubes</td>
<td>massage into entire body (avoid eyes, nose, mouth), wash off after 8-14 hours</td>
<td></td>
</tr>
<tr>
<td>Petroleum Jelly pcks #144/box (CIN#5519996)</td>
<td>1 box</td>
<td>apply to affected area as needed</td>
<td></td>
</tr>
<tr>
<td>Polyethylene glycol (Miralax) powder #258gm</td>
<td>3 bottles</td>
<td>mix 1 heaping tablespoon in 4-8 oz of liquid, then drink daily prn constipation</td>
<td></td>
</tr>
<tr>
<td>Sennosides (Senna) 8.6mg #10/bottle</td>
<td>5 bottles</td>
<td>2 tabs po BID prn constipation</td>
<td></td>
</tr>
<tr>
<td>Thiamine (Vitamin B1) 50mg #28/bottle</td>
<td>3 bottles</td>
<td>2 tabs po daily</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Quantity</td>
<td>Dosing Instructions</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
<td>--------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Acetaminophen 160mg/5ml #118ml bottle</td>
<td>5 bottles</td>
<td>Take _____ mL po q4 prn fever or pain</td>
<td></td>
</tr>
<tr>
<td>Ibuprofen 100mg/5ml #120ml bottle</td>
<td>5 bottles</td>
<td>Take _____ mL po q4 prn fever or pain</td>
<td></td>
</tr>
<tr>
<td>Saline Nose Spray #44ml bottle</td>
<td>4 bottles</td>
<td>use 2 sprays into each nostril q3 prn (conjunction with nasal suction)</td>
<td></td>
</tr>
<tr>
<td>Electrolyte Solution (Pedialyte) #1000ml bottle</td>
<td>4</td>
<td>take _____ teaspoon every 5 minutes prn vomiting/diarrhea</td>
<td></td>
</tr>
<tr>
<td>Glucometer</td>
<td>2</td>
<td>Use as directed for blood sugar monitoring</td>
<td></td>
</tr>
<tr>
<td>Lancets #100/box</td>
<td>2</td>
<td>Use as directed for blood sugar monitoring</td>
<td></td>
</tr>
<tr>
<td>Glucose Strips #50/box</td>
<td>2</td>
<td>Use as directed for blood sugar monitoring</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 10 Nicotine Use Guidelines

Overview:

Most clients at COVID-19 Assessment Center/Recovery Center (AC/RC) and Isolation and Quarantine (I&Q) facilities will have a respiratory infection. Continuing to smoke or vape puts them at higher risk of complications from their infection. All clients who use tobacco products should be counseled on the risks of continuing to smoke or vape, encouraged to stop or decrease their use, and offered nicotine replacement with patches and gum to assist them with this behavior change. For clients 21 years of age and over who are unwilling or unable to stop smoking or vaping with the use of nicotine replacement therapy, staff may offer Snus or a limited number of cigarettes per day to facilitate the client remaining at their site for the recommended length of time.

Guidelines for clients 21 years of age and over:

- Ask all clients about their tobacco use on intake.
- Provide cessation counseling and educate clients on the increased risk of complications from their respiratory infection and other associated health problems if they continue to smoke or vape.
- A DOH infographic on smoking and COVID can be found here and will be provided to clients https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/Infographic-Smoking-Vaping.pdf?8fb00
- For all clients who use tobacco, offer nicotine replacement with patches and gum before offering any other tobacco product and document counseling in EPIC.
- Nicotine replacement therapies are stocked onsite and can be provided under physician standing order.
- If client still chooses to smoke, provide them with appropriate instructions to smoke at a designated smoking area while keeping the required physical distance from other clients and staff. There will be no smoking allowed indoor in the I&Q facilities.
- Ask clients to use their own supply first or have a friend/family member drop off their preferred product if possible.
- If client is unable to obtain their tobacco product and will not remain at their I&Q site without continuing to use tobacco, staff may provide them with King County-procured Snus or up to 5 cigarettes per day if they remain at their I&Q site for the recommended length of time.
- Continue to monitor respiratory symptoms throughout their length of stay.

Guidelines for clients under 21 years of age:

- Ask all clients about their tobacco use on intake.
- Provide cessation counseling and educate clients on the increased risk of complications from their respiratory infection and other associated health problems if they continue to smoke or vape.
• A DOH infographic on smoking and COVID can be found here and will be provided to clients
• For all clients who use tobacco, offer nicotine replacement with patches and gum and
document counseling in EPIC.
• Nicotine replacement therapies are stocked onsite and can be provided under physician
standing order.
• If client still chooses to smoke, provide them with appropriate instructions to smoke at a
designated smoking area while keeping the required physical distance from other clients
and staff. There will be no smoking or vaping allowed indoor in the I&Q facilities.
• Staff may not provide King County-procured tobacco products to clients <21 years of age.
• Clients who will not remain at their I&Q site without continuing to use tobacco may use
their own supply.
• Continue to monitor respiratory symptoms throughout their length of stay.
Appendix 11 Alcohol Withdrawal Prevention Guidelines

Candidates:

Clients who reports recent regular heavy alcohol use (>4 standard drinks/day for at least 5 days in a row), or any alcohol use in last 7 days with a h/o withdrawal symptoms in past

For individuals who are currently in active alcohol withdrawal at time of referral, triage to the emergency department should be advised by the consulting physician.

For stable individuals referred with a history of complications including severe withdrawal, delirium tremens, withdrawal seizure, hospital admission for withdrawal, significant medical comorbidity or pregnancy, alternatives to I&Q may be extremely limited. Consulting physician should advise triage to a facility able to provide a higher level of medical care if it is available. If no alternative facility is available, attempted management at I&Q with close monitoring is reasonable, with the recommendation to transfer to the emergency department if severe withdrawal symptoms or medical complications develop.

Intake & monitoring:

- Document amount and duration of current alcohol use, time of last drink, and history of withdrawal symptoms, seizures, or delirium tremens
- Call clinician if client reports alcohol withdrawal symptoms or appears to be in withdrawal
  - Anxiety, agitation, sweats, tremor, nausea/vomiting, headache, visual/auditory disturbances/hallucinations, confusion, delirium, tactile disturbances (bugs crawling under skin, etc.), tachycardia, hypertension

Medications:

- Vitamin B1 (thiamine) 50mg tabs, 2 tabs PO daily x 5 days
- Folic acid 1mg tab PO daily x 5 days
- Multivitamins 1 tab PO daily x 5 days
- Gabapentin 400 mg PO QID x 7 days
- Benzodiazepines are not prescribed at I&Q

Other interventions:

- See “Managed Alcohol Use Guidelines” for harm reduction strategy

Transferring to higher level of care:

- Develops active alcohol withdrawal symptoms, severe agitation/tremor, unstable vital signs, over sedation, seizure, delirium
Appendix 12 Managed Alcohol Use Guidelines

Context:
The purpose of Isolation and Quarantine (I&Q) facilities is to decrease the community spread of COVID-19 and preserving hospital system capacity while providing vulnerable people with safe places to isolate or quarantine and recover from COVID-19 illness. Clients staying at the sites who use alcohol regularly may not want to stop, and they are at risk of withdrawal if they do so abruptly. All clients should be offered information on the risks of drinking alcohol in the setting of COVID-19 illness, and those who do want to stop drinking alcohol will be offered medications to prevent dangerous withdrawal symptoms. For clients who decline alcohol cessation, alcohol use at I&Q sites can facilitate their ability to stay and safely complete their isolation or quarantine for the recommended length of time.

Candidates:
Clients 21 years or older admitted to I&Q sites who report regular alcohol use, are at risk for alcohol withdrawal, and who decline alcohol cessation while in isolation or quarantine.

- **At risk for withdrawal:** clients consuming > 4 drinks/day for past 5 days OR any alcohol use in past 7 days with a history of withdrawal symptoms in past are considered at risk for withdrawal.
- Clients who are not at risk for withdrawal will be informed that recreational alcohol will not be facilitated or administered at IQ facilities.
- If this is a barrier to the client remaining for the recommended length of time, an individualized plan will be made for these individuals based on their circumstances in consultation with the clinical and leadership team.

Intake & Counseling:
- At intake nurses should document the following information for clients at risk of withdrawal:
  - daily alcohol intake, time of last drink, history of alcohol withdrawal symptoms and/or hospitalization for withdrawal in past, seizures or delirium tremens (“DTs”) from withdrawal.
  - Nursing staff should use the Epic dot phrase “.KINGIQMANAGEDALCOHOL” for guidance in asking questions and estimating appropriate alcohol intake limits.
  - Prior to allowing alcohol use at I&Q, nursing and behavioral health staff must document the client was offered alcohol withdrawal management but declined.
  - Nursing and behavioral health staff must first offer the client information on the risks of drinking alcohol while sick with COVID-19 or another infection.
  - Nursing staff should use the dot phrase “.IQALCOHOLUSE” to document these discussions in Epic.
- Nursing and behavioral health staff should use motivational interviewing techniques to engage clients in discussions on the risks of their ongoing alcohol use throughout their stay at I&Q.
### Alcohol type and quantity*

<table>
<thead>
<tr>
<th>Alcohol Type</th>
<th>Standard Drinks</th>
</tr>
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<tbody>
<tr>
<td>12 oz of 5% beer</td>
<td>1</td>
</tr>
<tr>
<td>8-9 oz of 7% malt liquor</td>
<td>1</td>
</tr>
<tr>
<td>5 oz of 12% wine</td>
<td>1</td>
</tr>
<tr>
<td>1.5 oz of 80 proof distilled spirits</td>
<td>1</td>
</tr>
<tr>
<td>½ pint distilled spirits</td>
<td>5.5</td>
</tr>
<tr>
<td>1 pint distilled spirits</td>
<td>11</td>
</tr>
<tr>
<td>A “fifth” distilled spirits</td>
<td>17</td>
</tr>
<tr>
<td>A “handle” distilled spirits</td>
<td>40</td>
</tr>
<tr>
<td>1 table wine bottle</td>
<td>5</td>
</tr>
<tr>
<td>3-liter box wine</td>
<td>20</td>
</tr>
</tbody>
</table>

*This chart is intended for reference only and should not imply that staff will be able to procure these types of alcoholic beverages.

#### Calculating standard drinks consumed in 24 hour-period:

- Ask client how much and what type of alcohol they usually consume in a 24-hour period.
- If client comes from a facility that helps manage their alcohol use, attempt to corroborate self-reported alcohol use and how to most effectively help manage their use with staff from facility.
- Calculate the estimated number of standard drinks consumed by client in a 24-hour period.

### Procurement and storage of alcohol:

- Alcohol will be supplied by one of the options below according to treatment plan:
- Clients will first be asked to bring their own supply of alcohol with them to the site on admission.
- Clients may have a family member, friend, or case manager drop off alcohol for them.
- Through King County procurement process, staff may provide privately funded alcohol to clients who are unable to obtain it on their own.
- Alcohol should be kept by staff in a locked and secure location and managed in accordance with King County policy.
- Clients who bring their own alcohol will be asked to give their supply into our custody for inventory and disbursement.

### Managing alcohol use:

- A team discussion involving behavioral health, nursing, and physician on-call should take place to ensure the team is aware of the client’s alcohol use.
- Staff must contact on-call physician if client reports consuming > 10 Standard Drinks per day.
- Staff will not provide any client > 10 standard drinks per day without prior physician approval.
- Staff may bring alcohol to client according to guideline as long as they are not too intoxicated.
- If client shows evidence of intoxication, or if nursing and behavioral health staff determine their alcohol use is too unsafe, staff may further limit their alcohol intake according to a managed alcohol use guideline.
- All clients drinking alcohol should be considered at risk of withdrawal and placed in Tier 1.
Determining alcohol intake limits:

<table>
<thead>
<tr>
<th>Self-reported daily consumption</th>
<th>Max amount &amp; frequency</th>
<th>Daily limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 standard drinks</td>
<td>3 standard drinks daily</td>
<td>3 drinks/day</td>
</tr>
<tr>
<td>4-6 standard drinks</td>
<td>1-2 standard drinks every 2-4 hours</td>
<td>6 drinks/day</td>
</tr>
<tr>
<td>7-10 standard drinks</td>
<td>2 standard drinks every 2-4 hours</td>
<td>10 drinks/day</td>
</tr>
<tr>
<td>&gt; 10 standard drinks*</td>
<td>Discuss with physician on-call</td>
<td>Discuss with physician on-call</td>
</tr>
</tbody>
</table>

*Clients should not be provided > 10 standard drinks per day without prior approval by physician on-call.

A custom guideline allowing larger amounts of alcohol at a time may be developed after a team discussion between physician, behavioral health, and nursing staff. This discussion should occur any time a client has questions about their managed alcohol use plan.

Documenting managed alcohol use:
- Each client should have an alcohol use log started at the beginning of their stay (Appendix A).
- Log should be updated by staff each time alcohol is dispensed.

Monitoring for intoxication and withdrawal:
- Nursing should do brief assessment of client’s level of intoxication prior to alcohol being dispensed.
- If client is determined to be “too intoxicated,” withhold alcohol for 2 hours and then reassess. Resume dispensing alcohol once client is no longer too intoxicated.
- Signs/symptoms of intoxication include: unstable gait, slurred speech, disorientation, confusion, oversedation, or dysregulated behavior leading to inability to follow rules/requirements necessary to remain at I&Q.
- If client reports alcohol withdrawal, provide additional alcohol per guideline if their limits have not been exceeded and consider performing adapted CIWA-Ar.
- If client reports alcohol withdrawal and their alcohol limits have been exceeded, nursing should evaluate them for withdrawal signs/symptoms or perform a modified CIWA-Ar score (Appendix B) to the best of their ability and then contact the provider on-call.
  - CIWA score <8: continue to monitor
  - CIWA score 8-15: contact provider on-call
  - CIWA score >15: contact provider on-call and strongly consider transfer to hospital
  - (Note, frequency of CIWA scoring has been adapted to I&Q setting and does not follow a traditional protocol used in an inpatient setting.)
- Signs/symptoms of alcohol withdrawal include: anxiety, agitation, sweats, tremor, nausea/vomiting, headache, visual/auditory disturbances/hallucinations, confusion, delirium, tactile disturbances (bugs crawling under skin, etc.), tachycardia, hypertension.
- Clients reporting withdrawal symptoms should be monitored more closely by nursing staff. Check-in with client every 4 hours while awake. If more frequent monitoring is required, then arrange transfer to a higher level of care.

I&Q Exit:
- All precautions should be taken to avoid dangerous activities for clients consuming alcohol on the day of exit (e.g. driving, riding bicycle), and these should be clearly documented.
- Staff may not provide alcohol to clients “to go” upon exiting the facility unless the alcohol was brought by the client or their support person.
Appendix 13 Benzodiazepine Withdrawal Guidelines

Candidates: Clients admitted to IQ who report regular daily benzodiazepine use.

Contraindications to treating at IQ: History of severe benzodiazepine withdrawal, hospitalization for withdrawal, seizure or delirium due to withdrawal, using > 40 mg diazepam equivalents/day for > 2 months, significant medical comorbidity, pregnancy

Intake & monitoring:
- Ask about amount, type, frequency, and duration of benzodiazepine use, whether prescribed or illicit, and history of withdrawal symptoms, seizure, or delirium
- Ask about alcohol and opioid use
- If the client has a current prescriber, obtain an ROI to coordinate care
- Call clinician if client reports withdrawal symptoms or appears to be in withdrawal
- Tremor, sweats, headache, confusion, hallucinations, nausea/vomiting, anxiety, insomnia

Clients using benzodiazepines as prescribed:
- Should continue taking their benzodiazepine as prescribed if not over sedated
- Usual prescriber should be contacted for refills if needed
- Clients can keep their medication with them in a locked box or staff can store in a locked secure area and administer daily with appropriate documentation

Clients using illicit benzodiazepines or not taking as prescribed:
- Estimating total daily amount of illicit benzodiazepines used can be attempted but is unreliable due to counterfeit pills
- Benzodiazepine tapers are not prescribed at IQ
- Gabapentin 400 mg TID-QID and mirtazapine or diphenhydramine qhs for sleep should be considered
- If withdrawal symptoms are not adequately controlled by these medications arrange for transfer to a more appropriate setting
Appendix 14 Stimulant Use and Withdrawal Guidelines

Information on stimulant use and stimulant withdrawal:
- Clients under the influence of stimulants may present as hyperactive, irritable, agitated, anxious, unable to sleep and with elevated blood pressure and heart rate.
- Some clients, especially those who use methamphetamine, may have psychosis or delusions. These can sometimes persist through their withdrawal and for days afterwards.
- Methamphetamine withdrawal can take a while to develop (sometimes up to 24 hours).
- Many clients who use methamphetamine go multiple days in a row without sleeping, eating, or drinking very much.
- Symptoms of stimulant withdrawal are generally irritability, anxiety, depression, severe lethargy, amotivation, and increased appetite.

Managing stimulant intoxication:
- Care is mostly supportive; you should follow general guidelines for managing clients with significant agitation or irritability.
- Encouraged fluid intake and soft, easy to chew and swallow foods.
- Mirtazapine (Remeron) 15-30 mg qhs can be helpful to begin regulating sleep.

Managing stimulant withdrawal:
- Care is mostly supportive; no medications are approved to treat stimulant withdrawal or stimulant cravings.
- Clients generally need lots of time to sleep and may be very irritable when awoken.
- Clients will likely be dehydrated with an increased appetite so they should be offered more food and fluids than usual.
- Monitor for the development of severe depression or suicidality.
- Mirtazapine (Remeron) 15-30 mg qhs can be helpful to begin regulating sleep and may help a small amount with cravings for methamphetamine.
Appendix 15 Opioid Withdrawal and Buprenorphine Guidelines

Candidates: clients admitted to IQ facilities who report regular opioid use, opioid withdrawal symptoms, or a history of opioid use disorder

Contraindications to treating at IQ: pregnancy, significant medical comorbidity

Monitoring and intake:
- Ask about amount and type of opioid used, time last used, as well as alcohol/benzo use.
- Ask what symptoms of opioid withdrawal are most bothersome. Signs and symptoms of withdrawal include: Restlessness, muscle/bone/joint pain, congestion/tearing, gooseflesh, yawning, anxiety, tremor, stomach cramps, nausea/vomiting, diarrhea, pupillary dilation.
- Check Prescription Drug Monitoring Program (PDMP).
- Offer buprenorphine/naloxone (Suboxone) as a treatment option.
- If client has current opioid prescriber or goes to a methadone clinic, obtain an ROI.
- Make sure client is staying hydrated and mental health is stable.
- Offer naloxone nasal spray (Narcan) on intake or at time of discharge.

Buprenorphine guidelines:
- If already on buprenorphine, contact usual prescriber for refills.
- A phone visit with a clinician must be conducted before buprenorphine is prescribed.
- Clients should be given a home induction handout and follow the instructions, making sure they are in mild-moderate withdrawal and it is at least 12 hours since their last heroin or opioid use.
- Clinicians should usually prescribe 7 days of medication at a time and consider providing refills.
- Follow-up visits can be done by RN or clinician over the phone.
- Urine drug screen is only needed if buprenorphine prescribed at site for more than 1 month.
- Clients may be given their full week of medication all at once, but it should be stored in a locked box for safety. Alternatively, staff can store in a locked secure location for them and administer daily with appropriate documentation.

Methadone guidelines:
- Coordinate with client’s methadone clinic on how to obtain carries while at ACRC.
- Follow methadone clinic’s recommendation on whether the client can safely self-manage their carries and keep them in a locked box in their room or by bedside. If not, staff should store medication in a locked and secure location and administer daily with appropriate documentation.
- Do not administer methadone if client is over sedated or has respiratory rate <12.

Symptomatic medications for opioid withdrawal:
- Restlessness/anxiety Clonidine (Catapres)
- Restlessness/anxiety Gabapentin
- Diarrhea Loperamide (Imodium)
- Nausea/vomiting Ondansetron (Zofran)
- Stomach cramps Dicyclomine (Bentyl)
- Anxiety/Insomnia Hydroxyzine (Vistaril)
- Insomnia Diphenhydramine (Benadryl)/Mirtazapine (Remeron)/Trazodone
- Muscle aches/headache Acetaminophen (Tylenol) / Ibuprofen (Motrin/Advil)
- Muscle aches/restlessness Methocarbamol (Robaxin)
How to Start Buprenorphine (Patient Instructions)
(For patients currently dependent on opioids)

Before you begin, you should feel sick from withdrawal

It should be at least...

- 12 hours since your used heroin/fentanyl
- 12 hours since you snorted pain pills
- 16 hours since you swallowed pain pills
- 36 hours since you used methadone
- Waiting longer is better; if you take it too soon, or take too much for your first dose, you can feel worse, instead of better.

You should have at least 3 of these symptoms...

- Restlessness
- Yawning
- Runny nose
- Enlarged pupils
- Fast heart beat
- Body Aches
- Shaking/twitching
- Chills or sweating
- Anxious, irritable
- Watery eyes
- Gooseflesh
- Loss of appetite
- Stomach cramps, nausea, vomiting, or diarrhea

Once you’re ready, follow these instructions to start the medication

How to take the medication:

- Put the tablet OR film under your tongue. It will not work if you chew or swallow it.
- In order to absorb all the medication:
  - Let the tab/film fully dissolve, which usually takes about 5 minutes.
  - If your mouth is dry, the tab/film can take longer to dissolve (up to 20 minutes). Drink a glass of water before to help it dissolve faster.
  - Do not eat, drink, or talk while it’s dissolving.
  - Do not eat or smoke 30 minutes before taking.
- Once it’s dissolved, you can either swallow or spit the saliva.

What else you need to know:

Most people feel better with a 2 tab/film (16 mg) daily dose, or less. It may take a couple weeks to feel totally normal. You should not feel sleepy; if you do, the dose may be too high. Be sure to tell your provider how you’re feeling.

Day 1

- Once you’re in moderate withdrawal, take ½ tab/film (4 mg).
- Wait 2 hours. If you feel worse, wait 4-8 hours, then start over. If you feel the same or better, take another ½ tab/film (4 mg).
- Wait 2 hours.
  - If you feel OK, don’t take any more.
  - Your regular dose is 1 tab/film (8 mg).
  - If you still feel sick from withdrawal, or if you have cravings for opioids, take another ½ tab/film (4 mg).
- Wait 2 hours.
  - If you feel OK, don’t take anymore.
  - Your regular dose is 1.5 tabs/films (12 mg) daily.
  - If you still feel sick from withdrawal, or if you have cravings for opioids, take another ½ tab/film (4 mg).
  - Do not take any more than this (2 tabs total) on Day 1. Your daily dose is 2 tabs (16 mg)

Day 2

Take your regular dose (8, 12, or 16 mg), as determined on Day 1, once daily until your next appointment. If you still have cravings or withdrawal, tell your provider.
**Buprenorphine/Naloxone (Suboxone) FAQ**

1. **Why do I need to be abstinent or in withdrawal from opiates before starting the medication?**
   If you have been using other opiates, like heroin, buprenorphine will compete for the same space in your brain as those drugs. Essentially, it will push out the other opiates and quickly cause severe withdrawal (called “precipitated withdrawal”). By already being in some withdrawal when you take your first dose, the medication will make you feel better, not worse.

2. **When will I start to feel better?**
   Most people feel better 30 minutes after their first dose, with full effects after about 1 hour.

3. **How does buprenorphine work?**
   Buprenorphine activates the same receptors in the brain as other opiates, which helps stop cravings and withdrawal symptoms. It also blocks the effect of other opiates.

4. **Why does buprenorphine need to be placed under the tongue?**
   That’s how this particular medication is absorbed into the body. If the medication is chewed or swallowed, it will not work.

5. **Why can’t I talk, eat or drink while the medication is under my tongue?**
   Moving the tongue lets medication leak out from underneath. It needs to stay under the tongue until fully dissolved in order to get the full dose.

6. **How long does the medication last? If I forget to take my medication for a day, will I feel sick?**
   No. Buprenorphine lasts longer than 24 hours. However, make sure you take the missed dose as soon as possible, unless it’s close to the time of your next dose. Do not take 2 doses at once unless directed by your healthcare provider.

7. **Is it important to take my medication at the same time every day?**
   Yes, you should try to take your medication near the same time each day, in order to maintain stable levels of the medication in your body.

8. **I take more than one tab/film, do I take them together at the same time? Or can I split up my dose throughout the day?** It’s best to take your full dose in one “sitting,” unless you’re told otherwise by a provider, but you don’t need to fit all the tablets under your tongue at the same time. Some prefer to do it that way, while others prefer taking one tab after the other until they’ve finished their full dose.

9. **What if I continue to feel sick after being on buprenorphine for a while?**
   It may take a few weeks to feel normal on medication. Talk to your provider if you’re still not feeling well after that—they may need to either increase or decrease your dose.

10. **What are the side effects of the medication?**
    Some people have nausea, headaches, constipation and body aches and pain. Most will go away after 1-2 weeks. If you are experiencing any side effects, tell your provider.

11. **What happens if I use heroin or other opiates while on buprenorphine?**
    As long as the medication is in your body, it will make those drugs have little or no effect.

12. **Why is their naloxone (Narcan) in Suboxone? What does it do?**
The naloxone in Suboxone is not active in the body when taken properly (dissolved under the tongue); it’s only active when the medication is misused by injecting it. If you inject the medication, the naloxone will make you go into withdrawal.

13. What’s the difference between Suboxone and Subutex?
Both medications consist of buprenorphine, which is the medication that blocks cravings and withdrawal. Suboxone also has naloxone (Narcan) in it, but Subutex does not. Since the naloxone is not active in the body when taken properly (see question 12), both medications work for the same purpose. Subutex is generally only given to pregnant women.
Appendix 16 Obtaining Buprenorphine Prescribing Steps

Steps to prescribing buprenorphine/naloxone for client at I&Q

1. You will be contacted with request by either intake staff or I&Q site staff.
2. Check the PMP to make sure the client doesn’t already have a buprenorphine prescriber.
3. If the request seems appropriate, coordinate a telephone visit with the client. This may take place either before or after the client arrives at their I&Q site. Buprenorphine can not be prescribed without a telephone visit between the prescriber and the client.
4. Ask the intake or I&Q site staff which pharmacy they would like the prescription sent to. If the client is uninsured than the Downtown Public Health pharmacy (206-477-8250) is preferred.
5. Conduct a telephone visit with the client and document in Epic using either a new telephone encounter or a new note in their I&Q Facility encounter. You can use the templates .BUPIQTELEPHONENEWPT for a new visit or .BUPIQTELEPHONEFU for a follow-up (you can copy these in Epic from David Sapienza if you don’t have access already).
6. Make sure you do not bill for the telephone visit encounter.
7. Consider prescribing buprenorphine-naloxone 16-4 to 24-6 mg/day divided 1-3X per day depending on the client’s use history and prior experience with buprenorphine.
8. Consider prescribing 1 week of medication with 1 refill as this should cover the length of stay for most clients.
9. Call the prescription into the chosen pharmacy.
10. Notify staff at the site the prescription has been called in.

Frequently Asked Questions (FAQ):
Is it legal to prescribe buprenorphine via a telephone visit only? In normal circumstances it is not considered appropriate to prescribe buprenorphine for a client you have not previously evaluated in person. However, due to the COVID-19 public health emergency the DEA has made an exemption to this rule: “...practitioners have further flexibility during the nationwide public health emergency to prescribe buprenorphine to new and existing clients with OUD via telephone by otherwise authorized practitioners without requiring such practitioners to first conduct an examination of the client in person or via telemedicine”. Further details of these regulatory changes can be found: https://www.samhsa.gov/sites/default/files/dea-samhsa-buprenorphine-telemedicine.pdf.

Who will contact me for a buprenorphine prescription? Most commonly you will be contacted by the intake team to arrange a plan for buprenorphine prior to a client being placed at an I&Q site. Sometimes, however, you will be contacted by staff at one of the sites if they identify a client who is an appropriate candidate for buprenorphine.

What if the client I am contacted about already has a buprenorphine prescriber? If the client already has a prescriber, the intake and/or I&Q site staff should first attempt to coordinate to obtain a prescription from their regular provider for the duration of their I&Q stay. If staff are unable to obtain a prescription from their regular provider, you may do a telephone evaluation and provide the prescription.
How will the telephone visit take place? Sometimes you may be asked to call the client on their cell phone prior to their placement at I&Q. Other times you may wait until the client has arrived at I&Q and then you can call their room.

Can I just prescribe without doing a telephone visit first? In most cases, No. the DEA has been very clear that a reasonable telephone encounter between the prescriber and client must take place and be documented for the prescription to be valid. The exception to this would be if the client is already receiving buprenorphine from a Public Health – Seattle & King County provider. In that case, you could consider yourself as covering for that provider and it could be appropriate to provide a prescription without talking to the client if you feel comfortable doing this after reviewing the prior visit documentation.

How do I send the prescription to the pharmacy and what pharmacy should I use? Suboxone (buprenorphine/naloxone) is a Schedule 3 medication which means it is appropriate to call the prescription into the pharmacy. You cannot e-prescribe the medication using PHSKC Epic at this time. You should ask the intake or I&Q site staff which pharmacy they would like you to use since staff will need to go pick it up for the client after they arrive.

How is the medication paid for? Most of the time the client will have insurance that will pay for the medication. If the client is uninsured or their insurance doesn’t cover the medication you can call the prescription into the Downtown Public Health Pharmacy (206-477-8250) when they are open (M-F, 8am-5pm) and it will be provided for free. Make sure to let the pharmacist know the client is at I&Q and a staff member will be picking the prescription up for them. If the public health pharmacy is not open, you might call a few days of medication into a retail pharmacy and the staff can use petty cash to pay for a small supply until it can be filled by our pharmacy.

How much medication should I prescribe? Ultimately this depends on your evaluation. Most clients will do well on 16-4 to 24-6 mg/day of Suboxone divided 1-3X per day. Consider prescribing 1 week of medication with 1 refill to last for the full length of their I&Q stay.

How do I document in Epic? You can document by either creating a new telephone encounter, or by making a new note in their I&Q Facility encounter, whichever you are more comfortable with. You can either use your own note template, or use the suggested .BUPIQTELEPHONENEWPT for an initial visit, and .BUPIQTELEPHONEFU for a follow-up visit.

What about billing? All visits should be “No charge” encounters. Clients at I&Q facilities should not be charged for any services they receive from PHSKC while they are there.

What about follow-up? All clients prescribed buprenorphine while at I&Q have the option to follow-up at the Bupe Pathways clinic: 2124 4th Ave Seattle, WA 98121, P: 206-458-8798. They can call to schedule an appointment or walk-in on a Monday or Thursday afternoon from 1-3:30 PM. It is also fine to offer the client follow-up in your own clinic if you have availability.
Appendix 17 Methadone Administration Process

If your client is admitted to the King County Isolation and Quarantine Facility (I/Q), the following processes and documentation will occur:

1. **Admission notification:**
   a. I/Q staff will notify home OTP of client admission to start the courtesy dosing request process
   b. Courtesy Dosing Request Form will serve as SAMHSA required notification of medical necessity of quarantine/isolation
      i. Per SAMHSA Division of Pharmacologic Therapies Guidance Released on 3-13-20, OTP must document in the client’s health records that the patient is medically ordered to be under isolation or quarantine. Ensure the documentation is maintained in the patient’s OTP record.

2. **3rd Party Proxy Attestation:**
   a. At the I/Q, the client will be asked to sign an attestation for KC staff to deliver methadone while at facility.
   b. The attestation address the handling of methadone and will supersede any other third party proxy form only during the client’s time spent at the King County facility.

3. **Courtesy Dosing Request & Delivery:**
   a. The home OTP of the client will submit a Courtesy Dosing Request Form to the courtesy dosing OTP
      i. I/Q staff will notify the home OTP of estimated length of time the client will spend in quarantine/isolation.
      ii. Home OTP will notify courtesy dosing OTP dispensary of methadone dose and number of allowed doses/carries.
   b. Clients will receive methadone from the designated courtesy dosing OTP per the courtesy dosing coordination protocol.
   c. Courtesy dosing OTP will hand off methadone to a licensed clinician or King County employee at the I/Q.

4. **Chain of Custody:**
   a. The I/Q nurse and an additional staff will document delivery of methadone to client and observation of client receipt.
      i. The nurse will dispense the daily dose by leaving it at the front door of the guest’s room.
   b. The methadone will be stored in a locked bag and the locked bag stored in a locked cabinet.
      i. If the client brings existing take home doses to the I/Q, the client will be permitted to store methadone in their individual room.
      ii. The lock bags have a unique key and a master key that the nurses will use.
   c. The I/Q staff will fax a copy of the chain of custody form back to the courtesy dosing OTP when the guest requires a refill of methadone.

5. **Discharge:**
   a. Client will take possession of all remaining doses of methadone which will be stored in the lock bag and client will take the unique key.
   b. I/Q staff will notify home OTP and courtesy dosing OTP of client discharge.
   c. I/Q staff will send a copy of the chain of custody form to the home OTP.
KING COUNTY CONTACT INFORMATION

King County points of contact
- First Contact: Steve Gustaveson; Steve.Gustaveson2@kingcounty.gov or 206 650-9476
- Back-up: Dr. Margaret Cary; MCary@kingcounty.gov or 206 769-6268

DesignatedCourtesy Dosing OTP Clinic
- THS : King County Aurora I/Q
  - Other sites/courtesy dosing clinics to be designated if/when needed
- Therapeutic Health Services, Shoreline
  - Address: 16715 Aurora Ave North Shoreline, WA 98133
  - Phone: (206) 546-9766
  - Fax: (206) 542-0326
  - Website: https://ths-wa.org/
  - Dispensary Hours: Monday – Saturday 6:30AM – 12:15PM
    - ***Request notification for courtesy dosing by 12:30 for same day delivery***
- King County Aurora I/Q Facility Contact
  - 1132 N 128th St Seattle, WA
  - Aurora Office: 206-600-8444
Appendix 18 Naloxone Prescribing Best Practices

Naloxone Prescribing Practice Guidelines

Naloxone is recommended for persons who:
- Use opioids illicitly, including heroin and fentanyl
- Are in treatment for opioid use disorder (OUD), including those prescribed buprenorphine or methadone
- Chronically use prescribed opioids at higher dosages or use extended-release or long-acting preparations
- Are friends with, family members of, or service providers of people who use opioids

Patients at highest risk for opioid overdose are those who:
- Have survived a prior opioid overdose
- Have reduced opioid tolerance due to recent hospitalization, incarceration, or OUD treatment
- Use opioids concurrently with benzodiazepine, alcohol, or other sedating drug

Patient education and counseling on naloxone:
When prescribing or dispensing naloxone, refer to stopoverdose.org brochure or video and discuss the following:

How to recognize an overdose:
- Signs include slow or no breathing, unresponsiveness, pinpoint pupils, and cyanosis
- If an overdose is suspected but unconfirmed, use naloxone. Naloxone is a safe medication that can reverse the effects of opioid overdose and has no effect on a person who has not taken opioids

How to respond to an overdose:
1. Call 911 and try to wake the person.
2. If pulse is present, perform rescue breathing and administer naloxone. If pulse is absent, perform CPR and administer naloxone.
3. Give a second dose of naloxone in 2-3 minutes if there is little or no improvement following initial administration.
4. Repeat steps 2-3 above if the person is still unresponsive and stay with the person until emergency responders arrive.

Need for a safety plan:
- Counsel patients to educate friends and family on where naloxone is stored, how to recognize an overdose, and how to respond to an overdose.

Good Samaritan Law:
- People who seek or receive medical assistance for an overdose cannot be prosecuted for drug possession.

Other recommendations:
- Be non-judgmental about opioid use.
- Naloxone can be described as:
  - Important to have “just in case” – “it’s like having a fire extinguisher”
  - A tool to save a life of a friend or family who uses opioids
- Caution patients about the risk of mixing opioids with benzodiazepine, alcohol, or other sedating drug.
  - Check Prescription Monitoring Program
- Caution patients that naloxone can cause acute opioid withdrawal.
- Discuss the risks of fentanyl. Mention that fentanyl is a potent opioid and can be present in varying concentrations and in any form, including powders and counterfeit pills. Fentanyl-involved overdoses may require additional administrations of naloxone.
- Find more information here: www.kingcounty.gov/fentanyl

For patients who use prescribed opioids:
- Avoid the term “overdose.” Patients taking opioids for chronic pain may not identify with the term. Instead, ask if they have “ever had trouble breathing or waking up” while taking the medication.
- Discuss safe storage and disposal of medications and refer to: www.takebackyournmeds.org

For patients who use opioids illicitly:
- Discuss strategies to reduce risk of overdose:
  - Do not use alone
  - Start low and go slow
  - Watch and wait before next person uses
- Provide information about the medications to treat OUD and refer to: www.warecoveryhelpline.org
  (Tel: 1-866-789-1511)

Resources:
- Public Health–Seattle & King County
  Overdose Prevention & Response: https://kingcounty.gov/overdose
  (Tel: 1-866-789-1511)
- Safe Medication Disposal: http://www.takebackyournmeds.org
- King County Overdose Data: https://kingcounty.gov/depts/health/examiner/overdose.aspx
- WA State Overdose Prevention and Response Video: http://stopoverdose.org/section/take-the-online-training
Appendix 19 Behavioral Health Wellness Plan (excerpt)

<table>
<thead>
<tr>
<th>During My Stay</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel safe today?</td>
<td></td>
</tr>
<tr>
<td>If no, further assess the client and utilize the Crisis Plan if needed.</td>
<td></td>
</tr>
<tr>
<td>Who are your supports?</td>
<td></td>
</tr>
<tr>
<td>To goal is to identify natural supports or existing outpatient supports that are important to the client.</td>
<td></td>
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<tr>
<td>What kind of emotional supports do you need while you are here?</td>
<td></td>
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<tr>
<td>The question is open ended to allow the client to space to bring up a range of emotional needs they may face. Also, discuss with the client what to expect with daily RN and BH staff check-ins. Note any preferences from the client about how often they want the IQ Team to check-in.</td>
<td></td>
</tr>
<tr>
<td>Is there anything else we need to know about you?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crisis Plan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilize as needed when client demonstrates signs of safety risks</td>
<td></td>
</tr>
<tr>
<td>Describe yourself when you’re feeling well:</td>
<td></td>
</tr>
<tr>
<td>Warning signs that I’m not feeling well:</td>
<td></td>
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<tr>
<td>What helps when I’m not feeling well:</td>
<td></td>
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<tr>
<td>Suicidal Ideation</td>
<td></td>
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<tr>
<td>Any current thoughts of SI?</td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Prior attempts:</td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Means:</td>
<td></td>
</tr>
<tr>
<td>Current/past self-harm?</td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Means:</td>
<td></td>
</tr>
</tbody>
</table>
| Homicidal Ideation | Any current thoughts of HI or harming others?  
☐ Yes  ☐ No  
Any plan?  
☐ Yes  ☐ No  
If yes, describe: | Prior attempts:  
☐ Yes  ☐ No  
Means:  
Dates:  
Access to firearms?  
☐ Yes  ☐ No | Duty to Warn:  
☐ Yes  ☐ No  
If yes, provide details: |
| --- | --- | --- | --- |
| Self-Care | Do you or other team members observe any concerns of the client being able to care for self due to psychiatric symptoms?  
☐ Yes  ☐ No | If yes, describe your concerns and safety plan: |  |

If a client says ‘yes’ to SI or HI (passive/active) or you are concerned about self-care, please make sure a plan to stay safe is documented in the Crisis Plan.  ☐  ☐
Appendix 20 COVID Testing Protocol

PPE
- Client self swab: Provider should wear eye shield, procedure mask, gloves
- Provider swab: Above + gown
- Assistant (outside room): gloves
- PPE conservation: if testing multiple clients, can conserve gown/mask/shield and change gloves with hand hygiene between clients

Equipment
- Test kit (swab and media)
- Extra swab
- Chux pad
- Tablet to show demo video of self-swab (or Qtip to demo)
- Sample bag large (outside)
- Sample bag small (inside) with absorbent pad inside (can be square of chux)
- Lab slip
- Refrigerator and fridge thermometer

Timing of Test
- Asymptomatic persons should be tested ideally at least 5-7 days from last exposure and not sooner than 48 hours after first exposure to a case or suspected case.
- If a patient arrives later at night and testing is warranted, it is fine to delay intake/testing to the morning assuming patient is stable.
- Consult with the physician on call about testing and isolation procedures when a couple or group has discordant results.

Procedure
- Assemble test materials
- Assistant waits outside the room (and at least 6 feet away from the patient) with the larger bag open and ready to receive using the “clean technique.”
- Printed lab requisition goes in the outside pocket of the bag
- Provider dons PPE
- Provider enters room and conducts intake process
- Provider sets up chux with swab and media tube

Anterior Nares (patient self-swab)- preferred method
- Demonstration (video or on self with a plain Q-tip) of anterior nares (AN) self-swab process
- Patient opens the swab container and removes the swab, taking care not to touch the tip to any surface or lay it down.
- Patient holds the swab with fingers placed on the score line
- Patient self-swabs, inserts swab in media tube, breaks off tip and closes top
**Anterior Nares (provider swab)**
- Provider performs swab and places swab in tube, seals top.
- Provider takes sample and drops in bag that assistant is holding outside the room and encloses lab slip; assistant seals bag. (no need to double bag)
- *Can perform nasopharyngeal testing if AN swabs not available*

**Label and Test Requisition**

IQ sites may order an interfaced COVID test to PH Lab via EPIC
- Lab labels and requisition form:
  - Print automatically out of EPIC when the order is signed
- Place requisition in outside pocket of specimen bag
- Bags should contain Chux square and tube, sitting up inside bag, and requisition in outside pocket with name and DOB facing outward

**Sample Storage and Submission**
Designate a refrigerator to be used only for sample storage and label it “LAB.” No food or other consumables should be stored in the lab fridge.
- Store specimens at 2-8°C (35.6 - 46.4°F) for up to 72 hours after collection.
- Call courier for pick up.
- At the time of transport, specimens should be on ice in a box.

**Courier Instructions**
- Keep specimens on ice/refrigerated for transport
- Deliver to PH lab at Harborview Medical Center 325 9th Ave Room 3
Appendix 21 Nursing Protocol for Minors

MEDICAL INTAKE

Notification of New Client: I&Q Coordinator will call site manager and/or nurse with:

1. Basic medical and mental health information
2. Mobility
3. Alcohol, opioid, or other possible withdrawal concerns
4. Estimated arrival time
5. Current COVID-19 Status
6. Confirmation that notification of minor location per RCW 13.32A.082 has occurred
   See Unaccompanied Minors: King County Isolation and Quarantine Facilities
7. Mature minor/consent status
   o Mature minor determination is made by triage team and documented in EPIC with dot phrase .kingmatureminor
   o If mature minor determination or other consent cannot be secured, the minor may be housed at IQ site without receiving routine medical evaluation or treatment. They may receive emergency or specially protected services.
   See PHSKC Consent for Health Care Policy PHL 13-2-1 and The Mature Minor Rule 9.6

Client Arrival:

1. Don PPE
2. Greet client upon arrival and show to their room
3. If general consent to treat (for routine medical evaluation and treatment) is obtained,
4. Obtain vital signs and symptom check, including weight measurement
5. Test for COVID-19 as indicated
   See COVID-19 Testing
6. Ensure client has telephone in room and inform that nurse will be calling shortly
   • No adult staff at an IQ facility shall interact in person with an unaccompanied minor placed at the facility without another adult staff at the facility present during those interactions.

Admission:

1. Bring client up on EPIC under Client Lists
   See EPIC IQ Nursing Intake Job Aid
2. If not already in EPIC, complete registration
   See EPIC IQ Registration Job Aid
3. Verify minor consent status is documented in EPIC.
4. Call client on cell phone within one hour of arrival to complete admission
5. If arrival occurs late in the evening, medical intake can occur the next morning
6. Review with client:
   • Client Code of Conduct
• Consent to treat form- can only be used for clients designated as mature minors, declared emancipated by a court, or married to an adult.
• If the consent is not secured, routine medical intake and evaluation cannot be provided. But, daily welfare checks, meals and appropriate non-medical services can be provided.
• Rounding/Wellness and method of contact
• Meal schedule
• Requests for trash pick-up, towels, clothing, and toilet paper
• No smoking/vaping in rooms and to notify care team for escort to smoke
• Other site-specific information

7. Complete medical intake and EPIC intake
   See EPIC IQ Nursing Intake Job Aid
8. Admission: Enter admit date and time and bed number
9. Isolation Status:
   • Client Infection Status: COVID-19 positive or COVID-19 pending
   • Client Isolation Status: Droplet/Contact/Standard Precautions
10. Problem List: Enter documented or client reported medical problems
11. Allergies: Enter client documented or client reported allergies
12. Medications:
    • Record client reported or documented medication in EPIC
    • Coordinate medications that client needs but does not have with on-call provider
      ▪ See Care Coordination Below
    • Homeless Status: Enter homeless status
    • Quick Questions: Enter interpreter needs if relevant
13. Tier client to Level 1 or Level 2
    See Client Tiering Below
14. Address Care Coordination needs
    See Care Coordination Below
15. Monitor to ensure that youth do not have contact with other adults also receiving services in the facility.

**TIERING FOR CLINICAL MONITORING**

Assess as Level 1 if client presents with:
1. Abnormal vital signs
   • Temperature of 100.4° F (38° C) or higher
   • Blood pressure systolic <90 mmHg or diastolic <60 mmHg
   • Heart rate <60 BPM or >100 BPM
   • Respiratory rate <12 or >24/min
   • Oxygen saturation <94% on room air
2. At risk of withdrawal from substance use disorder
   (See Substance Use Disorder Guidelines)
3. Clinical discretion based on underlying health condition or concerning clinical signs and symptoms
4. Consult with clinician regarding other health concerns

Assess as Level 2 if client has:
- Vital signs within normal limits
- Medical problems are stable and client is able to self-manage
- Behavioral health problems are stable and client is able to self-manage

Consult with clinician if:
- Blood pressure:
  - Systolic >140 or diastolic >90 after repeat measurement
  - Systolic <90 after repeat measurement
- Shortness of breath or respiratory distress
- Hypoxemia with oxygen saturation <94% on room air
- Any other acute medical or behavioral health problems or nurse-identified concern

**ROUNDING & WELLNESS CHECKS**

**Level 1:**
1. In person assess at each shift, AM and PM, for:
   - Temperature, pulse oximetry, respiratory rate, and symptom check
   - Other vitals signs such as blood pressure per clinician order
2. More frequency of checks determined by on-call provider at time of tiering and subject to change based on client status

**Level 2:**
1. Wellness checks by phone each shift, AM and PM:
   - May be conducted collaboratively with behavioral health staff.
   - Include temperature checks (2 times per day, can be self-report)
2. In-person welfare checks 2 times per day
   - If mature minor or other consent cannot be secured, conduct welfare/wellness checks without medical evaluation or assessment.
3. Given adolescent circadian rhythms, contacts should be shifted to start later in the morning and end later in the evening than for adults.

**Other client check-ins/contacts**
1. Standing order medications: dispense on-site standing order medications at provider discretion
   See *Pediatric and/or Adult Medication Standing Orders*
2. Food Delivery: breakfast, lunch, and dinner dropped off outside of client’s rooms at meal times determined by site
Adolescents typically have a higher caloric intake than adults and will require several substantive snacks per day in addition to standard meals.

**Substance Use Disorder Guidelines**

**Risk of opioid withdrawal:**
Clients on buprenorphine or willing to start buprenorphine

- See *Obtaining Suboxone (Buprenorphine/Naloxone) at IQACRC*
- If on buprenorphine: regular prescribing provider should continue Rx
- If not on buprenorphine or cannot contact client’s regular prescriber: clinician with buprenorphine waiver may prescribe or may consult with Addiction Medicine physician

**Risk of alcohol withdrawal:**
- Clinician may consult with Addiction Medicine physician or PAL
  - See *Alcohol Withdrawal Prevention Clinical Guidelines*

**Risk of benzodiazepine withdrawal:**
- Clinician may consult with Addiction Medicine physician or PAL
  - See *Benzodiazepine Withdrawal Prevention Clinical Guidelines*

**Risk of nicotine withdrawal:**
- Nicotine replacement therapy may be provided under physician standing orders
  - See *Nicotine Use Clinical Guidelines*

**Care Coordination & Managing Medical Problems**

**Medication Management:**
Clients with home medications upon arrival:
- Record medications in EPIC at intake
- Clients will self-manage regular medications during stay

Clients without prescribed medications upon arrival and needing refills:
- Ask client if anyone can locate and deliver medications to site
- Call stated pharmacy to request refills
  1. **If refills available:** site will arrange to have prescriptions picked up at pharmacy and delivered to client’s room
     - Small copays can be paid for out of site petty-cash
  2. **If no refills available:** call clinician to request refill

Clients who need a medication but do not have a current prescription and are unable to get a prescription from their primary care provider:
- Review medication need with IQ clinician
• IQ clinician will determine whether to fill medication, not to fill medication, or find an alternative.
• Nurse coordinates obtaining prescribed medication with site manager and communication with client

Managing Medical Problems:
• Medical problems related to COVID-19, chronic medical problems, or other acute problems are managed on case-by-case basis by standing order or by consulting with on-site or on-call clinician.
  o A pediatrician or family medicine physician and child/adolescent psychiatry resource will be available for pediatric consults.
• Telehealth visits: consultations with on-call clinician are coordinated by nurse with client-issued telephone.

Mandated Reporting of Abuse and Neglect
Mandated reporters should report suspected abuse, neglect or exploitation to DCYF at 1-886-ENDHARM.
See Public Health Policy: Reporting of Child and Vulnerable Adult Abuse, Neglect, and Exploitation Guidelines

TESTING AND LAB RESULTS

On-site testing procedure:
See COVID-19 Testing Protocol

Storage and pick up
1. After obtaining sample, store labs in designated refrigerator
2. Call courier for pick up

Follow-up on lab results for outside labs:
1. Call doctor or site where client was tested
2. Follow up with nursing supervisor about site-specific results and troubleshooting

DISCHARGE

• Determine criteria for discharge
  See Isolation and Quarantine Discharge Guidelines
• Connect with behavioral health team to help arrange discharge planning and to ensure the receiving agency completes the required Notification of Minor Location process
  See Unaccompanied Minors: King County Isolation and Quarantine Facilities
• If client leaves prematurely against advice, ensure notification of DCYF intake at 1-886-ENDHARM
• Complete discharge in EPIC

See EPIC IQ Discharge Job Aid
• Ensure site manager has scheduled appropriate room cleaning:
  • FMD for cleaning COVID-19 negative rooms
  • BioClean for cleaning COVID-19 positive rooms
Appendix 22 Unaccompanied Minors Policy

**Issue:** Serving homeless youth between the ages of 14 – 18 who are not in the physical custody of a parent or guardian (referred to as “unaccompanied minors”) at King County operated COVID-19 Isolation and Quarantine (I/Q) Facilities.¹

**Background:**
- RCW 43.330.702 provides the following definitions:
  - “child,” “juvenile,” “youth,” “minor” means any unemancipated individual who is under the chronological age of eighteen years.
  - “unaccompanied” means a youth or young adult experiencing homelessness while not in the physical custody of a parent or guardian.
- Unaccompanied minors are not a monolithic group and assumption of legal responsibility for their welfare in Washington State is not clear-cut. Homelessness alone is not an automatic qualifier.²
- Many unaccompanied minors are unable to reunite with families (in the short-term or at all) due to complex, deep-seated challenges that drove them from home in the first place. Despite not living with families, unaccompanied minors are often not prioritized for foster care by the child welfare system, which focuses limited resources on younger people who are less able to care for themselves.
- It is exceptionally challenging in many cases to place unaccompanied minors into long-term and skilled foster homes. It is not uncommon for unaccompanied minors placed in foster homes or other group facilities by the child welfare system to run away from these facilities or homes.
- Still, some unaccompanied minors retain relationships with their families, who may themselves be homeless and unsheltered. These minors may at times be able to access youth shelter for a period of time, subject to limitations on lengths of stay often related to fund source.
- On rare occasions, it may be difficult to determine, at the time a minor seeks admission to a King County operated Isolation and Quarantine facility whether that child is a state dependent.
- Youth of color and LGBTQ+ youth are over-represented in the unaccompanied minor population. Thus, ensuring King County operated COVID-19 Isolation and Quarantine Facilities provide access to unaccompanied minor youth between the ages of 14 – 14 aligns with King County’s equity and social justice policy goals.
- Providing access to King County operated COVID-19 Isolation and Quarantine (I/Q) facilities to unaccompanied minors between the ages of 14 – 18 in order to reduce the risk of community spread of COVID-19 aligns with the goals of King County operated COVID-19 Isolation and Quarantine facilities.
• **Isolation** is used for people who are currently ill and able to spread the disease and who need to stay away from others in order to avoid infecting them.

• **Quarantine** is used for people who are not currently showing symptoms but are at increased risk for having been exposed to an infectious disease.

• Unaccompanied minors who, by definition, cannot self-quarantine or isolate in their own home, and who do not have an alternate and appropriate location to self-quarantine or isolate, would benefit from an I&Q Center that provides a safe, clean and comfortable place to stay. Unaccompanied minors would be served by both of I&Q’s vital functions:
  - Be supported to get through a very difficult situation and
  - Slow down the spread of COVID-19 in our community.

**Requirements:**
King County operated Isolation and Quarantine facilities are not considered to be “agencies” under RCW 74.15.020(1). Accordingly, IQ facilities need not be licensed in order to accept unaccompanied minors.

Nevertheless, to ensure compliance with legal obligations established by the Revised Code of Washington, King County operated Isolation and Quarantine facilities should ensure the following conditions are met.

**Notification of Minor Location to Parent, Law Enforcement, or Department of Children, Youth, and Families**

RCW 13.32A.082 requires notification as a pathway for an unlicensed facility to obtain legal authority to provide care to youth. The facility shall promptly report the location of the child within eight hours.

• **Transferred youth:** King County operated IQ facilities should, during intake, ensure that referring entity (hospital, shelter, etc.) has taken the lead on and completed RCW 13.32A.082 notification before placement.

• **Non-transferred youth:** DCYF recommends that in the event an IQ facility receives non-transferred youth “off the street” and there is an inability to notify a parent or legal guardian of the youth’s whereabouts, IQ facilities report the youth’s location to DCYF intake at 1-886-ENDHARM.

• **Youth found to be dependents after placement:** In the unlikely event that a youth is discovered through the notification requirement to be a dependent after placement, DCYF indicates that the unlicensed provider (IQ facilities) shall receive placement permission from the child’s assigned social worker.

**Reporting**

• **Abuse or neglect:** Many of the staff supporting IQ operations are mandated reporters; this includes nurses, doctors, social service counselors, and psychologists.³ DCYF recommends that
all staff at IQ facilities that may interact with unaccompanied minors served at these facilities participate in mandatory reporter training and/or sign a mandated reporter statement.

- **Minor leaving isolation and quarantine:**
  - Post completion: I/Q facilities would follow the discharge protocol in place and as applicable work closely with the Homeless Youth Provider to support discharge efforts. When the youth is discharged I/Q facilities will assure the receiving agency completes the required Notification of Minor Location process.
  - Pre Completion: I/Q facilities would notify DCYF intake. In addition, I/Q facilities would work with Placement Team to notify any Homeless Youth Provider where the youth is actively receiving services.

**Staffing Ratio**
Due to the nature of IQ facilities and current operations, staffing ratios recommended by DCYF are met.

**Intake, Determination of Ability to Serve and Additional Provider Supports**
In creating the intake protocol for unaccompanied minors, a more thorough assessment based on provider, if available, and minor conversations should be made to determine whether King County operated IQ facilities that offer placement of unaccompanied minors are appropriate for the needs, maturity and resources of the unaccompanied minor seeking placement. Thought will be given to fit in light of the nature of isolation and quarantine itself and the hours a minor will spend alone in a single-occupancy room.

To better support minors placed at IQ, staff will connect with the provider referring the minor and any other provider with an established relationship with the minor and partner with the provider(s) to assist the minor in successfully completing the isolation or quarantine period. Rounding, frequency, time and manner, should be altered in the clinical protocols to align with the needs of this age group.

**Designated Staff and Staff Background Checks**
Due to COVID-19 limitations on the ability to conduct staff-wide fingerprint-based background checks on staff who may have unsupervised contact with minors placed at King County operated Isolation and Quarantine facilities, staff will only interact in person with minors placed at these facilities in sets of two or higher. No adult staff at an IQ facility shall interact with an unaccompanied minor placed at the facility without another adult staff at the facility present during those interactions.

**Shared Use of Space and Age Grouping**
Unaccompanied youth at King County operated Isolation and Quarantine facilities will not, as a matter of practice, be using shared living spaces during their isolation and quarantine period in a manner that would result in contact with adults also receiving services in the facility.
Unaccompanied minors at King county operated Isolation and Quarantine facilities will be isolating or quarantining in single-occupancy rooms and will not, therefore, be grouped with other youth in their sleeping quarters or bedroom sharing.

As determined by I&Q staffing and with appropriate supports and supervision, unaccompanied minors who are COVID-19 positive may be provided with opportunities to socialize for a dedicated amount of time in designated areas for the purpose of supporting their overall wellbeing in developmentally appropriate ways. If a determination is made to provide this opportunity, protocols and processes will be put in place to ensure that age grouping and staff supervision is appropriate for the number of unaccompanied minors and the specific needs of the individuals in the group.

Clinical Care and Mature Minor Consent

The Mature Minor Rule was created as a result of a court case, Smith v. Seibly, 72 Wn.2d 16 (1967), and is part of Public Health - Seattle & King County's policy which allows health care providers to treat youth under the age of eighteen as adults based upon an assessment and documentation of the youth’s maturity.

The Mature Minor Rule requires that providers consider the Mature Minor Factors below to determine whether a youth has the capacity to understand the proposed health care service and/or treatment and is sufficiently mature to make their own health care decisions. PHSKC will train I/Q MTT screening team on the process to make a mature minor determination and document the rational.

Minors may consent to the following specially protected services:

- Sexual Health and Reproductive Health Services (any age)
- Mental Health (age 13+)
- Substance Use Disorder Counseling and Treatment (age 13+)

To receive other I&Q health services, minors may consent if:

- Declared emancipated by a court
- Married to spouse who is an adult
- Determined by a provider to be a mature minor
- Determination must be made by a physician and documented in the health record.

Emergency exception: implied consent for emergency services

- occurs when there is a health care emergency (immediate treatment is necessary to preserve life or prevent serious deterioration of the client’s condition) and
- the client is not able to consent and/or a person who may consent on the client’s behalf is not readily available

See PHSKC Consent for Health Care Policy PHL 13-2-1 and The Mature Minor Rule Appendix 9.6 for determination details and other options for consent.
Appendix 23 Scrubs Policy

Background

The community’s confidence and trust are essential to King County’s ability to mount an effective response to the COVID-19 pandemic. While scrubs worn under a fluid-resistant gown pose little risk of transmitting COVID-19, it is easy to understand how the general public could have a different perception of the magnitude of this risk. Locally and across the country during this pandemic, medical personnel in scrubs have been approached by community members who are scared about the risk posed to their safety by providers wearing “dirty” scrubs in public. King County is therefore seeking to take a proactive stance to protect staff from any potential mistreatment and to avoid creating any misperceptions or fear regarding the safety of our IQ operations.

Guidelines for Use of Scrubs at IQ Sites

1. For purposes of infection control, scrubs or scrub alternatives should be worn under PPE by all staff who are entering client rooms to provide client care. Other staff are also welcome to wear scrubs.
2. Staff may bring their own scrubs or scrub alternatives or wear scrubs provided by King County.
3. Scrubs should be removed and bagged for laundering at the end of shift. If staff prefer active wear or other scrub alternatives, the same procedure should be followed. Any clothing worn to provide client care should be removed at the end of the shift.
4. Staff who use their own scrubs or scrub alternatives will bring home to launder themselves. There is laundry service available for King County-provided scrubs.
5. Staff should change into clean street clothes prior to departing the IQ facility.
6. Staff may not wear scrubs while walking, biking, driving or taking transit to or from the facility.
7. Scrubs should not be worn at any time by IQ staff in any public setting (including apartment building common areas, restaurants, convenience stores, grocery stores, gas stations, etc.) in order to avoid public perception of COVID-19 transmission risk.
Appendix 24 AIDET Skills

The acronym *AIDET* stands for five communication behaviors: **Acknowledge**, **Introduce**, **Duration**, **Explanation**, and **Thank You**.

As someone who works in healthcare, you constantly care for people who are feeling vulnerable, nervous, and even confused. AIDET is a communication framework for healthcare professionals to communicate with clients and each other in a way that **decreases client anxiety, increases client compliance, and improves clinical outcomes**.

- **A** **ACKNOWLEDGE**: Greet the client by name. Make eye contact, smile, and acknowledge family or friends in the room.
- **I** **INTRODUCE**: Introduce yourself with your name, skill set, professional certification, and experience.
- **D** **DURATION**: Give an accurate time expectation for tests, physician arrival, and identify next steps. When this is not possible, give a time in which you will update the client on progress.
- **E** **EXPLANATION**: Explain step-by-step what to expect next, answer questions, and let the client know how to contact you, such as a nurse call button.
- **T** **THANK YOU**: Thank the client and/or family. You might express gratitude to them for choosing your hospital or for their communication and cooperation. Thank family members for being there to support the client.