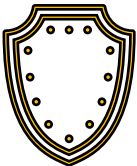
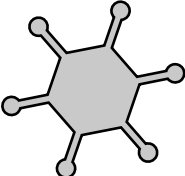


Additional Considerations: Immunocompromised Patients in Acute care

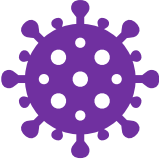
In addition to [Routine Practices](#)

	The AHS IPC Diseases and Conditions Table Recommendations for Management of Patients Acute Care identifies specific requirements for immunocompromised patients in several of the diseases and conditions. Immunocompromised patients may require a different type and/ or an extended duration of Additional Precautions because of one or more of the following reasons: • reduced immune response in clearing certain infections • prolonged shedding of a microorganism • greater risk of developing or reactivating certain infections • atypical presentation of a communicable illness • inadequate or weakened protective immune response post-infection
	Accommodation • Single room with private washroom is preferred for all patients considered to be clinically immunocompromised. • Room door may remain open (unless door alarms will activate). • If room-sharing, maintain at least two (2) meters of physical separation between bed/stretchers spaces for all circumstances, provide a dedicated bathroom or commode for each patient and close privacy curtains. • Position Statement on Spatial Separation of Patients in AHS and Covenant Health • Recommendations for Cohorting Inpatients on Additional Precautions in Acute Care Facilities • Setting-up Isolation without Walls in a Shared Space
	Accommodation: Additional considerations for Severely Immunocompromised Patients (Refer to Appendix A for definitions) • A protective environment (PE) room (where available) is the preferred accommodation for hematopoietic stem cell transplant recipients. This protective environment is a specially engineered patient room with HEPA filtered supply air and positive pressure airflow designed to minimize fungal spore counts in the air. • In the absence of a protective environment room (including a PE or AIR/PE room if available), a single room is recommended for hematopoietic stem cell transplant recipients or those considered severely immunocompromised (see Appendix A).

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	“Reverse isolation” is an outdated term and practice without evidence of benefit for hospitalized immunocompromised patients and such measures are not recommended.
	Masking - Masking by staff is <i>strongly recommended</i> when in contact with severely immunocompromised patients. Use of Masks to Prevent Transmission of Respiratory Viruses Directive Posters/Resources Masks Required, and Masks Strongly Recommended.
	Hand hygiene - Staff are encouraged to practice excellent hand hygiene according to the 4 Moments Of Hand Hygiene to prevent transmission of pathogens between patients. Hand Hygiene Alberta Health Services - Hand hygiene practices are part of AHS infection prevention and control program. AHS is required to monitor, audit and improve hand hygiene to achieve a minimum target of 90% compliance throughout the organization. Clean Hands System Training Alberta Health Services
	Patient ambulation outside room, bed space or transfer PPE to Transport Patients on Additional Precautions - Patients on additional precautions are encouraged to leave their room for essential purposes only.
	Ambulatory areas Ambulatory areas/clinics should refer to the IPC Recommendations for Ambulatory Care Clinics (including Laboratory Collection Sites) for specific recommendations.
	Environmental cleaning Special attention to minimize dust accumulation and dispersal is advisable, with daily routine and enhanced cleaning recommended for areas that care for immunocompromised patients.

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	Visitors (including pet visitation) • Family Presence: Designated Family / Support Person And Visitor Access Policy • Postpone in-person visits with patients if they are unwell. • Visitor Alert Poster- Do you have a cough? • With outbreaks or increased activity of infectious pathogens in the community, there may be a request to limit visitors or designated support persons to 2 or less. Pet visitation • Personal pet visitation is not recommended. • Animal Interactions, Personal Pet Visitation, and Qualified Assistance Dogs Policy
	Gifts, presents, flowers • For specialized units that predominantly care for clinically immunocompromised patients, it is recommended to exclude: ○ Plants and flowers (fresh, dried and artificial) • Horticulture in Healthcare • Horticulture in Healthcare Frequently Asked Questions
	Viral Respiratory Illnesses (VRIs) and COVID-19 specific recommendations • Contact and Droplet Precautions Sign Acute Care - Poster with N95s for Aerosol-generating Medical Procedures AGMPs - Poster ○ Aerosol-Generating Medical Procedure Guidance Tool ○ Acute Care Discontinuation of Contact and Droplet Precautions for Suspected or Confirmed Viral Respiratory Infection (VRI) Criteria for Clearing COVID-19 Positive Status for Immunocompromised Inpatient (see Appendix A for definitions) • Maintain Contact and Droplet Precautions until at least 14+1 days after patient's symptom onset date or positive test date (if symptom onset date not known or patient remains asymptomatic). • Proceed only if resolution of fever and patient's symptoms have improved to a new/pre-existing baseline for at least 48 hours.

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	Criteria for Clearing COVID-19 Positive Status for <u>Severely Immunocompromised Inpatient</u> (see Appendix A for definitions) • Maintain Contact and Droplet Precautions until at least 21+1 days after a patient's symptom onset date or positive test date (if symptom onset date not known or patient remains asymptomatic). • Repeat testing is recommended on day 22 or later when a patient is asymptomatic or at baseline. • Proceed only if resolution of fever and patient's symptoms have improved to a new/pre-existing baseline for at least 48 hours. ○ A negative test is <i>not</i> required, cycle threshold (Ct) value should be >30 OR use serial Ct values as applicable. Consult IPC.
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Appendix A

Definitions for Immunocompromised and Severely Immunocompromised

The following list is not necessarily complete as drugs and treatment modalities are introduced. For questions regarding immune status, please contact Infection Prevention and Control.

Immunocompromised	Severely Immunocompromised
Some partial B cell deficiencies and known intact T cell immunity (e.g., isolated IgA deficiency, IgG subclass deficiency, specific polysaccharide antibody deficiency (SPAD))	Severe B cell deficiency (defect of humoral immunity) (e.g., X-linked agammaglobulinemia, common variable immunodeficiency (CVID))
Some partial T cell deficiencies (e.g., partial DiGeorge syndrome) and a total CD4 lymphocyte count of $> 0.5 \times 10^9/L$ and normal mitogen response	Severe T cell deficiency (e.g., severe combined immunodeficiency (SCID), complete DiGeorge syndrome) Some partial T cell deficiencies (e.g., Wiskott-Aldrich syndrome, ataxia telangiectasia, X-linked lymphoproliferative disease, or familial predisposition to hemophagocytic lymphohistiocytosis)
Patients with extensive loss of skin/mucous membrane barrier defenses (e.g., graft vs. host disease, major burns, scalded skin syndrome, Stevens-Johnson syndrome)	Patients with neutrophil count $< 0.5 \times 10^9/L$ for duration ≥ 48 hours Patients with lymphocyte count $< 0.5 \times 10^9/L$ for duration ≥ 48 hours
HIV infection and CD4 T lymphocyte count $> 200 \times 10^6/L$ (or greater than 15%) and unsuppressed viral load	HIV infection and CD4 T lymphocyte count $< 200 \times 10^6/L$ (or less than 15%)
Methotrexate ≤ 0.4 mg/kg/week Azathioprine ≤ 3 mg/kg/day 6-mercaptopurine ≤ 1.5 mg/kg/day Patients on multiple immunosuppressant medications should be assessed on a case-by-case basis.	<u>Corticosteroid use equivalent to:</u> Prednisone ≥ 20 mg/day for duration of ≥ 14 days For Pediatrics, prednisone ≥ 2 mg/kg/day (or 20mg/day if over 10kg) for duration of ≥ 14 days Other immunosuppressants: Methotrexate > 0.4 mg/kg/week Azathioprine > 3 mg/kg/day 6-mercaptopurine > 1.5 mg/kg/day

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Immunocompromised	Severely Immunocompromised
Patients with rheumatologic, inflammatory or autoimmune conditions on immunosuppressive therapy (e.g., inflammatory bowel disease, multiple sclerosis, rheumatoid arthritis, systemic lupus erythematosus) (variable risk due to the heterogeneity of treatments; case-by-case assessment to determine if severely or non-severely immunocompromised)	<u>Anti-B cell therapy/ monoclonal antibodies:</u> (current or within last 6 months) Rituximab, ocrelizumab, obinutuzumab, ocaratuzumab, 90Y-ibritumomab tiuxetan, ofatumumab, veltuzumab, 131 I-tositumomab, ublituximab, blinatumomab, ineblizumab, Combotox (combination of anti-CD19 and anti-CD22 immunotoxins) <u>TNF antagonist therapy</u> (e.g., adalimumab, etanercept, infliximab and golimumab) Other biologic agents that are significantly immunosuppressive
Solid organ transplant recipients if on immunosuppressive therapy or within 2 years of transplantation (case-by-case assessment to determine if severely immunocompromised)	Hematopoietic stem cell transplant recipients within 24 months of stem cell transplant Solid organ transplant recipients within 6 months of organ transplant
	Chimeric antigen receptors (CAR) T cell therapy within the last 12 months
Oncology patients: - receiving active chemotherapy* (current or within the last 3 months) and/ or - receiving wide area radiation therapy (excluding brachytherapy or small, focused radiation, such as for localized skin cancers) (current or within the last 3 months)	Any active hematological malignancy (e.g., leukemia, multiple myeloma, lymphoma)

* If chemotherapy protocol includes anti-B cell therapy (e.g. rituximab) or another severely immunosuppressive agent, then the patient would be considered severely immunocompromised until 6 months from discontinuation.

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