Royal Devon University Healthcare NHS Foundation Trust

COVID-19 Guidelines

Reference Number: F4578
Date of Response: 12th July 2022

Further to your Freedom of Information Act request, please find the Trust's response, in **blue bold text** below:

Request and Royal Devon and Exeter NHS Foundation Trust Response

1. Current local guidelines for the treatment and management of Covid-19.

   Please see the following guidelines attached:

   - **Acute Paediatric Management of confirmed COVID-19**
   - **COVID-19 Empiric Guidance**
   - **Guidance for COIVD-19 positive cohort wards**

2. Current local infection control guidelines regarding testing and quarantining/isolation of Covid positive patients.

   Please see the following guidelines attached:

   - **COVID-19 Testing**
   - **COVID-19 Infection Prevention and Control Measures**
   - **COVID-19 Testing for Emergency Admissions and Inpatients**

   In addition to the above documents, please see the following links:

   https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

   https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

RD&E Paediatric inpatient management of confirmed COVID-19

Child (age 0-17 years) with confirmed COVID-19 (or strongly suspected)

Isolate in designated COVID-19 area and use droplet PPE: single use disposable gloves, apron, eye protection and fluid resistant surgical mask[2]

For any patient undergoing an aerosol generating procedures (AGP) and all COVID-19 patients in HDU or ITU staff to use aerosol PPE: single use disposable gloves, single use disposable or reusable long-sleeved gown, visor and FFP3 mask or powered respirator with buddy system to don and doff[2]

If not critically ill

Manage according to clinical presentation

Monitor for persistent fever and other organ involvement (eg respiratory, renal, liver) and follow RCPCH guidance[9,10]

On discharge advise 14 days self-isolation of child and all household members. Advise on red flags to look out for and where to seek help. See NHS advice on self-isolation[6]

If critically ill

- **Level 1 PCC: Basic criticial care eg high flow nasal cannula**
- **Level 2 PCC: Intermediate critical care eg non-invasive ventilation**
- **Level 3 PCC: Advanced critical care eg invasive ventilation**

Manage child according to clinical presentation and follow PCC guidance[3]

Discuss with Wales and West Acute Transport for Children (WATCh)[5]- early intubation may be recommended. Other specialists will be dialled in as needed

Discuss all cases with Bristol paediatric infectious diseases team

Recommended monitoring and investigations for critically ill patients[9,10]

Close monitoring of oxygen saturations, RR, HR and BP, temperature and fluid balance

Blood tests: blood gas, FBC, renal and liver profiles, CRP, ferritin, coagulation including D-dimer and fibrinogen, LDH, troponin, blood culture, serology for COVID-19 [3], serum save and lymphocyte subsets if severe illness in <2 yr olds to exclude SCID

Other: 12 lead ECG, urine dipstick, portable CXR if clinically indicated, cultures (blood, urine, throat, and sputum if available), and viral respiratory panel

Additional investigations if multi-organ involvement as per RCPCH guidelines[9,10]

Management in liason with Bristol paediatric infectious diseases team and WATCh[5] as needed

Give oxygen (nasal prongs/ face mask) to keep sats 92-94%, using minimum oxygen necessary. Position child with head up

Follow RD&E paediatric respiratory support guidelines[7], using AGP such as high flow nasal cannulae (HFNC) or CPAP only if patient hypoxic on standard oxygen therapy and if deemed necessary, ensuring staff use AGP PPE

If sats ≤90-92% in 50-60% oxygen have early discussion with WATCh[5]/ ITU and consider early intubation

IV fluids if not tolerating oral fluids- conservative unless shocked

If secondary bacterial pneumonia or sepsis is suspected, follow trust antimicrobial guidelines for choice of antibiotic(s)[7]. If chronic condition or foreign travel discuss with microbiology

Treat associated complications as per RD&E guidelines[7] such as sepsis, acute kidney injury, and respiratory failure

Refer to RCPCH guidelines for further information on medical management of COVID-19[10] and multi-inflammatory syndrome[9]

Antivirals +/ or immunomodulation may be considered in liason with Bristol Paediatric Infectious Diseases team and as part of recruitment to the paediatric arm of the Recovery trial[11]

Notify all cases to the relevant paediatric COVID-19 surveillance systems[12]

Resources linked to flowchart

1. RD&E COVID-19 case definition: https://hub.exe.nhs.uk/a-z/coronavirus-covid-19-info-hub/clinical-guidance/case-definition/
2. RD&E COVID-19 clinical guidance including PPE: https://hub.exe.nhs.uk/a-z/coronavirus-covid-19-info-hub/clinical-guidance/
3. Paediatric Critical Care guidance on COVID-19 including advise on AGPs, managing a ventilated child in a DGH and critical care transport: https://picsociety.uk/covid19/
4. COVID-19 Public Health England (PHE) Infection Control Guidance including use of Equipment: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control
5. Wales and West Acute Transport for Children (WATCh): https://www.watch.nhs.uk/ Tel 0300 0300 789
6. NHS advice on self-isolation https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-advice/
7. RD&E paediatric clinical guidelines on hub: https://hub.exe.nhs.uk/a-z/paediatrics/paediatric-documents/?opentab=1
8. RCPCH/BPAIIG Tonsillar examination infection control implications. Hosted by RCPCH, link to current pdf in downloads section at the bottom of: https://www.rcpch.ac.uk/resources/covid-19-guidance-paediatric-services
9. RCPCH guidance on paediatric multi-system inflammatory syndrome temporarily associated with COVID-19: https://www.rcpch.ac.uk/resources/guidance-paediatric-multisystem-inflammatory-syndrome-temporally-associated-covid-19-pims
10. RCPCH paediatric COVID-19 guidance https://www.rcpch.ac.uk/resources/covid-19-clinical-management-children-admitted-hospital-suspected-covid-19
11. Contact the paediatric research nurses and find further information at https://www.recoverytrial.net/files/recovery_paeds_guidancev7_20201006.pdf
12. See details on where to report cases to at https://www.rcpch.ac.uk/resources/covid-19-data-collection

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 Clinical Guidance Front Sheet

COVID-19 CLINICAL GUIDANCE: COVID-19 Empiric Guidance in Adult Patients

Summary of recommendation for change/development:

Point of Contact/author	[redacted]
Approved by:	Clinical Effectiveness Committee
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Document Version:	V2.2 - 23 July 2020 V2.3 – 4 December 2020 V3 – 6 September 2021 V4 – 1 November 2021 V4.1 – 21 March 2022
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Date document becomes live:	28 July 2020 V2.3 5 December 2020 V3 7 September 2021 V4 – 1 November 2021 V4.1 – 21 march 2022

1. Causative agent

SARS-CoV-2 is a novel β-coronavirus, and the causative agent of COVID-19

2. Incubation period

4-5 days (range 1-14 days). Median time from onset of symptoms to hospitalisation is 7 days Unlike other β-coronaviruses patients may have transmissible disease in the asymptomatic phase of illness.

3. Transmission routes

Transmission is believed to be primarily through the respiratory route, either through large droplets from respiratory secretions or via smaller aerosols in certain circumstances. The virus may also survive on high touch surfaces with hand-to-mouth (fomite) transmission being a risk. Personal Protective Equipment (PPE) centers on prevention of contamination of airway and mucous membranes and hand-to-mouth transmission. Alcohol gel and soap and water are effective for decontamination of hands.

4. Clinical presentation

There is a spectrum of disease from mild respiratory symptoms to severe illness, particularly in the elderly or patients with co-morbidities. The main morbidity is through viral pneumonia, a hyperinflammatory state and respiratory failure. As with influenza, other clinical problems may arise in patients with pre-existing comorbidities. **See case definition below in Box 1**.

5. Initial assessment

Screening questions for symptoms compatible with COVID-19 should be asked prior to initial assessment. Standard medical assessment is then required, with particular attention to respiratory status and documenting RR, HR, O2 sats. PPE is required as defined in the Trust PPE policy.

6. Diagnosis

Nose and throat swabs for SARS-Cov-2 PCR are the main diagnostic test for patients who meet the case definition (**see box 1 below**). Testing for other respiratory viruses including influenza will not be done routinely in these cases, but broader testing panels are available for selected groups or cases of diagnostic difficulty.
CT scans often show diffuse changes but are not currently recommended as a standalone diagnostic test and should be reserved for special circumstances such as looking for alternative pathology or complications.

Box 1: Case definition

Individuals with any of the following:

1) **A new persistent cough (item included since March 23rd 2020**
2) **Either clinical or radiological evidence of pneumonia (including hospital acquired)**
3) **Acute Respiratory Distress Syndrome**
4) **Influenza like illness** (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing). Patients may also experience myalgia and fatigue similar to influenza.
5) **New respiratory symptoms or fever without another cause or worsening of a pre-existing respiratory condition** (item included since April 3rd 2020)
6) **A loss of, or change in, normal sense of taste or smell (anosmia)** in isolation or in combination with any other symptoms (item included since 19th May 2020)
7) **New onset confusion or delirium**

Atypical presentations are common, particularly in the elderly and immunocompromised; COVID19 should be considered in a wide range of presentations where alternative diagnoses are not evident

7. Investigations

In all patients requiring admission:

- FBC, U&Es, LFTs, CRP, nose/throat swab for SARS-CoV-2
- Chest X-ray

- Patients who test positive for COVID 19 by PCR: COVID antibody testing should be requested at the point of admission or as close to diagnosis as possible (seronegative patients may benefit from monoclonal antibody therapy)

In patients with severe illness including those requiring > 2L/minute of oxygen to maintain saturations ≥92%, respiratory ≥ 25, cardiovascular compromise, and evidence of rapid deterioration

- ABG
- Coagulation screen and D-dimer
- ECG +/- Troponin
- LDH
- Ferritin
- CK
- Blood cultures
- Sputum culture
- Repeat CXR

    - Consider ABGs in any patient with COPD or other severe pre-existing lung disease requiring O2

The commonest abnormalities include leukopenia, lymphopenia, leukocytosis and elevated liver transaminases.

8. Initial management

- Oxygen –To support a target SpO2 greater than or equal to 92%
    - Use the least amount of oxygen to maintain O2 sats, eg starting with nasal cannulae if possible, moving to a face mask if flow rates of >4L/minute are required.
    - If high oxygen flow rates are required for a prolonged period, humidification may be required
    - If O2 sats cannot be maintained despite 60% oxygen then High Flow Nasal Oxygen can be considered in discussion with ITU or the respiratory team
- Fluids – conservative fluid management unless evidence of cardiovascular shock as aggressive fluid resuscitation may worsen oxygenation
- Antipyretics and analgesia
- Secondary bacterial infection is not present in most cases. Antibiotics should not be routinely employed, but where secondary bacterial infection is suspected, commence as per trust guidelines for pneumonia.
- Anticoagulation - see NICE guidelines. A formal assessment of bleeding risk should be undertaken at admission. Treatment dose LMWH should be considered in hospitalised patients with COVID-19 who are likely to stay for at least 3 days, are requiring supplemental oxygen but who are NOT requiring high-flow oxygen, continuous positive airway pressure, non-invasive ventilation or invasive mechanical ventilation. If a patient goes on to require any of these additional measures, the dose of LMWH should be reduced to either intermediate or standard dosing.
- Discuss ANY foreign travel with microbiology. In particular cases with travel from regions associated with travel bans or Variants of Concern should be highlighted to microbiology immediately as additional isolation precautions may be required.

COVID -19 therapy – see NICE rapid guideline for further information:
https://www.nice.org.uk/guidance/ng191

Remdesivir is not recommended routinely following the results of the SOLIDARITY trial (December 2020). Further, the benefit in reducing the length of stay has been minimized by the impact of widespread vaccination on length of stay. For the immunocompromised patients, monoclonal antibodies provide a proven greater benefit, albeit with a significantly higher cost.
For the immunocompromised patient, who cannot receive mAB therapy, it may be considered when presenting in the initial 10 days of illness and provided eGFR is > 30ml/minute and ALT < 5 times the upper limit of normal. (**requires Blueteq submission for each patient**). Treatment for immunocompromised patient is 5 days in most cases, although may be extended to 10 days.

Recommended dose is 200mg IV loading dose on Day 1 followed by 100mg daily

Dexamethasone: Following results of the RECOVERY trial dexamethasone has been associated with improved outcomes in selected patients Use is indicated in:

- Hospitalised patients with COVID-19 (suspected or confirmed) having oxygen therapy, non-invasive or invasive ventilation, or ECMO. The recommended dose schedule is as follows:

For dexamethasone 2mg tablets: dosage three tablets once a day for 10 days
For dexamethasone 2mg/5mL oral solution: dosage 15mL once a day for 10 days
For dexamethasone 3.3mg/mL intravenous 1ml ampoules: dosage 6.6ml (6.6mg) once a day for 10 days
Treatment should stop if discharged from hospital within the 10 days

For patients able to swallow and in whom there are no significant concerns about enteral absorption, tablets should be prescribed. IV administration should only be used where tablets or oral solution are not appropriate, or not available.

In pregnancy or breastfeeding women, prednisolone 40 mg administered by mouth (or intravenous hydrocortisone 80 mg twice daily) should be used instead of dexamethasone.

Tocilizumab.(**requires Blueteq submission for each patient**) Subsequent to the RECOVERY trial update in January 2021 Tocilizumab is recommended for patients with COVID-19 who:

- are having or have completed a course of corticosteroids
- have no evidence of a bacterial or viral infection (other than SARS-CoV-2) that might be worsened by tocilizumab.

And they either:

- need supplemental oxygen and have a C-reactive protein level of 75 mg/litre or more, or
- are within 48 hours of starting high-flow nasal oxygen, continuous positive airway pressure, non-invasive ventilation or invasive mechanical ventilation.

The dose is 8mg/kg with a maximum of 800mg, given as a single dose

Sarilumab can be considered as an alternative if tocilizumab is unavailable

Casirivimab and imdevimab (REGN-COV2) (**requires Blueteq submission for each patient**). The RECOVERY trial reported an 18% reduction in mortality for immunocompromised patients who were not immunized or who had not seroconverted after vaccination. There was no benefit, indeed the trend towards harm for those who had were

seropositive for anti-spike antibodies against SARS COV2. Therefore, immunocompromised individuals should have their anti spike-protein (anti-S) antibodies evaluated on admission.
Treatment criteria

- Negative for baseline serum anti-spike (anti-S) antibodies against SARS-CoV-2
- Aged 50 and over; OR
- Aged 12-49 and determined to be immunocompromised by multi-disciplinary team (MDT) assessment

Exclusion criteria

- Weight <40kg
- Previous treatment with casirivimab and imdevimab at the 2.4g (combined) dose or higher

The decision to administer should be made by an MDT consisting of the Duty Covid Consultant, a ward Nurse (as patient advocate, not necessarily with significant COVID experience) and one other of specialist pharmacist, another covid consultant, respiratory consultant on-call or microbiologist on call. If a pharmacist is not already involved, the duty pharmacist should be included in the decision making process

- Casirivimab and imdevimab 2.4g (1.2g each of casirivimab and imdevimab), is administered as a combined single slow intravenous infusion over a minimum of 30 minutes

Venous Thrombo-embolism prophylaxis (LMWH or Rivaroxaban)

All people with COVID-19 have an increased risk of VTE, thus there is a need to initiate prophylactic low molecular weight heparin as soon as possible, within 14 hours. The risk of VTE is perpetuated for 7 days beyond the admission in those who require oxygen therapy.

A standard prophylactic dose of a low molecular weight heparin should be given as soon as possible, and within 14 hours of admission, to young people and adults with COVID-19 who need any sort of ventilatory support (including low flow oxygen), who do not have an active bleed or other absolute contra-indication.

Treatment should be continued for a minimum of 7 days, including after discharge.

Potential Variance
Two studies have demonstrated a trend towards better outcomes for the use of treatment dose in people with moderate to severe COVID-19 for mortality (RR 0.5 (95%CI 0.13-1.88)) and disease progressions (RR 0.63 (0.39 -1.02)). Both of these were relatively small studies, and therefore underpowered to confirm or refute benefit. The HEP-COVID RCT recruited 253 patients with a D-dimer ≥ 4 times the upper limit of normal. This demonstrated a RR of 0.68 (0.49-0.96) for major thrombotic events with treatment dose LMWH vs prophylactic dose if used before admission to ITU (NNT 5).

Thus in individual circumstances, treatment dose may be indicated the discretion of the responsible consultant.

9. Negative swabs and repeat testing

There is some concern over the sensitivity of nose and throat swabs for SARS-Cov2. False negatives can occur particularly early in the course of the disease or if the swab is not adequately taken.

- If a high clinical suspicion for COVID-19 remains then a negative swab should not be taken as evidence that COVID-19 has been excluded.

- Patients with a clinical diagnosis of COVID-19 should NOT be cohorted in bays with proven cases but can be managed in a side room, including on COVID-19 cohort wards **(see pathway on HUB)**

Isolation and PPE should remain in place and a repeat test after 24 hours considered if:
1) Ongoing deterioration or failure to improve
2) Escalation to a higher level of care (such as ITU) or where NIV or ventilatory support is required
3) No alternative diagnosis has been reached
4) A deep sample can be obtained – these have the highest sensitivity

Testing, including repeats, is also required for:
1) Mortuary cases as directed by the coroner
2) Pre-transfer to another healthcare facility such as cardiothoracic surgery in Derriford
3) Prior to discharge to nursing or residential facilities in the community
4) Staff as directed by the Absence Hub – all staff requests require prior authorisation
5) Acute admissions (at point of admission and repeated at intervals as defined in the current Testing Policy) or prior to other hospital contact as defined by the current Testing Policy
6) Daily testing of inpatient contacts of a case of COVID19

Testing for influenza and other respiratory viruses is available and should be utilized when repeating swabs and in select patient groups including paediatrics, immunocompromised patients, respiratory and HDU or ITU.

10. Monitoring

Oxygen saturations (ideally continuous if requiring oxygen therapy and/or elevated respiratory rate).
HR, BP, Temperature; fluid balance may be required

11. Escalation

Hospitalised patients are at a high risk of requiring Critical Care

- **Discuss early with ITU as transfer needs to be as predicted and planned wherever possible:**

Discuss with ITU any patient with rapidly worsening hypoxaemia, or requiring > 35% oxygen/8L/min to keep sats ≥ 92%, rising respiratory rate or evidence of respiratory fatigue, ↑pCO2 on blood gases or worsening multiorgan dysfunction.

Further resources:
NICE guidelines: https://www.nice.org.uk/guidance/ng191/chapter/Recommendations

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Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 Clinical Guidance Front Sheet

COVID-19 CLINICAL GUIDANCE: Guidance for COVID-19 positive cohort wards

Summary of recommendation for change/development:
Update to guidance and removal of reference to raspberry scrubs

Point of Contact/author	[redacted]
Approved by:	Clinical Reference Group
Date approved:	V2.0 23 November 2020 V2.1- 4 January 2021
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Date notified to Gold Command:	V2.0 24 November 2020 V2.1 - 5 January 2021
Date document becomes live:	23 November 2020 V2.1- 4 January 2021

1. Background

- COVID-19 is a Coronavirus, a group of viruses which are common viruses. There are 7 coronaviruses.
- Human coronaviruses usually cause mild to moderate upper-respiratory tract illnesses. However, COVID-19, MERS and SARS have the potential to cause severe illness.
- The method of transmission is via respiratory droplets, hand/mucous membrane contamination and aerosols during aerosol generating procedures
- The main symptoms of infection are a new persistent cough, a fever of 37.8 or above, a loss of, or change in sense of taste or smell (anosmia).
- The following information identifies the IPC measures required for COVID-19 positive wards.

2. Infection Control Measures

- Patients who test positive for COVID-19 must be isolated in a single room on their base ward if specialist care is required or transferred to a COVID-19 cohort on a designated ward.
- Patients must have allocated toilet and bathroom facilities. If the single room or cohort bay is not en-suite or the patient cannot use the en-suite facilities, a commode must be allocated.
- Visiting staff to the ward, such as Allied Health Professionals (AHP) should where practical see all non-COVID-19 patients prior to those with confirmed COVID-19 and adherence to IPC and PPE guidance must be maintained. Visits to the

affected ward by non-ward based staff must be kept to an unavoidable minimum (both in frequency and numbers).
- Although not a requirement in either local or Public Health England IPC guidance on uniform/ workwear, COVID-19 cohort wards, may, if they choose wear scrubs (see appendix 1)
- Windows must be opened frequently to increase ventilation in the cohort or side room.
- Cleaning of all multi use equipment such as BP and ECG machines, thermometer, WOWs etc. must occur frequently throughout the day using a clinell universal wipe.

3. Hand Hygiene

- Hand hygiene is the single most important measure to reduce transmission of the infection. Coronaviruses are susceptible to alcohol hand gel. Hand hygiene must be performed using soap and water if visible soiling is present on hands.
- Hand hygiene must be performed before and after removing PPE along with the '5 Moment for Hand Hygiene'

4. Personal Protective Equipment (PPE)

- PPE must be worn by all staff within 2 meters of patients. The following PPE is required:

Standard care (enhanced PPE)	**Aerosol Generating Procedures (AGP)**
Disposable gloves	Disposable gloves
Disposable plastic apron	Disposable gown
FFP3 face mask	FFP3 face mask or powered respirator
Face visor	Face visor

For a full list of AGPs refer to the Trust PPE guidance (here)

- PPE must be removed/doffed in the correct order and in the correct place. Please speak to the nurse in charge if you are unsure where to remove your PPE and in which order.
- When working in a cohort bay where no AGPs are undertaken, you must change your gloves and apron and perform hand hygiene between patients. FRSMs and eye protection can be worn on a sessional basis.
- When working in a cohort bay where AGPs are undertaken you must change your gloves and clean your hands between patients. FFP3 mask, face visor and long sleeve gown can be worn on a sessional basis.

5. Waste

- All waste must be disposed of as clinical waste using the designated waste streams.

6. Laundry

- All laundry, including scrubs (if worn) must be disposed of in a water-soluble bag, followed by a red outer bag. Laundry will be collected in the normal way.

7. Food Service

- For information about the food service on affected wards, please see Appendix 2

8. Cleaning

- Daily cleaning of the ward environment to minimise environmental contamination should continue using Chlor-clean or Tristel. PPE must be worn as per guidance above and will be determined by the area being cleaned.
- When a patient is discharged or transferred to another area, the bed space/isolation room must be cleaned as above and the curtains must be changed.
- If AGPs have occurred in the room, windows should be opened and the room must be left for 1 hour prior to cleaning unless in airborne PPE. After the 1 hour fallow period standard PPE can be worn for cleaning.

9. Visits to other departments

- Visits to other departments should be kept to a minimum but can occur to aid the patient's diagnosis and recovery. IPC precautions must be adhered to during transfer and the receiving department must be informed of the patient's status. The patient must be taken straight down for the procedure/investigation and straight back to the ward to ensure they are not waiting unnecessarily in other departments. If safe to do so, the patient must wear a FRSM while travelling to and from their procedure. Staff transferring the patient and staff in the receiving department must wear the correct PPE.
- Equipment must be decontaminated with a chlorine releasing agent or universal clinell wipe in accordance with the decontamination policy.

10. Transfer to Augmented Care Area

- If a patient requires transfer to an augmented care area such as ITU, staff who are transferring the patient must wear the appropriate PPE. The appropriate PPE will be dictated by the level of care required by the patient (e.g. whether AGPs are occurring).
- The patients bed must returned to the area it came from where it will be decontaminated using a chlorine releasing agent as part of the bed space clean.

11. Care of the Deceased

- The principles of IPC continue to apply whilst a deceased individual remains in the care environment due to 'the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients' (PHE, 2020).
- Staff who are transferring the deceased to the mortuary should wear, in addition to a FRSM, gloves and a disposable apron and perform hand hygiene on removal of PPE. Staff may choose to wear enhanced PPE.
- For further detail refer to Care of the Deceased Adult Patients Policy

12. Patient Property

- Patient property should be placed into a property bag and wiped with a universal clinell wipe or placed into a second clean bag held by a colleague before being given to family/friends to take home.

13. Visitors

- No visiting will be allowed unless for specific reasons of safety (dementia or learning disability where anxiety would be increased significantly), inpatients who are under the age of 18 years old (one parent/guardian only) or a patient receiving end-of -life care.
- Even under these circumstances visitors should not visit if they have any signs of COVID-19.
- If visiting has been agreed, then only one person is permitted to visit. All visitors should be provided with a FRSM to wear. Visitors must always be advised to clean their hands immediately prior to leaving the cohort bay/isolation room and leave Trust premises directly.

14. Discharge Home

- When a COVID-19 positive patient is discharged home or transferred to another care area/facility, the bed space/single room must receive a terminal clean using a chlorine releasing agent and curtains must be changed. All patients must be given a surgical face FRSM to wear for their journey through the hospital and advised to go directly home.

Appendix 1 – Provision of scrubs for COVID-19 cohort wards

Purpose:

- To provide staff working on affected wards with clothing that can be laundered on site
- To ensure that staff have clean clothes to change into following a shift on the Covid-19 ward
- Scrubs are not a requirement in either local or Public Health England IPC guidance but are recognised to increase staff morale and wellbeing.

Procedure:

- Scrubs are available in a variety of sizes and will be stored in the central linen room.
- In normal working hours (Monday-Friday 8am- 4pm) scrubs can be delivered to the cohort ward once the linen room has been notified by the IPC team. Out of hours, the Site Practitioner can contact the porters to request that they collect a supply of scrubs from the linen room and take them to the affected ward. Three cages of scrubs will be kept in the Linen Room for this purpose - each cage containing a 24 hour supply.
- A cage will be delivered to the ward. Do not decant into the linen cupboard as there will not be enough room.
- The cage will usually contain 50 sets of scrub suits for a 24 hour period in a variety of sizes (5 small, 15 medium, 25 large, 5 extra large). If additional scrub suits are required or more of a particular size, contact the Linen Room or out of hours the Site Practitioner who will contact the porters.
- The cohort ward will identify a staff changing room. If the room chosen is large enough, the delivery cage containing the scrubs can be kept in the room. If not large enough, the cage will have to be kept elsewhere on the ward – for local determination.
- All ward based staff can change into scrubs at the start of their shift if they choose.
- Appropriate PPE is still required when working in bays/side rooms.
- Visits to the affected ward by non-resident ward staff must be kept to an unavoidable minimum (both in frequency and numbers).
- Staff uniform presents a very low risk of transmission of COVID-19. Staff may leave a COVID-19 cohort ward in their scrubs to visit any other area of the site.
- When scrubs are removed they should be placed in a water soluble laundry bag and then into a red laundry bag. Make sure that any badges, watches, tissues etc. are removed from tunic and pockets first. Secure neck of full laundry sacks and put in the waste disposal cupboard/room for collection in the usual way.
- Scrubs are not intended for use by visitors.

Appendix 2 – Food Service on Wards Affected by Covid-19

The role of the Domestic Assistant

- At the start of the day the domestic assistant will, wearing a clean uniform, prepare the breakfast trolley and deliver food to the patients as his/her first job of the day.
- The breakfast trolley must not be taken in to bays/side rooms. Food must be passed into ward nursing staff within these bays where possible.
- Strict hand hygiene must be observed at all times.
- Following breakfast, the foodstuffs can be put away with clean hands prior to collecting used crockery and cutlery from the ward.
- The domestic assistant should collect crockery/cutlery by positioning the trolley just outside the doors of the affected bay/side room.
- No used crockery or cutlery should be placed on the trolley during food service.
- Crockery and cutlery can be returned to the main kitchen for cleaning.

The role of the Catering Assistant

- On template wards where there is a shared kitchen, the unaffected ward's catering assistant should fill the catering trolleys for the affected ward for service and push them to the ward doors for collection at the appropriate times.
- The catering assistant of the affected ward should limit entry to the shared kitchen once he/she has been on his or her ward.
- Water jug refreshment should be carried out in the same way.

Nursing staff

- Where possible (if the kitchen is shared with a non COVID-19 ward), staff working on COVID-19 cohort wards should avoid going into the kitchen.
- Overnight, when alternatives are unavailable, nurses should only go into the kitchen having removed all PPE and cleaned hands.
- Other measures, such as taking flasks of water onto the ward in advance should be explored if they will limit the need for kitchen access.

COVID-19 CLINICAL GUIDANCE for:

COVID-19 Testing - patients admitted to RDE / DPT

Point of Contact/author	[redacted]
COVID Testing Steering Group	[redacted]
Clinical Effectiveness Committee	[redacted]
Date document becomes live:	16th March 2022

As of 2200 on Wednesday 16 March 2022, the lab will NOT re-run positive COVID-19 results, nor process routine second confirmatory swabs on positive cases. All results will be reported immediately:

1. Strong positives will be reported immediately as DETECTED
2. Weak or Low positives (CT Value > 35) will be reported immediately as INDETERMINATE
3. Negatives will be reported immediately (no change) as NOT DETECTED

This will affect the Infection Prevention and Control (IP&C) guidance and patient placement as follows:

1. COVID DETECTED patients can be immediately placed in a COVID ward
2. COVID INDETERMINATE patients should be moved to a side room on the base ward (if not already in one), and will require a second swab.
3. The second swab can be run as a rapid test if needed for patient placement (tel: 01392 402931 for Molecular lab or 01392 403174 for ED lab)
4. The result of the second swab will also be reported immediately. BOTH results will need to be interpreted as a pair, using clinical picture, and COVID-19 history to decide on the clinical / infection control actions. This may require discussion with microbiology +/- IP&C Team
5. Reasons for indeterminate results are:
    a. prior infection within 90 days
    b. poor swab technique / not enough sample
    c. early infection (goes up very quickly)
    d. "assay issues"
6. If the second swab remains INDETERMINATE, continue to isolate and repeat after another 24 hours.

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Infection Prevention and Control Measures for SARS-CoV-2 (COVID-19) in Healthcare Settings

Post holder responsible for Procedural Document	[redacted] Lead Nurse/DIPC Infection Prevention & Control
Author of Guideline	[redacted] Lead Nurse/DIPC Infection Prevention & Control
Division/ Department responsible for Procedural Document	Specialist Services/ Infection Control
Contact details	[redacted]
Date of original policy / strategy/ standard operating procedure/ guideline	Eastern Services: March 2021 Infection Prevention and Control Guidance for Seasonal Respiratory Infections (to include COVID-19) Northern Services:
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Approving body and date approved	Joint Clinical Effectiveness Committee: 13 June 2022
Review date (and frequency of further reviews)	Document is dynamic and will be subject to review in the event of new national guidance/changes to local prevalence, identification of new variants of concern.
Expiry date	See above
Date document becomes live	15 June 2022

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience	✓	Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:	✓	Delivery of Care Closer to Home	
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: FINAL	
Version	Date	Author (Title not name)	Reason
1.4	10/6/2022	Lead Nurse/DIPC Infection Prevention & Control	New national guidance - Learning to live with COVID-19

Associated Trust Policies/ Procedural documents:	Standard Infection Control Precautions Source Isolation Policy Waste Policy Decontamination Policy
Key Words:	COVID – 19 PPE Face masks Transmission based precautions
In consultation with and date: Membership of CEC - Eastern Services and Northern Services	
Contact for Review:	Lead Nurse/DIPC Infection Prevention & Control

KEY POINTS OF THIS PROCEDURAL DOCUMENT:

- Infection prevention and control guidance has continued to evolve throughout the pandemic. The UK Health Security Agency (UKHSA) has recently updated guidance as part of 'Learning to Live with COVID-19'.

- This document provides guidance on the application of standard infection control precautions and COVID-19 specific transmission based precautions

- Patients suspected or known to have COVID-19 will continue to be managed in single room, or isolation cohort, using transmission based precautions as would be the case for other respiratory viral infections such as Influenza and RSV.

- In general, the need for universal masking for patients, visitors and healthcare staff is no longer required, unless it is personal preference. Exceptions to this are:
    - Settings where triage and testing has not yet been undertaken e.g. ED, AMU / MAU, SDEC, STAU / AAA, etc
    - Settings that provide care for patients who are severely immunocompromised i.e. oncology and haematology and renal services.

- Other control measures remain extremely important i.e. good ventilation of work spaces, high standards of cleaning, good hand hygiene, absence from work when staff are suspected or known to have COVID-19.

- 2 metre social distancing is no longer required. However, 1 metre social distancing should be maintained **where this is practical**.

- This guidance is dynamic and will be subject to review in the event of new national guidance/changes to local prevalence, identification of new variants of concern.

1. INTRODUCTION

1.1 This guidance provides disease specific infection prevention and control guidance to prevent transmission of COVID-19 during the delivery of care to patients in all Royal Devon University Healthcare NHS Foundation Trust, including the acute hospitals, community hospitals, care at home, maternity and children's services.

1.2 This guidance is dynamic and will be subject to review in the event of new national guidance/changes to local prevalence, identification of new variants of concern.

2. PURPOSE

2.1 The purpose of this document is to provide information to ensure the Trust is able to provide care to patients with COVID-19 in a safe, rationale and pragmatic manner and the safety of staff, patients and visitors is maintained

3. DEFINITIONS

3.1 **FRSM** – Fluid Resistant Surgical Mask

3.2 **FFP3** – Filtering Face Piece Mask

3.3 **PAPR** – Powered Air Purifying Respirator

3.4 **AGP** – Aerosol Generating Procedures. A medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract. The defined list of AGPs is currently under review.

3.5 Patient facing staff - clinical and support staff in patient care settings (i.e. wards, clinics and patients own homes). This includes, but is not limited to, nurses, doctors, therapists, admin staff, domestic assistants, porters

3.6 **Standard Infection Prevention and Control Precautions (SICPs)**

3.6.1 Standard infection control precautions (SICPs) are to be used by all staff, in all care settings, at all times, for all patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment. SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. Sources of (potential) infection include blood and other body fluids, secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated.

3.6.2 The elements of SICPs are:

- patient placement and assessment for infection risk (screening/triaging/testing)
- hand hygiene
- respiratory and cough hygiene
- use of appropriate Personal Protective Equipment (PPE)
- safe management of the care environment
- safe management of patient care equipment
- safe management of healthcare linen

- safe management of blood and body fluids
- safe disposal of waste (including sharps)
- occupational safety: prevention and exposure management

3.7 Transmission based Precautions (TBPs)

3.7.1 TBPs are the additional measures that may be required when caring for patients with known/suspected infection or colonisation.

3.7.2 TBPs are categorised by the route of transmission of the infectious agent - contact, droplet or airborne (some infectious agents, including respiratory viruses, can be transmitted by more than one route).

3.7.3 The elements of transmission based precautions relevant to COVID-19 include:

- patient placement and assessment in a single room (or cohort isolation ward if/when COVID-19 confirmed)
- safe management of patient care equipment in the isolation/cohort area
- safe management of the care environment
- use of Personal Protective Equipment (PPE) relevant to the route of transmission
- consideration of whether of aerosol generating procedures (AGPs) will be required
- maintaining TBPs during care of the deceased

4. HIERARCHY OF CONTROLS

4.1 The 'hierarchy of controls' can be used to help implement effective controls and reduce the spread of respiratory pathogens in healthcare. Safe systems of work outlined in the hierarchy of controls are an integral part of IPC measures.

4.2 The most effective measures in the hierarchy of controls are those that **eliminate** the risk and includes:

- Screening, triaging and/or testing for COVID-19 - This must be undertaken to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.

4.3 When a source of infection cannot be eliminated **substitutions** should be implemented to reduce or control the risk. Some services may be able to consider the use of virtual consultations.

4.4 **Engineering controls** are used to reduce or control the risk of exposure at source. They include design measures such as ventilation and screens and include:

- Ensuring ventilation systems i.e. mechanical/or natural, meet national recommendations for minimum air changes.
- Dilute air with natural ventilation by opening windows and doors where appropriate or introducing air scrubbers.
- If considering screens/partitions in reception/waiting areas, ensure air flow is not affected and cleaning schedules are in place.

4.5 **Administrative controls** are implemented to help prevent the introduction of infection and to control and limit the transmission of infection in health and care facilities. They include:

- Regular assessments of physical space and bed spacing, considering potential increases in staff to patient ratios and equipment needs.
- For patients who are known or suspected to be positive with a respiratory pathogen and their treatment cannot be deferred, care should be provided from services able to operate in a way which minimises the risk of spread of the virus to other patients/individuals.
- Provision of appropriate education for staff, patients and visitors in infection control along with hand hygiene stations and signage.
- Providing adequate spaces for staff breaks areas/changing facilities. NB 2 metre social distancing is no longer required. 1 metre social distancing should be maintained **where this is practical**.

4.6 **Personal Protective Equipment controls** - use of PPE for those who cannot avoid close contact with the patient suspected or known to have COVID-19. (refer Appendix 1).

5. INFECTIOUS PERIOD

5.1 Transmission of COVID-19 occurs from 9 days before symptom onset to 15 days after symptom onset, with most transmission occurring 3 days before symptom onset to 5 days after symptom onset.

5.2 Severely immunocompromised individuals may remain infectious for a longer period of time, even in the absence of symptoms. Refer to **section 8** for duration of precautions, for further information.

6. TRIAGING AND TESTING FOR COVID-19

6.1 Triaging

6.1.1 Triaging within all healthcare facilities should be undertaken to enable early recognition of patients with COVID-19 (and other respiratory infectious agents). Triage should be undertaken by clinical staff who are trained and competent in the application of clinical case definitions as soon as possible on arrival and used to inform patient placement.

6.1.2 Patients with symptoms that may be associated with COVID-19 should be assessed in a segregated area, ideally a single room, and away from other patients pending their test result

6.1.3 The main symptoms include:

- A new persistent cough
- A fever of 37.8 or above
- A loss of, or change, in normal sense of taste of smell (anosmia)

6.1.4 Examples of other symptoms include, shortness of breath, fatigue, loss of appetite, myalgia (muscle ache), sore throat, headache, nasal congestion (stuffy nose), runny nose, diarrhoea, nausea and vomiting. Older people may present with less common

symptoms. **NB** Older people may also present with an acute delirium and this must be taken into consideration in the absence of symptoms above.

6.1.5 In some individuals cough or a loss of, or change in, normal sense of smell or taste may persist several weeks/months, and are not considered an indication of ongoing infection when other symptoms have resolved.

6.1.6 Individuals who are infected with SARS-CoV-2 and who are asymptomatic can still transmit virus to others, however there is emerging evidence suggesting that asymptomatic cases are less infectious than symptomatic cases.

6.1.7 Staff must follow routine asymptomatic testing guidelines, and if symptomatic follow guidance re isolation and testing as per links in section 6.2

6.2 Testing

Testing for patients and staff should be performed as per Testing Guidance (https://hub.exe.nhs.uk/a-z/coronavirus-covid-19-info-hub/clinical-guidance/)
https://ndht.ndevon.swest.nhs.uk/coronavirus-covid-19/clinical-guidance/patient-testing-inpatients-and-elective/
https://ndht.ndevon.swest.nhs.uk/coronavirus-covid-19/staff-testing-and-contact-tracing/asymptomatic-staff-testing-lateral-flow/

7. INFECTION CONTROL PRECAUTIONS AND PPE

7.1 The application of SICPs for all patient care, regardless of diagnosis, and TBPs for those with **suspected or known infection** should be followed.

7.2 PPE when caring for known or suspected COVID-19

7.2.1 As a minimum, contact and droplet precautions must be applied when caring for patients with **known or suspected** COVID-19. In specific circumstances airborne precautions should also be applied, for example, when performing AGPs.

7.2.2 Appendix 1 of this guidance describes the personal protective equipment (PPE) required when providing direct care to patients with **suspected or known** COVID-19

7.3 Use of FRSM (and other face coverings) by staff in non- COVID care settings

7.3.1 Staff are, in general, not required to wear facemasks e.g. FRSM or other face coverings in any non-clinical areas e.g. offices, staff rooms, social settings, unless this is their personal preference.

7.3.2 Patient facing staff are not routinely required to wear FRSM or other face coverings in clinical areas or patients own homes **with the exception o**f areas where untriaged patients are received such as ED, medical and surgical emergency admission wards e.g. Same Day Emergency Care, Acute Medical Unit, Medical Admission Unit, Surgical Triage and Assessment Unit / Acute Assessment Area, Maternity triage, Paediatric Assessment Unit and Caroline Thorpe ward.

7.3.3 Staff who are very high risk for adverse consequences of COVID-19 infection e.g. staff who have had organ transplants must undergo individual risk assessment and

advice sought from Occupational Health as to whether they should continue to wear a FRSM even in non COVID-19 areas.

7.3.4 Patient facing staff should continue to wear FRSM in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology and renal services.

7.4 Use of face coverings by patients

7.4.1 In-patients **suspected or known** to have COVID-19, who are transferring to another care area, should wear a surgical facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination *en route*.

7.4.2 In-patients who are **not** suspected or known to have COVID-19 are not required to wear a facemask unless this is their personal preference. However, in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology, renal services, patients will be encouraged to wear a facemask, unless in a single room.

7.4.3 Out-patients with respiratory symptoms who are required to attend for emergency treatment should wear a facemask/covering, if tolerated, or offered one on arrival.

7.4.4 All other out-patients are not required to wear a facemask unless this is a personal preference.

7.4.5 The requirement for patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required or where it causes distress, eg paediatric/mental health settings.

7.5 Use of face coverings by visitors

7.5.1 Visitors are not routinely required to wear face coverings unless it is their personal preference. The exception to this is in settings, inpatient or outpatient, where patients are at high risk of infection due to immunosuppression, e.g.oncology/haematology and renal services, when visitors will be asked to wear a facemask unless they are medically exempt.

7.5.2 Visitors and individuals accompanying patients to ED and admission areas will continue to be encouraged to wear face coverings

7.5.3 Visitors will be asked to wear a surgical facemask if visiting a high-risk area or a patient with suspected / known COVID-19.

8. DURATION OF COVID-19 TRANSMISSION BASED PRECAUTIONS

8.1 For in-patients with COVID-19, transmission based precautions/isolation should continue up to 10 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms), provided the following clinical criteria have been met:

- clinical improvement with at least some respiratory recovery

- absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication
- no underlying severe immunosuppression (refer 8.4)

8.2 A cough or a loss of, or change in, normal sense of smell or taste (anosmia), may persist in some individuals for several weeks, and are not considered an indication of ongoing infection when other symptoms have resolved.

8.3 The isolation period can be reduced to 7 days in patients who meet the clinical criteria above and have had two LFD tests from day 6, 24 hours apart, as well as showing clinical improvement as above. The residual risk of infection after a negative test on day 6 and 7 is similar to stepping down precautions without testing at day 10. If either of these test results is positive, the patient should continue their isolation until day 10. The likelihood of a positive test after 10 days of isolation is low. They do not need a further test before stepping down precautions provided they continue to meet the clinical improvement criteria above.

8.4 Severely immunocompromised patients

8.4.1 It is possible for severely immunocompromised patients to remain infectious for prolonged periods, even if they do not display any symptoms of COVID-19. The isolation period for these patients whilst in hospital should be at least 14 days.

8.4.2 In severely immunocompromised patients, resolution of symptoms should not be used as a marker of decreased infectiousness and these patients should be isolated in side rooms or cohorted until they return a negative PCR test. Staff must adhere to recommended IPC measures throughout the inpatient stay.

8.4.3 Severely immunocompromised patients can end their isolation after a single negative PCR test result taken no earlier than 14 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms).

9 IPC CONSIDERATIONS FOR CONTACTS OF CASES (INPATIENTS)

9.1 In-patients who are considered significant contacts of COVID-19 whilst in hospital will be identified by the Infection Prevention and Control Team and will be isolated with droplet precautions for five days from the point when their contact with a positive patient ended.

9.2 Contacts will be tested by PCR on days 1,3, and 5 of their isolation period. If negative at day five isolation precautions may cease.

9.3 If a contact becomes symptomatic during this period and/or tests positive they must be removed from the contact cohort and transferred to a single room for isolation or to a COVID 19 cohort ward/bay.

10. CARE AT HOME

10.1 PPE used in patients' homes matches that used in hospitals. This means that the use of FRSM for care in the home is no longer universal but is dependent on a risk assessment.

10.2 Promoting the use of PPE based on the patient's COVID-19 status and any presenting symptoms remains important. It also remains important to consider others in the property when visiting someone in their own home. Risk assessment questions should include the following to inform PPE use:

- Whether the patient or any household contact currently unwell with symptoms suggestive of COVID-19.
- Whether the patient or any household contact currently self-isolating for any reason
- Whether anyone in the household in the extremely vulnerable group.

10.3 If patients in their own homes would like visiting staff to wear a mask, their wishes should be respected.

10.4 Donning and doffing of PPE, other than the FRSM if worn, should occur inside the property, at a distance more than 2m from the patient.

10.5 Disposal of PPE in the home should be carried out according to Trust guidance, Community and Nightingale Waste Manual.

10.6 While in the patient's home, natural ventilation should be encouraged such as opening windows.

10.7 Staff who visit care homes should take direction from the care home staff about their local policy for use of PPE and abide by that policy.

11. ARCHIVING ARRANGEMENTS

The original of this guideline, will remain with the author, lead nurse/DIPC, Infection Prevention & Control. An electronic copy will be maintained on the Trust intranet, P – Policies – I – Infection Prevention & Control Measures for SARS-CoV-2 (COVID-19) in healthcare settings.

12. SURVEILLANCE AND MONITORING/OUTBREAK MANAGEMENT/ REPORTING

12.1 Ongoing surveillance of COVID-19 should continue within healthcare settings and for hospital/organisation onset cases (staff and patients/individuals) must continue.

12.2 Positive cases of COVID-19 identified after admission who fit the criteria for a healthcare associated infection (HCAI) should trigger a case investigation. If two or more cases are linked in time and place, an outbreak investigation should be undertaken.

12.3 COVID-19 is a notifiable organism/disease. Further information on reporting can be found here - Notifiable diseases and causative organisms: how to report - GOV.UK (www.gov.uk)

13. References

UK HAS (May 2022) COVID-19: information and advice for health and care professionals
Background information and advice on coronavirus (COVID-19) for health and care professional Available at: COVID-19: information and advice for health and care professionals - GOV.UK (www.gov.uk) Accessed 6/6/2022

NHSE/I (June 2022) Next steps on infection prevention and control (IPC) Publication approval reference: C1657 Available at: https://www.england.nhs.uk/wp-content/uploads/2022/04/C1657_next-steps-on-infection-prevention-and-control-letter_010622.pdf Accessed 6/6/2022

Appendix 1: Personal Protective Equipment required while providing direct care for patients with suspected or confirmed COVID-19

Before undertaking any procedure, staff should assess any likely blood and body fluid exposure risk and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken.
If there is no direct contact with the patient or their environment, gloves and aprons/gowns are not required.
Refer to guidance on donning (putting on) and doffing (removing) PPE for droplet and airborne precautions.

PPE required by transmission/exposure	Disposable gloves	Disposable/reusable fluid-resistant apron/gown	FRSM/RPE	Eye/face protection (goggle/visor)
Droplet PPE	As for standard infection control precautions	As for standard infection control precautions	Single use FRSM Type IIR for direct patient care (1)	Single use or reusable (1)
Airborne PPE (When undertaking or if AGPs are likely) (3) Or if an unacceptable risk of transmission remains following application of the hierarchy of controls (4)	Single use	Single use fluid-resistant gown	Single use FFP3 (2) or reusable respirator/powered respirator hood (RPE)	Single use or reusable (2)

(1) FRSM can be worn sessionally (includes eye/face protection) if providing care for cohorted patients. All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

(2) RPE can be worn sessionally (includes eye/face protection) in high risk areas where AGPs are undertaken for cohorted patients All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

(3) Consideration may need to be given to the application of airborne precautions where the number of cases of respiratory infections requiring AGPs increases and patients cannot be managed in single or isolation rooms.

(4) Where a risk assessment indicates it, RPE should be available to all relevant staff. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area. The hierarchy of controls can be used to inform the risk assessment. Staff should be provided with training on correct use.

Royal Devon University Healthcare NHS Foundation Trust
Eastern Services

COVID-19 Testing
Emergency Admissions and Inpatients

Author of Clinical Guideline	[redacted] Specialist Services
Division responsible for the guidance	Specialist Services
Contact details	[redacted]
Version number	Version 2.4
Replaces version number	Version 2.3
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Approving body and date approved	COVID-19 Testing Steering Group Clinical Effectiveness Committee: 10.06.22
Review date	September 2022 Sooner if any change with national guidance
Expiry date	October 2022
Date document becomes live	29 April 2022

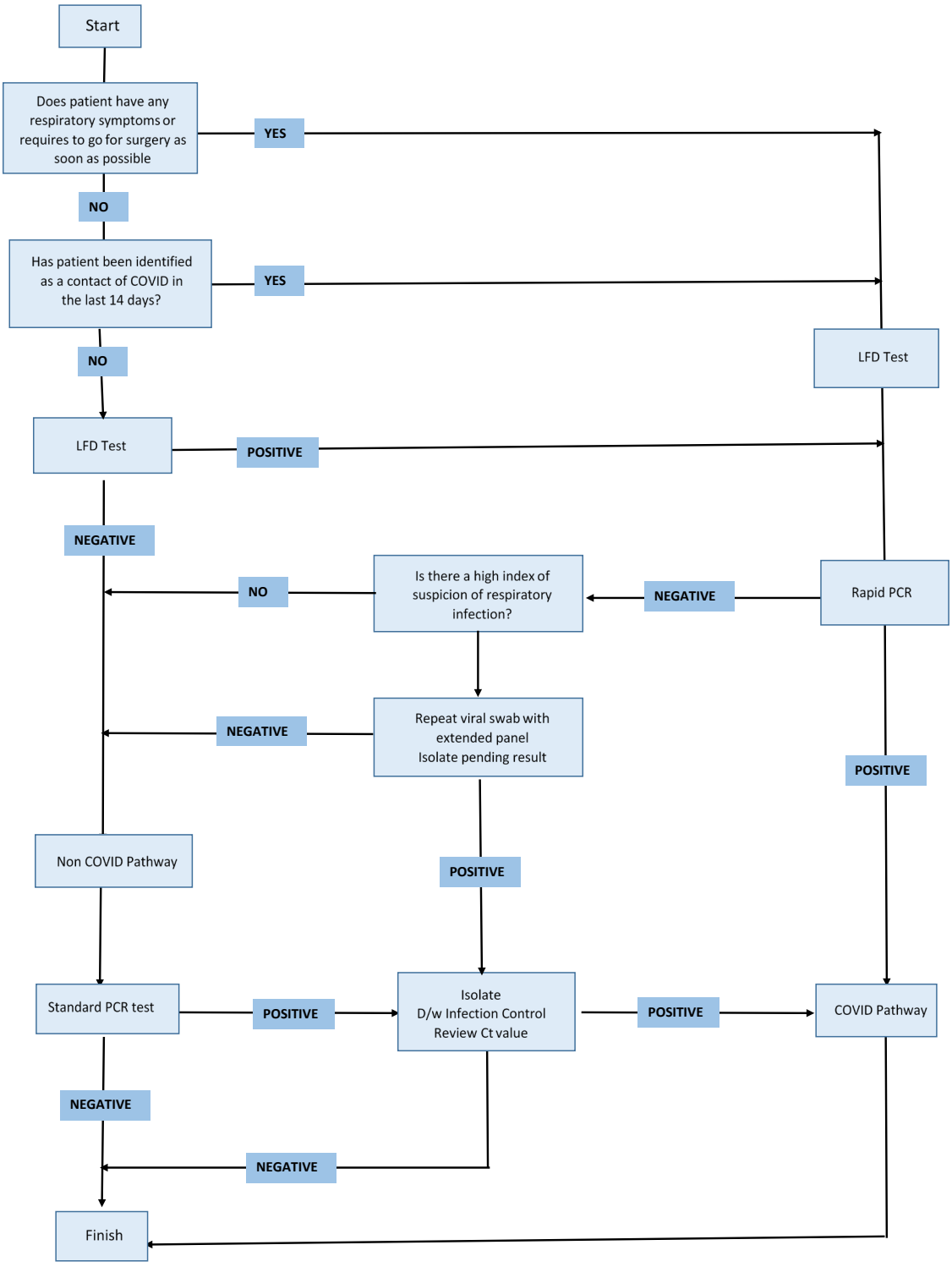
SUMMARY

This guidance outlines the process to provide testing for emergency admissions, symptomatic and asymptomatic testing for inpatients using LFDs, or PCR tests if clinically recommended.

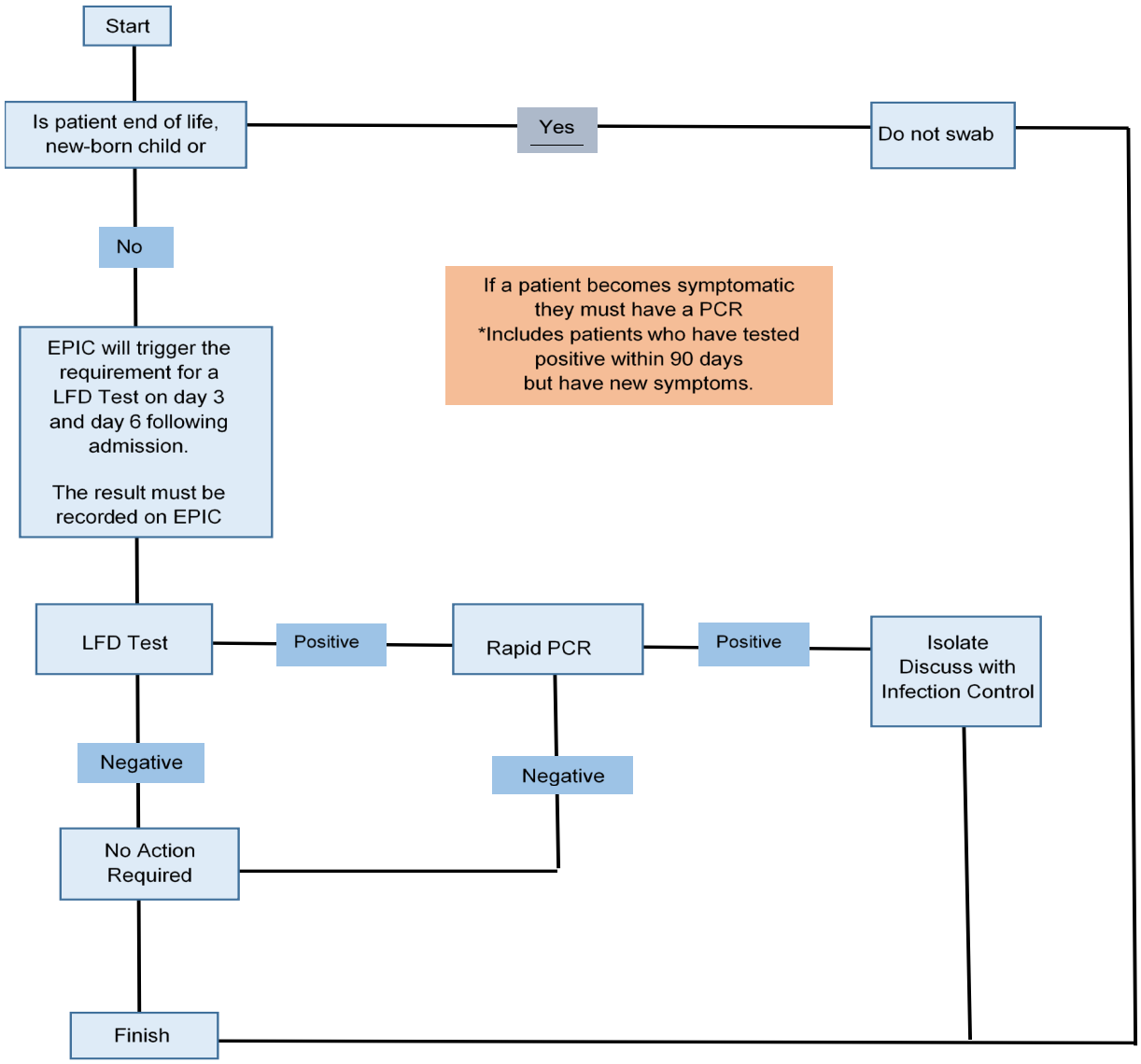
CONTENTS

KEY POINTS

Protocol for Testing for SARS-CoV2 in Non-Elective Patients Being Admitted to Hospital



Protocol for COVID-19Testing for Inpatients Requiring Asymptomatic Screening



1 INTRODUCTION

1.1 To provide guidance for COVID-19 testing for emergency admissions using polymerase chain reaction (PCR) tests and lateral flow devices (LFDs). This will reduce the risk of nosocomial transmission and allow for action to be taken to isolate COVID-19 positive inpatients.

1.2 This guidance includes the process to provide symptomatic and asymptomatic testing for inpatients using LFDs or PCR tests if clinically recommended.

2. BACKGROUND

2.1 During the management of the COVID-19 pandemic, national guidance has specified pathway protocols for patients to minimise the risk of disease transmission amongst patients and staff.

2.2 Updates to the guidance from the UK Health Security Agency (HSA) now promotes a move away from polymerase chain reaction (PCR) testing to Lateral Flow Device Testing (LFD) for asymptomatic inpatients screening.

3. DEFINITIONS

3.1 PCR: Polymerase Chain Reaction

3.2 LFD: Lateral Flow Device

4. COVID-19 Testing for Emergency /Unplanned and Inpatients

4.1 Emergency and unplanned patients presenting to the hospital should be tested immediately with a LFD Test whether admitted or seen in an assessment area.

4.2 If the patient is symptomatic whether admitted or seen in an assessment area they should have an ultra-rapid PCR test as soon as possible, this should include other high-risk groups e.g. Immunosuppressed patients.

4.3 All emergency admissions who do not meet the criteria for an ultra-rapid PCR including asymptomatic patients should have a standard PCR (turnaround time 8-12 hours).

4.4 Surgical patients admitted with a PCR result pending and require emergency surgery should have an ultra-rapid test to reduce any delay going to Theatre.

4.5 Women admitted to the labour ward or setting should be tested as soon as is practical at the hospital site using LFD or Rapid PCR tests. Their birth partner does not require a test.

4.6 All inpatients including paediatric patients requiring a test by a clinician to support clinical decisions during their care and treatment pathway should be offered a PCR test as part of their usual diagnostic pathway.

4.7 Inpatients who have previously tested negative and develop COVID-19 symptoms whilst in hospital must have a PCR test at onset of new symptoms and if negative should have

a clinical review. Discuss further testing, placement and management with IPC & microbiology team.

4.8 Inpatients will require two asymptomatic LFD Tests on day 3 and day 6 of their stay, this should be performed by ward staff. Epic will trigger the days that tests are required to be completed. Every assisted LFD test result, positive, invalid and negative, must be documented on EPIC. When completing the LFD Test follow the guidance in Section 6.2 for the procedure for completing the test on the ward.

4.9 Inpatients that require surgery should have a LFD Test on the day prior to going Theatre.

4.10 Inpatients who test positive on a LFD should have confirmatory PCR as soon as possible.

4.11 Inpatients who develop new symptoms that raises a concern about COVID but test negative on a LFD Test should have a rapid PCR Test and be isolated if possible until the result is known. This should be discussed with IPC Team or Microbiology for clinical advice.

4.12 Inpatients who are identified as a contact of COVID-19 as determined by the IPC team will be screened every two days by PCR with a final PCR test on day 5. The final test must be negative before any step down of isolation precautions or as advised by the IPC Team.

4.13 Severely immunocompromised patients who transfer to another ward within the hospital should be tested using PCR tests rather than LFDs.

4.14 Patients on discharge to other care settings including care homes, or hospices should have a PCR within 48 hours before the transfer. If a patient is anticipated to be discharged to a care home additional LFD Testing every 5 days should be undertaken as part of asymptomatic testing.

4.15 Patients transferring to a community hospital require a LFD Test prior to transfer.

4.16 Acute Trust inter-hospital transfers require a PCR Test within 48 hours of transfer or if an emergency transfer a rapid PCR should be completed but should not delay the transfer. Discuss with a microbiologist or IPC Team if there are any concerns.

4.17 Outbreak testing should be undertaken using PCR tests as determined by the IPC Team.

4.18 LFD Tests will be provided by the logistics service. Wards that currently have top up will receive their supply through this route, all other areas will use the EROS ordering system.

5. MONITORING COMPLIANCE WITH THIS GUIDELINE

5.1 The COVID-19 Testing Steering Group chaired by Dr C Hayes, AMD Specialist Services will monitor compliance, consider any changes and recommend to the Clinical Effectiveness Committee for formal approval prior to implementation.

6. ASSOCIATED CLINICAL GUIDELINES AND PROCEDURES

6.1 COVID-19 Symptoms

The official list of COVID-19 symptoms has been expanded and covers:

- a high temperature or shivering (chills),
- a new continuous cough
- a loss or change to your sense of smell or taste
- shortness of breath
- feeling tired or exhausted
- an aching body
- a headache
- a sore throat
- a blocked or runny nose
- loss of appetite
- diarrhoea
- feeling sick or being sick

6.2 Procedure for Day 3 and Day 6 Asymptomatic LFD Testing

- Alert will come up on EPIC when patient requires a test.
- Take testing kit to the patient bedside.
- Print patient label and attach to the back of the test or/write the name of the patient on the back of the test.
- Undertake the test at the patient's bedside.
- Leave the test on the patient locker until ready to be read, see below.
- Input result on EPIC.
- Dispose of the test as per IPC protocol.

Reading the results beyond the time period in the instructions can lead to false positive results and the test will need to be repeated.

Results should be read in line with the following:

- Negative: The presence of only the control line (C) and no test line (T) within the result window indicating a negative result.
- Positive: The presence of the test line (T) and the control line (C) within the result window, regardless of which line appears first, indicating a positive result. The presence of any test line (T), no matter how faint, indicates a positive result.
- Invalid/void result: If the control line (C) is not visible within the result window after performing the test, the result is considered invalid.