Pan London COVID-19 Recovery: Infection Prevention & Control Guidance v4

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Introduction

- This guidance does not supersede the latest National Infection Prevention and Control (IPC) Guidance but aims to assist with local interpretation, decision making and development of a framework for standardised, high quality care across London.
- This document replaces the previous version of London guidance (version 3) and applies where there there is determined to be low-level COVID-19 transmission in the local community
- As recommended by the NICE COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services:
  - For maternity and antenatal services follow the RCOG guidance on COVID-19 infection in pregnancy.
  - For children and young people having elective surgery follow the RCPCH guidance for the recovery of elective surgery in children.
- It is recommended that where deviations from this guidance are agreed, a risk assessment is documented and deviations are agreed as part of a clear governance process, preferably at ICS rather than individual institution level.
- This document is subject to frequent revision and in order to respond effectively to local need and learn from best practice across London, DIPCs and ICS leads are encouraged to feed back comments and questions to s.kingsland@nhs.net

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ACUTE CARE PATHWAYS

Key principles for Acute Care Providers

- Patient screening and triage within all health care facilities must be undertaken to enable early recognition of COVID-19 cases.
- For **all** patient attendances and admissions, triage should be performed by trained staff competent in the application of the clinical case definition either prior to arrival in the care area, or as soon as possible on arrival (p.6).
- COVID-19 testing should be performed on every individual **admitted** to an in-patient facility. In the case of elective/planned procedures involving general, regional and local anaesthesia or sedation, a test should be performed up to 72h before the planned care as recommended by NICE guidance.
- Based upon a combination of triage and COVID-19 testing, emergency and elective admissions or attendances are allocated to one of 3 patient care pathways: High, Medium and Low risk (page 5)
- **All** patients scheduled for elective procedures are advised to follow comprehensive social distancing and hand hygiene measures for 14 days prior to the planned care. NICE guidance for shared decision making when arranging planned care should be followed, for example for all procedures involving general, regional and local anaesthesia or sedation:
  - Patients undergoing higher risk procedures, with risk factors associated with a poorer outcome (e.g. 'Clinically extremely vulnerable') and/or individual circumstances that might increase exposure to COVID-19 before the planned care (e.g. occupational risk) may be advised to self-isolate for 14 days prior to the procedure.
  - Others should self-isolate from the time of their pre-admission swab until the procedure itself.
- PPE required depends upon the patient's care pathway and the task undertaken. As the number of cases decline, provided COVID-19 cases can cared for in single/isolation rooms, the entire Critical Care Dept is no longer classified as a 'high risk aerosol generating procedure (AGP) area" for example.
- A patient's infection risk must be clearly communicated between staff in areas along the allocated care pathway.
- Where applicable, screening for other infections e.g. Flu, MRSA etc. should be performed alongside COVID-19 testing.

Care pathways & clinical settings

High risk pathway

Any care facility where any of the following apply:

a) untriaged individuals present for assessment or treatment (symptoms unknown)
b) Confirmed COVID-19 positive individuals
c) Symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results.
d) Symptomatic individuals who decline testing.

Medium risk pathway

Any facility where triaged/ clinically assessed individuals are **asymptomatic** and any of the following apply:

a) waiting a COVID-19 test result and have no known recent COVID-19 contact
b) where testing is not required or feasible on asymptomatic individuals and infectious status is unknown
c) asymptomatic individuals who decline testing in any care facility

Low risk pathway

Where any of the following apply:

a) Individuals triaged/clinically assessed prior to treatment with no COVID-19 contacts or symptoms AND
have had a negative COVID-19 test within 72 hours of care and have self-isolated since the test AND
for planned admissions, have complied with comprehensive social distancing/ hand-hygiene measures for the previous 14 days (plus self isolation /shielding if indicated).
b) Patients who have recovered from COVID-19 (pages 7 & 8).
c) Patients/ individuals in any care facility where testing is undertaken regularly & they remain negative (page 8).

Within each pathway, examples of patient groups/facilities (non-exhaustive) include:

- Designated areas within Emergency Depts /Resuscitation areas
- Walk in centres
- Facilities where confirmed or suspected/symptomatic COVID-19 patients are cared for e.g.
  - emergency admissions to in-patient areas (adult & children)
  - Mental health
  - Maternity
  - Critical Care Units
  - Renal dialysis units

- Designated areas within Emergency Depts / Resuscitation areas
- Designated areas within walk-in centres
- Non-elective admissions
- In-patient facilities (adult & children) e.g. Mental health, Maternity, Critical Care Units
- Outpatients including Diagnostics/ Endoscopy

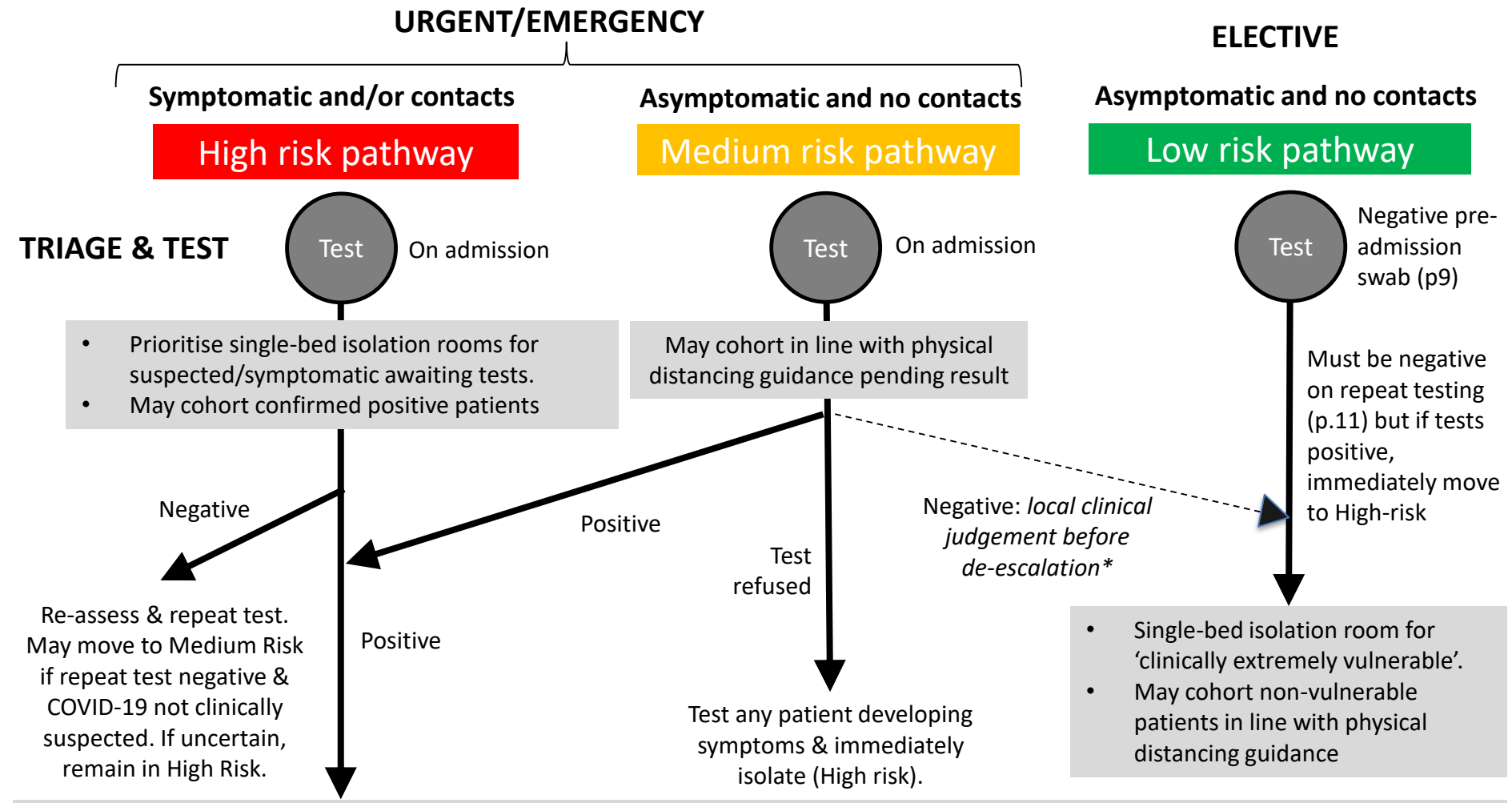
- Planned / elective surgical procedures including day cases
- Oncology / chemotherapy patients and/or facilities
- Planned in -patient admissions (adult and children), Mental health, Maternity
- Outpatients including Diagnostics/ Endoscopy

Example triage tool

		YES	NO
Contacts/Exposure risk	Do you have a confirmed COVID-19 diagnosis? *If yes, wait the recommended time (‘Stay at home guidance’) before treatment i.e. resolution of fever plus a minimum of 10 days (minimum 14 days if discharged from hospital).*		
	Do any of your household members have a confirmed COVID-19 diagnosis? *If yes, wait the until the 14 day self-isolation period (‘Stay at home guidance’) is over before treatment.*		
	Are you or any household members currently waiting for a COVID-19 test result? *If yes, ascertain if treatment can be delayed until the results are known.*		
	Have you travelled in the past 14 days to countries or territories exempt from Government advice against ‘all but essential’ international travel? *If yes, 14 days quarantine will apply before treatment.*		
	Have you been in contact with someone with COVID-19 or been in isolation with a suspected case in the past 14d (except self-isolation prior to an elective procedure)? *If yes, complete the recommended 14 days isolation period before treatment.*		
Symptoms	Do you have any of the following symptoms? • High temperature or fever • New, continuous cough • A loss or alteration to taste or smell		

If YES to any question, provide advice on who to contact GP/NHS 111 but if urgent admission is required, follow the HIGH-risk pathway

Admission to in-patient facilities



The decision to step-down from isolation/cohort is a judgment made by the responsible clinician and should include: a minimum of 14 days after symptom onset **AND** at least 3 days without fever **AND** ***EITHER*** no respiratory symptoms ***OR*** improved respiratory symptoms and a single negative COVID-19 nose & throat swab (for Critical Care/ Immunosuppressed patients, 2 x negative tests 24h apart are required). If the patient is asymptomatic, then 14 days after the initial positive result.

**Based upon factors including: further clinical assessment, including pre-admission exposure risk; the clinical specialty (e.g. exercise more caution if cardiac surgery); the physical estate (isolation bed availability); the local community incidence of COVID-19. Depending on the outcome, further observation on the medium risk pathway may be required and consideration given to another test before de-escalation.*

Elective procedures involving general, regional and local anaesthesia or sedation

Individuals triaged/clinically assessed prior to treatment with no COVID-19 contacts or symptoms
AND
have had a negative COVID-19 test within 72 hours of care and have self-isolated since the test
AND
for planned admissions, have complied with comprehensive social distancing/ hand-hygiene measures for the previous 14d (plus self-isolation /shielding if indicated).

Patients recovered' from COVID-19 with:
- a minimum of 14d after symptom onset **AND**
- at least 3d without fever **AND**
- ***EITHER*** no respiratory symptoms ***OR*** improved respiratory symptoms and a negative COVID-19 nose & throat swab (2 negative tests 24h apart required if a Critical Care or immunosuppressed patient.
- If the patient is asymptomatic, then 14d after initial positive result.

Low-risk pathway

- Patients/ individuals already within any care facility where regular testing is undertaken & they remain negative (e.g. p11)
- For inter-hospital transfers, patients should have tested negative within the past 72h.

Within the LOW-RISK pathway the following apply:
- Standard theatre cleaning and time for air changes provides appropriate level of IPC and there is no requirement for additional cleaning or theatre down time unless the patient has another infectious agent requiring additional IPC measures.
- Airborne precautions are not required for AGPs provided the patient has no other airborne infectious agent e.g. patients do not need to be anesthetised or recovered in the operating theatre if intubation/ extubation is required.

If a procedure is urgent (e.g. required within 2 weeks), asymptomatic patients with no contacts may be allocated to the Medium-risk pathway:
- Where possible, patients should be asked to self-isolate prior to the procedure.
- Airborne IPC precautions must be taken e.g. PPE (p10), down time between cases for clearance of airborne infectious particles if an AGP has been performed, anaesthetise and recover patients in theatre, enhanced cleaning between cases.
- Organise procedure lists so that Low risk patients are first, starting with the most vulnerable, through to highest risk last.

Example tool for determining pre-procedure isolation periods

- All patients scheduled for elective procedures are advised to follow comprehensive social distancing and hand hygiene measures for 14 days prior to planned care.
- NICE guidance for shared decision making when arranging planned care should be followed. Depending upon a *balance of risks* approach, patients may be advised to self-isolate for 14 days prior to the procedure OR from the time of their pre-admission swab (see example table below). This decision should include weighing up factors such as:
  - The complexity of the planned procedure itself and risk to the patient if complicated by COVID-19.
  - Patient risks associated with a poorer outcome belonging to the 'clinically extremely vulnerable' (***high*** risk), 'clinically vulnerable' (***moderate*** risk) and ***other*** risk (e.g. BAME) groups.
  - Individual circumstances that might increase SARS-CoV-2 exposure before/after planned care e.g. occupation or living arrangements (multigenerational, hospice or social care).

	General Anaesthetic, Regional Anaesthetic AND/OR multi-day admission expected	Local Anaesthetic, or sedation and multi-day admission NOT expected
Any *high* patient risk factor*	14 days self-isolation	Self-isolation from COVID-19 swab test
More than one *moderate* patient risk factor*	14 days self-isolation	Self-isolation from COVID-19 swab test
Single *moderate* patient risk factor* only	Risk assess best option	Self-isolation from COVID-19 swab test
Individual patient circumstances or *other* risk*	Risk assess best option	Self-isolation from COVID-19 swab test
None of the above	Self-isolation from COVID-19 swab test	Self-isolation from COVID-19 swab test

*For patient risk groups refer to: https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/

Personal Protective Equipment

- PPE should be worn by clinical staff providing direct patient care within 2m distance or less.
- The PPE required depends upon the patient's care pathway and the task performed

PPE for non aerosol generating procedures

	Disposable gloves	Disposable apron	Disposable long-sleeved gown	Face mask	Eye protection
Low	Single use*	Single use*~		Surgical mask Type IIR for extended use FRSM Type II for direct patient care§	Risk assess~
Medium	Single use	Single use~		FRSM Type II for direct patient care§	✓
High	Single use	Single use~		FRSM Type II for direct patient care§	✓

PPE when undertaking aerosol generating procedures

	Disposable gloves	Disposable apron	Disposable long-sleeved gown	Face mask	Eye protection
Low	Single use	Single use~		FRSM Type II for direct patient care§	✓
Medium	Single use		Single use	FFP3 or Purified Air Powered Hood	✓
High	Single use		Single use	FFP3 or Purified Air Powered Hood	✓

* If contact with blood and/ or body fluids is anticipated

~Risk assess first and wear single use long-sleeved gown (instead of apron) and eye protection if risk of body fluid exposure i.e. splashing/ spraying.

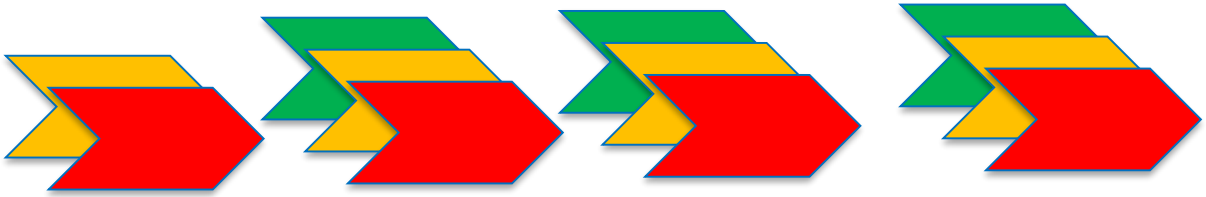
§FRSM can be worn sessionally if providing care for cohorted patients.

Routine hospital patient testing (PCR)

Pre-admission
Low-risk only

Maximum of 72h before planned care

Care pathways for admitted patients



Immediately on admission with triage.

Day 5-7d after admission

Every 7d thereafter until discharge *if laboratory capacity exists*

48h before discharge:

- If to an institutional-type care setting e.g. nursing or care home
- If a household member is clinically extremely vulnerable/shielding.
- Consider if ongoing, regular hospital or healthcare worker contact e.g. frequent out-patient appointments etc.

Ensure results are relayed to the receiving organisation before discharge.

In addition to the routine regimen, ASYMPTOMATIC in-patient contacts of COVID-19 positive cases will be monitored daily for development of COVID-19 symptoms and screened on days 0, 3, 5 and 10 following any exposure whilst remaining in hospital.

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NON-ADMITTED PATHWAYS

UPDATE ON V.3 INCLUDED ON THE USE OF PPE IN VACCINATION CLINICS (P.16)

Short contact appointments: Planned Care

Community care, primary care, secondary care outpatients

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- Key Principles
  - Comply with current national guidance on patient management in community and other settings
  - Comply with PPE guidance
  - Equality of patient access and outcomes must be maintained
  - Talk-Intervene-Walk
  - Only patients who are asymptomatic seen/attend for planned care appointments
  - Enhanced arrangements for vulnerable (shielding) patients
  - Plan daily activities by patient COVID risk
    - E.g. separate teams
    - E.g. See low risk patients first
  - Staff
    - Ensure line management daily check in for teams working remotely to ensure robust symptom checking, welfare support and testing as required

- Talk-Intervene-Walk
  - Talk
    - Initial triage
      - Condition related
      - COVID related
    - Patient self screening for booked activity
      - Information in letters
    - Symptomatic
      - Defer or move to U&EC stream
  - Intervene
    - Virtual where possible
    - Domiciliary where possible for community services
  - Walk
    - Screen on arrival with hard stop (questions +/- temp)
    - Environment that can support good IPC
      - Surface and equipment cleaning between patients

Short contact appointments: Urgent and Emergency Care

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Community care, primary care, secondary care outpatients

- Key Principles
  - Comply with current national guidance on patient management in community and other settings
  - Comply with PPE guidance
  - Equality of patient access and outcomes must be maintained
  - Talk-Intervene-Walk
  - Enhanced arrangements for vulnerable (shielding) patients
  - Plan daily activities by patient COVID-19 risk
    - E.g. separate teams
    - E.g. See low risk patients first
  - Staff
    - Ensure line management oversight daily of teams working remotely to ensure robust symptom checking, welfare support and testing as required

- Talk-Intervene-Walk
  - Talk
    - Initial triage
      - Condition related
      - COVID related
  - Intervene
    - Virtual where possible
    - Domiciliary where possible for community services
  - Walk
    - Separate pathways for COVID-19 likely (hot hub) and COVID-19 unlikely patients
    - Screen on arrival (questions +/- temp)
    - Environment that can support good IPC
      - Cleaning between patients
    - Comply with physical distancing
      - Specific appointment slots
      - Distancing in waiting rooms
      - Consider
        - » patient waiting in car
        - » Patients in consulting rooms, clinicians move between
        - » One way traffic

Managing the clinic/surgery environment to promote effective IPC

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- Measures to reduce waiting
  - Appointment timings
  - Reduce early arrivals
    - E.g. Phone on arrival, wait in car and enter when called
- Environment / layout that enforces social distancing
    - Specific appointment slots
    - Distancing in waiting rooms
    - Consider
      - Patient waiting in car
      - Patients in consulting rooms, clinicians move between
      - One way traffic
- Enhanced cleaning
  - Increased frequency of cleaning
  - Stripped back environment in rooms to aid cleaning
  - Necessary equipment only in each room

Specific Considerations for Primary Care

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Physical separation of patient pathways

- Maximise physical separation of areas used by patients for COVID-19 high risk and COVID-19 indeterminate patients
  - Planning of care delivery at PCN level
  - Hard stop triage at front door
    - Screening questions all patients
    - Identified isolation area if needed
  - Minimise patient to patient contact within surgeries
    - Review appointment timings
    - Options to implement social distancing include:
      - Spacing between chairs in waiting room

Staffing considerations

- Minimise movement of staff between COVID-19 high risk and COVID-19 indeterminate patients
- Excellence in IPC
  - Follow the single national IPC guidance
  - All areas must be free from clutter and easy to clean
  - Hand washing facilities for staff and patients and monitoring of use

Vaccination Clinics

In some clinical outpatient settings, such as vaccination/injection clinics, where contact with individuals is minimal, the need to use single use PPE items for each encounter, i.e. gloves and aprons is not necessary. Gloves and aprons are recommended when there is (anticipated) exposure to blood/ body fluids or non-intact skin. Staff administering vaccinations/ injections must apply hand hygiene between patients and wear a sessional facemask.

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MENTAL HEALTH: ADMITTED AND DAYCASE PATHWAYS

Mental Health

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It is anticipated that NHS E/I will be publishing specific Mental Health Guidance in the near future. Pan London IPC Guidance will be reviewed following publication to ensure aligned.

- Community settings
  - Use general non-admitted pathway guidance
  - Maintain physical distancing in all settings
  - Extended use of Face Coverings
    - Specifically consider
      - Mealtimes
      - Therapeutic groups
        - Virtual where possible
      - Other group activities

- Admitted
  - Maximise opportunities to create physical and or visible separation of planned and emergency care pathways
  - Regional level provision may be required to enable adequate segregation
  - Inpatient wards

    Risk assessments must be done on individual inpatient areas to determine capacity for isolation, cohorting and number of patients in bays/ dormitory wards to facilitate physical distancing