Guidance

4. COVID-19 infection prevention and control guidance: care pathways

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This publication is available at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/care-pathways

These pathways are specific to the COVID-19 pandemic and are examples of how organisations may separate COVID-19 risks. It is important to note that these pathways do not necessarily define a service to a particular pathway and should not impact the delivery and duration of care for the patient or individual. Moving patients between pathways should be based on their infectious status (testing required), clinical need, availability of services and this should be agreed locally. Implementation strategies must be underpinned by patient/procedure risk assessment, appropriate testing regimens (as per organisations or country specific) and epidemiological data. Additional information on specific settings can be found in: NICE (2020) COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services (https://www.nice.org.uk/guidance/ng179/resources/covid19-rapid-guideline-arranging-planned-care-in-hospitals-and-diagnostic-services-pdf-66141969613765).

Triaging and testing within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. See Appendix 1 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/953310/Infection_Prevention_and_Control_Appendix_1.pdf) for an example of triage questions. Triage should be undertaken by clinical staff who are trained and competent in the application of the clinical case definition (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection) prior to arrival at a care area, or as soon as possible on arrival, and allocated to the appropriate pathway. This should include screening for other infections/multi-drug resistant organisms, including as per national screening requirements.

Infection risk and infection prevention and control precautions, for example Standard Infection Control Precautions (SICPs) or Transmission Based Precautions (TBPs) must be communicated between care areas/pathways, including when discharge planning.

Patients with respiratory symptoms should be assessed in a segregated area/ideally a single room pending test result to define the causative organism.

4.1 High - Risk COVID-19 Pathway

Any care facility where:

a) Untriaged individuals present for assessment or treatment (symptoms unknown).

OR

b) Confirmed SARS-CoV-2 PCR positive individuals are cared for.

OR

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.

OR

d) Symptomatic individuals decline testing.

Examples of patient (individual) groups/facilities within these pathways: these lists are not exhaustive

- designated areas within Emergency/Resuscitation Departments
- GP surgeries/walk in centres
- facilities where confirmed or suspected/symptomatic COVID-19 individuals are cared, for example:
  - emergency admissions to in-patient areas (adult and children)
  - mental health
  - maternity
  - critical care units
  - renal dialysis units

4.2 Medium Risk COVID-19 Pathway

Any care facility where:

a) Triaged/clinically assessed individuals are asymptomatic and are waiting a SARS-CoV-2 test result.

OR

b) Triaged/clinically assessed individuals are asymptomatic with COVID-19 contact/exposure identified.

OR

c) Testing is not required or feasible on asymptomatic individuals and infectious status is unknown.

OR

d) Asymptomatic individuals decline testing.

4.2.1 Examples of patient (individual) groups/facilities within these pathways: these lists are not exhaustive

- designated areas within Emergency/Resuscitation, GP surgeries and walk-in centres
- non elective admissions
- primary care facilities, for example general dental and general practice
- facilities where individuals are cared, for example in-patients; adult and children, Mental health, Maternity, Critical Care Units
- outpatient depts. including Diagnostics and Endoscopy
- care homes*
- prisons
- renal dialysis units

*This guidance does NOT apply to Adult Social Care settings in England.

4.3 Low Risk COVID-19 Pathway

Any care facility where:

a) Triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact/exposure.

AND

Have a negative SARS-CoV-2 PCR test within 72 hours of treatment and, for planned admissions, have self-isolated for the required period or from the test date.

OR

b) Individuals who have recovered (14 days) from COVID-19 and have had at least 48 hours without fever or respiratory symptoms.

OR

c) Patients or individuals are part of a regular formal NHS testing plan and remain negative and asymptomatic.

4.3.1 Examples of the patient (individual) groups/facilities within these pathways: these lists are not exhaustive

- 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
- care homes*
- prisons

*This guidance does NOT apply to Adult Social Care settings in England.

4.4 Administration measures for the pathways

1. Establish separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas:
    - care areas (for example, ward, clinic, GP practice, care home) may designate, self-contained area(s) or ward(s) for the treatment and care of patients/individuals at high, medium and low risk of COVID-19. Temporal separation may be used in clinics/primary care settings
    - as a minimum in smaller facilities or primary care outpatient settings physical/ or temporal separation of patients/departments at high risk of COVID-19 from the rest of the facility/patients
2. Ensure that hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:
    - hand hygiene facilities including instructional posters
    - good respiratory hygiene measures
    - maintaining physical distancing of 2 metres at all times (unless wearing PPE due to clinical care or personal care)
    - increasing frequent decontamination of equipment and environment

- considering improving ventilation by opening windows (natural ventilation) if mechanical ventilation is not available
- clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. This will include:
  - use of face masks/coverings by all outpatients (if tolerated) and visitors when entering a hospital or GP/dental surgery or other care settings
  - use of a surgical facemask (Type II or Type IIR) by all patients across all pathways, if this can be tolerated and does not compromise their clinical care, such as when receiving oxygen therapy. This will minimise the dispersal of respiratory secretions and reduce environmental contamination
  - extended use of facemasks by all staff in both clinical and non-clinical areas within the healthcare or care setting
  - where visitors are unable to wear face coverings due to physical or mental health conditions or a disability, clinicians/person in charge should consider what other IPC measures are in place, such as physical distancing and environmental cleaning, to ensure sufficient access depending on the patient's condition and the care pathway

3. Where possible and clinically appropriate remote consultations rather than face-to-face should be offered to patients/individuals.
4. Ensure restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff, including patient transfer and in communal staff areas (changing rooms/restaurant). If the prevalence/incident rates decline this may not be necessary between pathways providing the IPC measures are reliably maintained.
5. Ensure areas/wards are clearly signposted, using physical barriers as appropriate to ensure patients/individuals and staff understand the different risk areas.
6. Ensure local standard operating procedures detail the measures to segregate equipment and staff, including planning for emergency scenarios as the prevalence/incidence of COVID-19 may increase and decrease until cessation of the pandemic.
7. Ensure a rapid and continued response through ongoing surveillance of rates of infection within the local population and for hospital/organisation onset cases (staff and patients/individuals). Positive cases identified after admission who fit the criteria for a healthcare associated infection should trigger a case investigation. If 2 or more cases are linked in time and place, an outbreak investigation should be conducted. Refer to country specific definitions.
8. If prevalence/incidence rate for COVID-19 is high, where possible, assign separate teams of health and care workers, including domestic staff to care for individuals in isolation/cohort rooms/areas/pathways. If a member of staff is required to move between sites/hospitals due to the unique function of their role, all IPC measures including physical distancing must be maintained.
9. Providers of planned services should be responsive to local and national prevalence/incidence data on COVID-19 and adapt processes so that services can be stepped-up or down. This can be assessed using the respective countries weekly COVID-19 surveillance report/SARS-CoV-2 positivity data on admission, and local capacity and resources.
10. Safe systems of working including administrative, environmental and engineering controls are an integral part of IPC measures.

4.5 Community settings

Areas where triaging for COVID-19 is not possible for example, community pharmacy:

- signage at entry points advising of the necessary precautions
- staff should maintain 2 metres physical distance with customers / service users, using floor markings, clear screens or wear surgical face masks (Type IIR) where this is not possible. Patients/individuals with symptoms should be advised not to enter the premises

4.6 Outpatient/primary/day care

In outpatient, primary care and day care settings:

- where possible and appropriate, services should utilise virtual consultation
- if attending outpatients or diagnostics, service providers should consider timed appointments and strategies such as asking patients/individuals to wait to be called to the waiting area with minimum wait times
- patients/individuals should not attend if they have symptoms of COVID-19 or are isolating as a contact/exposure and communications should advise actions to take in such circumstances for example for patients/individuals receiving chemotherapy and renal dialysis
- communications prior to appointments should provide advice on what to do if patients/individuals suspect they have come into contact with someone who has COVID-19 prior to their appointment
- outpatient letters should be altered to advise patients/individuals on parking, entrances, IPC precautions and COVID-19 symptoms
- patients/individuals must be instructed to remain in waiting areas and not visit other parts of the facility
- prior to admission to the waiting area, all patients/individuals and accompanying persons should be triaged for COVID-19 symptoms and assessed for exposure to contacts
- patients/individuals and accompanying persons will also be asked to wear a mask/face covering at all times

NB. SARS-CoV-2 confirmed positive patients/individuals or those self- isolating should still be assessed and reviewed following the high/medium care pathway in these settings, to ensure urgent treatment/appointments are accommodated. This is important to avoid unwarranted poor patient outcomes.

NB. In some clinical outpatient settings, such as vaccination/injection clinics, where contact with individuals is minimal, the need for PPE items for each encounter, for example, gloves and aprons are only 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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