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Guidance

COVID-19 infection prevention and control guidance: high risk pathway - key principles

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Contents

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This pathway applies to any emergency/urgent care facility where:

a) untriaged individuals present for assessment or treatment (symptoms unknown*)
OR
b) confirmed SARS-CoV-2 (COVID-19) positive patients 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 who decline testing

*Once assessed, if asymptomatic with no contact history, patients/individuals may move to the medium risk pathway awaiting test result.

1. Patient placement

If the patient/individual has symptoms or a history of contact with a case, they should be prioritised for single room isolation OR cohorted (if an isolation room is unavailable) until their test results are known, for example use privacy curtains between bed spaces to minimise opportunities for close contact between patients/individuals. This should be locally risk assessed to ensure this does not compromise patient safety.

If single rooms are in short supply, priority should be given to patients with excessive cough and sputum production, diarrhoea or vomiting and to those in the high risk/extremely high risk of severe illness.

Local risk assessments and clinical decisions must be made regarding placement of surgical patients/individuals with availability of single rooms taken into consideration.

2. Personal protective equipment (PPE)

Droplet/contact PPE	**Disposable gloves**	**Disposable apron/gown**	**Face masks**	**Eye/face protection (visor)**
If suspected/ confirmed COVID-19 patient/individual	Single use	Single use apron (gown required if risk of spraying / splashing)	FRSM Type IIR for direct patient care*	Single use or re-usable

Airborne**	**Disposable gloves**	**Disposable apron/gown**	**Respirator**	**Eye/face protection (visor)**
When undertaking AGPS on confirmed or suspected COVID-19 patient/individual	Single use	Single use gown	FFP3 or Hood for AGPs	Single use or re-usable

*FRSM can be worn sessionally if providing care for COVID -19 cohorted patients/individuals
**Consideration may need to be given to the application of airborne precautions where the number of cases of COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms.

Respiratory protective equipment (RPE) FFP3 (filtering face piece or hood)

Respirators are used to prevent inhalation of small airborne particles arising from aerosol generating procedures (AGPs).

Respirators should:

- be well fitting, covering both nose and mouth
- always worn when undertaking an AGP on a COVID-19 confirmed or suspected patient/individual
- not be allowed to dangle around the neck of the wearer after or between each use
- not be touched once put on
- be removed outside the patient's/individual's room or cohort area or COVID-19 ward
- respirators can be single use or single session use (disposable or reusable) and fluid-resistant
- valved respirators are not fully fluid-resistant unless they are also 'shrouded'; valved non-shrouded FFP3 respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated
- all staff who are required to wear an FFP3 respirator must be fit tested for the relevant model to ensure an adequate seal or fit (according to the manufacturers' guidance); fit checking (according to the manufacturers' guidance) is necessary when a respirator is put on (donned) to ensure an adequate seal has been achieved
- where fit testing fails, suitable alternative equipment must be provided, or the healthcare worker should be moved to an area where FFP3 respirators are not required
- respirators should be compatible with other facial protection used (protective eyewear) so that this does not interfere with the seal of the respiratory protection
- the respirator should be discarded and replaced and NOT be subject to continued use if the facial seal is compromised, it is uncomfortable, or it is difficult to breathe through
- reusable respirators can be utilised by individuals if they comply with Health and Safety Executive (HSE) recommendations; reusable respirators should be decontaminated according to the manufacturer's instructions

Additional literature on RPE (https://hpspubsrepo.blob.core.windows.net/hps-website/nss/1722/documents/1_tbp-lr-rpe-v3.1.pdf) is available.

Full body gowns or fluid repellent coveralls must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids;
- worn when undertaking aerosol generating procedures
- worn when a disposable apron provides inadequate cover for the procedure or task being performed
- changed between patients/individuals and immediately after completing a procedure or task unless sessional use is advised due to local/national data

3. Safe management of care environment/equipment/blood and body fluids

Please refer to information given in the medium risk pathway.

4. Aerosol generating procedures (AGPs): procedures that create a higher risk of respiratory infection transmission

Critical care

Droplet precautions would apply however, consideration may need to be given to the application of airborne precautions where the number of cases of COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms.

Operating theatres (including day surgery)

Patients/individuals should be anaesthetised and recovered in the theatre if intubation/extubation (AGP) is required using airborne precautions. This is not required for regional, neuraxial or local anaesthesia.

Ventilation in both laminar flow and conventionally ventilated theatres should remain fully on during surgical procedures where patients/individuals have suspected/confirmed COVID-19. Air passing from operating theatres to adjacent areas will be highly diluted and is not considered to be a risk.

5. Duration of precautions

Patients/individuals should remain in isolation/cohort with TBPs applied for at least 14 days after onset of symptoms and at least 3 consecutive days without a fever or respiratory symptoms. For asymptomatic patients/individuals, TBPs may be discontinued 14 days after initial positive result. The decision to modify the duration of, or ‘stand down’ TBPs (contact/droplet/airborne) should be made by the clinical team managing the Individual s care.

Step down of TBPs for COVID-19 for home discharge may require some individual clinical assessment at local level depending on the severity of the disease and underlying conditions, including testing requirements.

6. Visitor guidance

In this pathway, visiting should continue to be limited to only essential visitors, for example birthing partner, carer/parent/guardian.

The need for visitors to wear PPE should be assessed.

7. Discharge or transfer

Discharge from an inpatient facility can occur when the individual is well enough and the clinician has provided them with advice to self -isolate for 14 days post discharge from the date of the positive SARS-CoV-2 PCR test (providing their symptoms resolve).

In England, to ensure testing does not delay a timely discharge, testing for patients due to be discharged to a care home will need to be planned up to 48 hours before the scheduled discharge time. The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home. No-one should be discharged from hospital directly to a care home without the involvement of the local authority.

Discharge to another care area may be dependent on testing and/or isolation facilities available.

Discharge information for patients/individuals should include an understanding of their need for any self-isolation and/or quarantine, as well as their family members.

Ambulance services and the receiving facilities must be informed of the infectious status of the individual.