**Patient Management and Flow Covid-19**

**(from 26-04-2022)**

This guidance is subject to change and is dependent on rates of nosocomial transmission within the Trust in addition to prevalence of Covid-19 in the community.

**Summary of changes to previous guidance:**

* Isolation time reduced to 10 days for COVID-19 positive patients
* Asymptomatic contacts of a COVID-19 patient are no longer required to isolate

**When admitting to ward areas consideration/risk assessment continues to be required** for those patients who are extremely clinically vulnerable from COVID-19. These patients will require protective IPC measures depending on their medical conditions treatment e.g. priority for single room isolation.

**High Risk and Standard Risk Pathways**

* High Risk pathway – Chavasse side rooms, cohort bays
* Standard Pathway – Subspecialty cohorting on the wards

**ALL PATIENTS MUST BE TRIAGED PRIOR TO PLACEMENT ON A PATHWAY**

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| **High risk COVID-19 Pathway** |
| * Confirmed Covid-19 positive (Lateral Flow Device or PCR)
* Symptomatic or suspected Covid-19 pending LFD/PCR
* Those who have had close contact with a case of COVID-19 within the previous 10 days, and are awaiting results
* Symptomatic patients who decline testing
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| **Standard Pathway** |
| * Triaged/clinically assessed as asymptomatic, waiting a COVID-19 result and no known recent COVID-19 contact
* Testing is not required (e.g. OPD/diagnostic treatment) or feasible on asymptomatic individuals
* Asymptomatic individuals decline testing
* Individuals who have recently recovered from COVID-19 and have now stepped down from isolation.
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**For elective and emergency pathways refer to Appendix1 COVID-19 screening Pathway**

1. **Theatre**

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| **Theatre** | All patients will be treated on the **Standard Theatre pathway**  if the following criteria is met:* Negative test within 24 hours – PCR or LFD
* Asymptomatic
* No COVID contact in the last 5 days

Please ensure Theatres are provided with this information to avoid delays |

 **COVID-19: Guidance for Testing, Isolation and Management of Asymptomatic Contacts**

**Symptomatic Patient**

Cough, pyrexia/ change in smell or taste/HAP

**LFD positive**, move to Chavasse Isolate for 10 days after the onset of symptoms

**LFD negative**, move to Chavasse, perform PCR and await result

**PCR Negative**

* Review/risk assessed by medical team (discuss with IPC team if required)
* Transfer back to ward

**PCR positive**

Isolate for 10 days after the onset of symptoms. Step down day 11 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](https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharg#immsupp)

No further testing required

**Asymptomatic contacts of COVID-19 positive**

* Bay closure **not required**
* Routine testing not required (unless requested by IPC Team)
* Continue routine screening (day 0,3,7)
* Replace curtains around bed space (routine replacement of all curtains in the bay is not required
* Deep clean bay
* Review patient risk prior to admitting to the bay e.g. immunosuppression, vaccination status etc

**Ensure the following is adhered to**

* Regular opening of windows /doors to maximise ventilation
* Clear curtain bed space dividers are pulled/remain in place
* Patients wear masks unless clinical condition compromised
* Staff wear PPE correctly

**Aerosol Generating Procedures (currently under review)**

* Tracheal intubation and extubation
* Manual ventilation
* Tracheotomy or tracheostomy procedures (insertion or removal)
* Bronchoscopy
* Dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills
* Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
* High flow nasal oxygen (HFNO)
* High frequency oscillatory ventilation (HFOV)
* Induction of sputum using nebulised saline
* Respiratory tract suctioning\*
* Upper ENT airway procedures that involve respiratory suctioning
* Upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
* High speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved
* Upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs beyond the oro-pharynx

**\***It is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is considered an AGP that is oral/pharyngeal suctioning is not an AGP.

**Respiratory Physiotherapy**

(Reviewed 23-12-21)

* Adjuncts to physio including: MI:E (cough assist), IPPB (bird), metaneb, MHI (bagging)
* Open suction (this includes using a closed suction circuit on someone with a single limb oxygen deliver circuit i.e. Fisher Pakel circuits or Airvo`s). Open suction also includes nasopharyngeal suction
* Presence of a tracheostomy/open laryngectomy stoma (tracheostomy care and tracheostomy changes)
* Deep yankauer suction for upper respiratory track secretion clearance (this is beyond basic oral care requirements)

**References**

1. <https://www.nice.org.uk/guidance/ng179>
2. <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>
3. NHSE (March 2022): Living with COVID-19 – testing update
4. <https://cpoc.org.uk/guidance-sars-cov-2-infection-covid-19-and-timing-elective-surgery>)