University Hospitals Dorset
NHS Foundation Trust

Rapid guidance on the management of incidental and primary Covid-19 patients

28 March 2022

Introduction

The overwhelming majority of our patients with Covid-19 are admitted to hospital for other health issues. Currently we have patients admitted where Covid-19 is the primary reason for hospitalisation, as well as an increase in patients where Covid-19 is not the primary cause of admission - this is known as 'incidental Covid-19'.

This document outlines how to manage patients with Covid-19 on our wards, whilst promoting better patient flow and patient safety.

Background

This current capacity and demand pressure means the current guidance we are using as a Trust is not a process that we can continue to follow without causing additional harm to those patients either waiting at home for an ambulance or those who are in our ED departments waiting a bed. The current process is contributing to ED overcrowding which means the level of risk to our patients is increased in ED, this subsequently is contributing to queueing ambulances which contributes to risk in the community.

Across the South West, local teams are using their own risk assessments and making decisions to work differently and learn. Two or more cases remains a trigger for outbreak review however UHD IPC Team are working flexibly around this to keep wards open as much as possible.

A risk-based move to change IPC guidance in-relation to ward and bay closure and stepping down isolation precautions are described on the following pages.

Below outlines the process to manage incidental Covid +ve cases on an admission pathway for RBH and PH sites.

Process to manage incidental Covid +ve patients on an admissions pathway (AMU/OPAU/Stroke/CCU)

(RBH site)

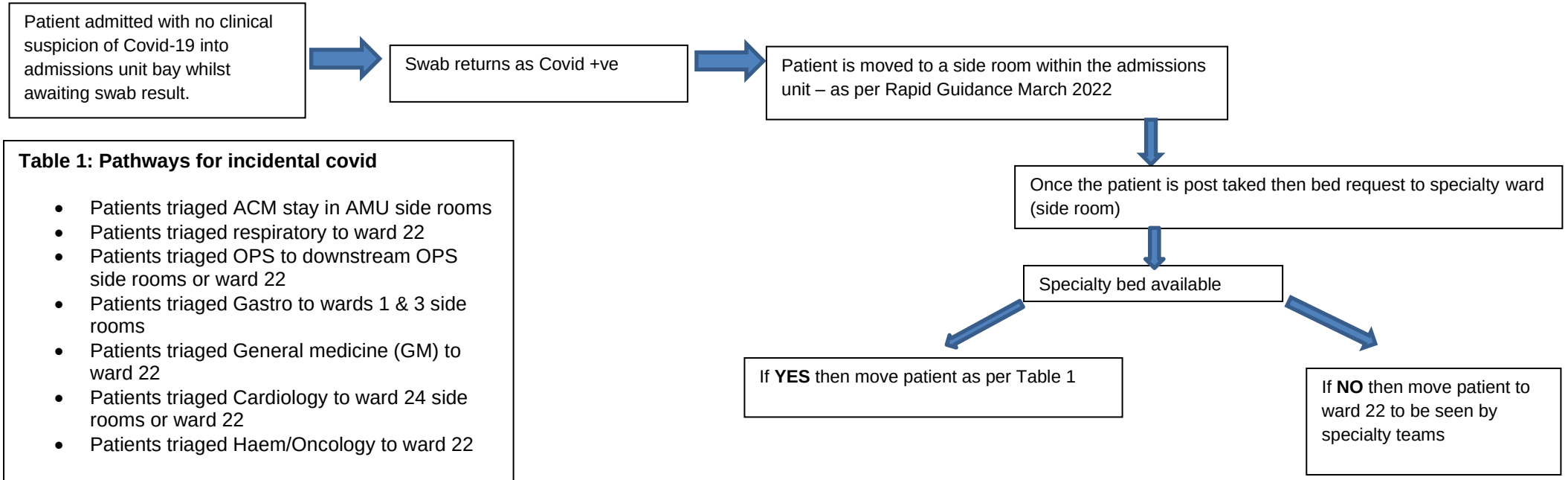


Table 1: Pathways for incidental covid

- Patients triaged ACM stay in AMU side rooms
- Patients triaged respiratory to ward 22
- Patients triaged OPS to downstream OPS side rooms or ward 22
- Patients triaged Gastro to wards 1 & 3 side rooms
- Patients triaged General medicine (GM) to ward 22
- Patients triaged Cardiology to ward 24 side rooms or ward 22
- Patients triaged Haem/Oncology to ward 22

Ward 22 is currently a base general ward looked after by respiratory.

Speciality (non-GM) patients will be looked after by their own speciality teams

Patients in 'open' contact bays to be swabbed daily by 09:00 and swabs to be labelled for **Porton Down**

Process to manage incidental Covid +ve patients on an admissions pathway (AMU & RACE)

(PH site)

Patient admitted with no clinical suspicion of Covid-19 into admissions unit bay whilst awaiting swab result.

Swab returns as Covid +ve

Patient is moved to a side room within the admissions unit – as per Rapid Guidance March 2022

Once the patient is post taked then bed request to specialty ward (side room)

Specialty bed available

If **YES** then move patient as per Table 1

If **NO** then move patient to ward A4 to be seen by specialty teams

Table 1: Pathways for incidental covid

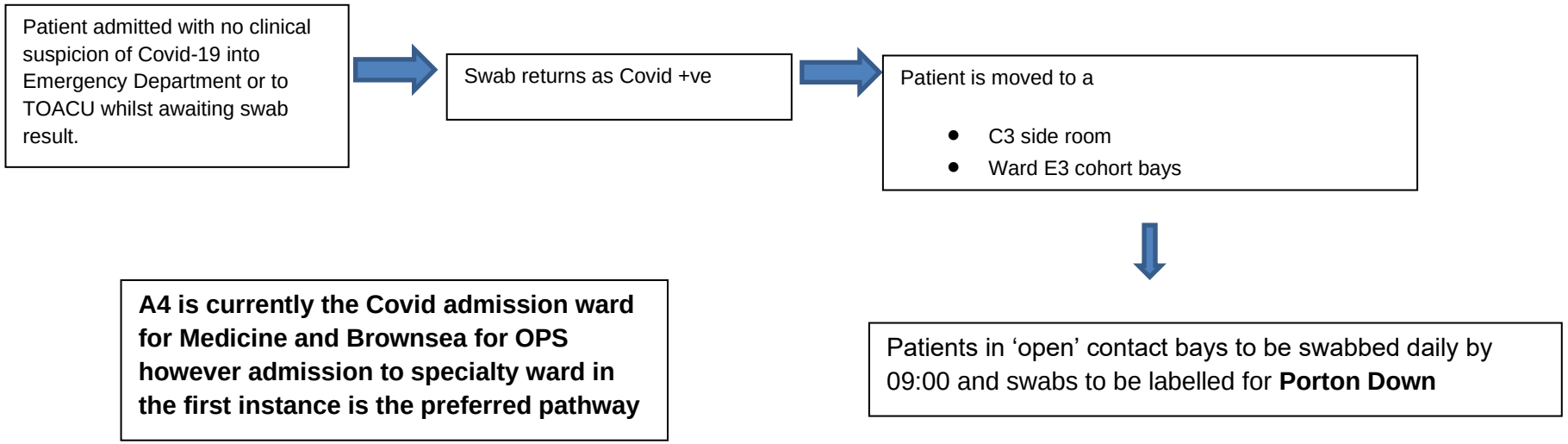
- Patients triaged ACM stay in AMU side rooms
- Patients triaged respiratory to ward A4
- Patients triaged OPS to downstream OPS side rooms
- Patients triaged Gastro/Cardio/D & E to ward A5 & B5 side rooms
- Patients triaged Cardiology to ACU
- Patients triaged Haem/Oncology to ward A5 & B5

A4 is currently the Covid admission ward for Medicine and Brownsea for OPS however admission to specialty ward in the first instance is the preferred pathway

Patients in 'open' contact bays to be swabbed daily by 09:00 and swabs to be labelled for **Porton Down**

Process to manage incidental covid +ve patients on an admissions pathway - Trauma

(PH site)



A4 is currently the Covid admission ward for Medicine and Brownsea for OPS however admission to specialty ward in the first instance is the preferred pathway

Process to manage incidental covid +ve patients on an admissions pathway - Surgery

(PH site)

Patient admitted with no clinical suspicion of Covid-19 into Emergency Department or via AEC whilst awaiting swab result.

Swab returns as Covid +ve

If in a Bay, Patient is moved to a…….

- SAU side room (if result known whilst still on admission unit)
- Side room within a downstream surgical ward (currently B2)
- Bay bed space is Terminally Cleaned and reopened

Patients in 'open' contact bays to be swabbed daily by 09:00 and swabs to be labelled for **Porton Down**

Bay and ward management for incidental Covid-19

Situation	Bay/ward status	Summary of actions
One incidental covid +ve case in an admissions bay following swab result	Bay remains **open** to new admissions – this is known as a ***contact bay***	Endeavour to isolate the case in a side room and once post-take, move downstream to specialty side room/cohort Covid +ve bay. Complete terminal clean of any bed spaces of patients with Covid-19 once they have left the bed space. Keep bay open and screen contacts. Contacts do not need isolating unless go on to develop symptoms or test +ve Keep list at ward level of all contacts, any transfers to downstream wards to be handed over as contacts, not isolated but to continue daily screening for 10 days or until discharge. Highly vulnerable patients with existing chronic conditions must not be admitted to contact bays
One hospital onset case in a bay	Bay remains **open** to new admissions – this is known as a ***contact bay***	Endeavour to isolate case as a priority and screen contacts. Contacts do not need isolating unless go on to develop symptoms or test +ve. Bay to re-open once remaining patient screens have returned Keep list at ward level of all contacts, any transfers to downstream wards to be handed over as contacts, not isolated but to continue daily screening for 10 days or until discharge. CPI flag patient contacts and ensure handed over when transferring patients to other wards. Highly vulnerable patients with existing chronic conditions must not be admitted to contact bays.

		Complete terminal clean of any bed spaces of patients with Covid-19 once they have left the bed space.
Two or more cases identified as hospital onset (ie after day seven of admission)	Bay is **closed** to new admissions – this is known as a ***closed bay*** Ward remains **open** to new admissions	Bay is closed to all new admissions except stepped down patients - patients who have been isolated for Covid-19 Screen all contacts in the bay on a daily basis. Move positive cases to cubicles or if in need of respiratory input to the specialist pathway. If contact screens return negative results, reopen the bay but continue to screen contacts every day for 10 days (if another positive health care onset case then review the ward for potential outbreak closure) Highly vulnerable patients with existing chronic conditions must not be admitted to contact bays. Enhanced cleaning in contact bays and cubicles (twice daily cleaning on all high touch surfaces). Complete terminal clean of any bed spaces of patients with Covid-19 once they have left the bed space.
Additional hospital onset case/s identified in a further bay on the same ward	Bay is **closed** to new admissions (***closed bay)*** Ward remains **open** to admissions Ward/IPC/CMT to review ward status if further cases in further bay/s	Follow contact management flow chart below for any patient identified as a contact Screen all patients on the ward who have not had a swab completed in the last 24 hours. Repeat screen all patients on the ward (who are not previously positive or currently positive).

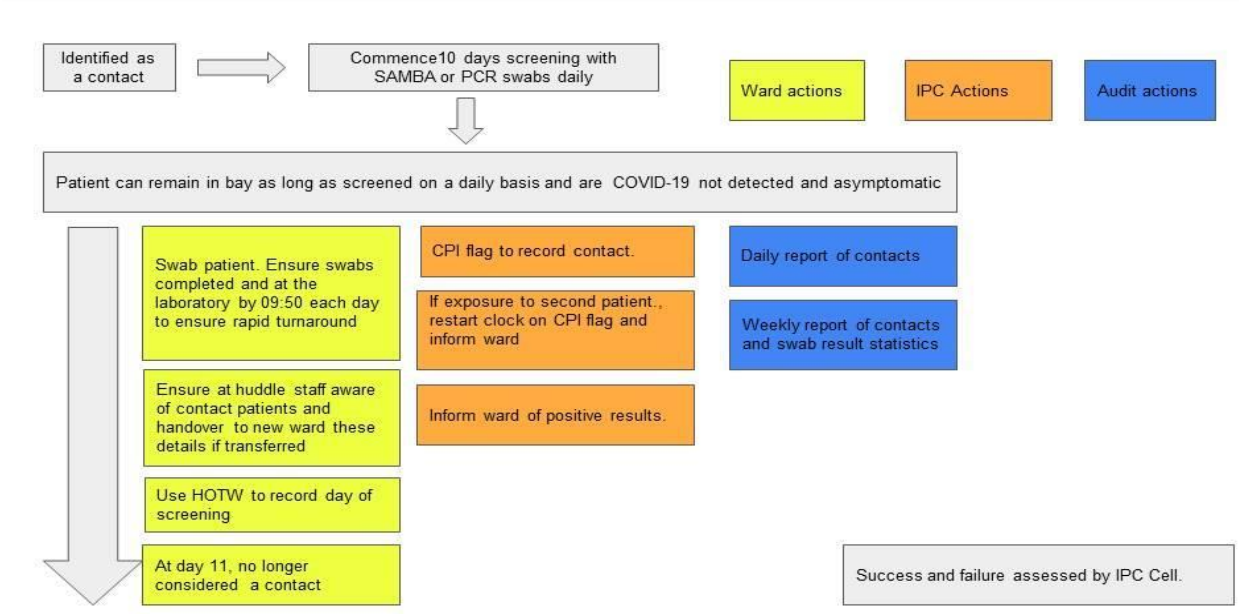
		If subsequent positive cases found cohort cases in bays. Move high risk patients into protective isolation. IPC risk assessment to take place to determine if ward should close to protect patients. In hours completed by IPC Team, out of hours CST review. On call microbiologist are available to help. Enhanced cleaning in contact bays and cubicles (twice daily cleaning on all high touch surfaces). Complete terminal clean of any bed spaces of patients with Covid-19 once they have left the bed space.

Guide to contact management – flow chart

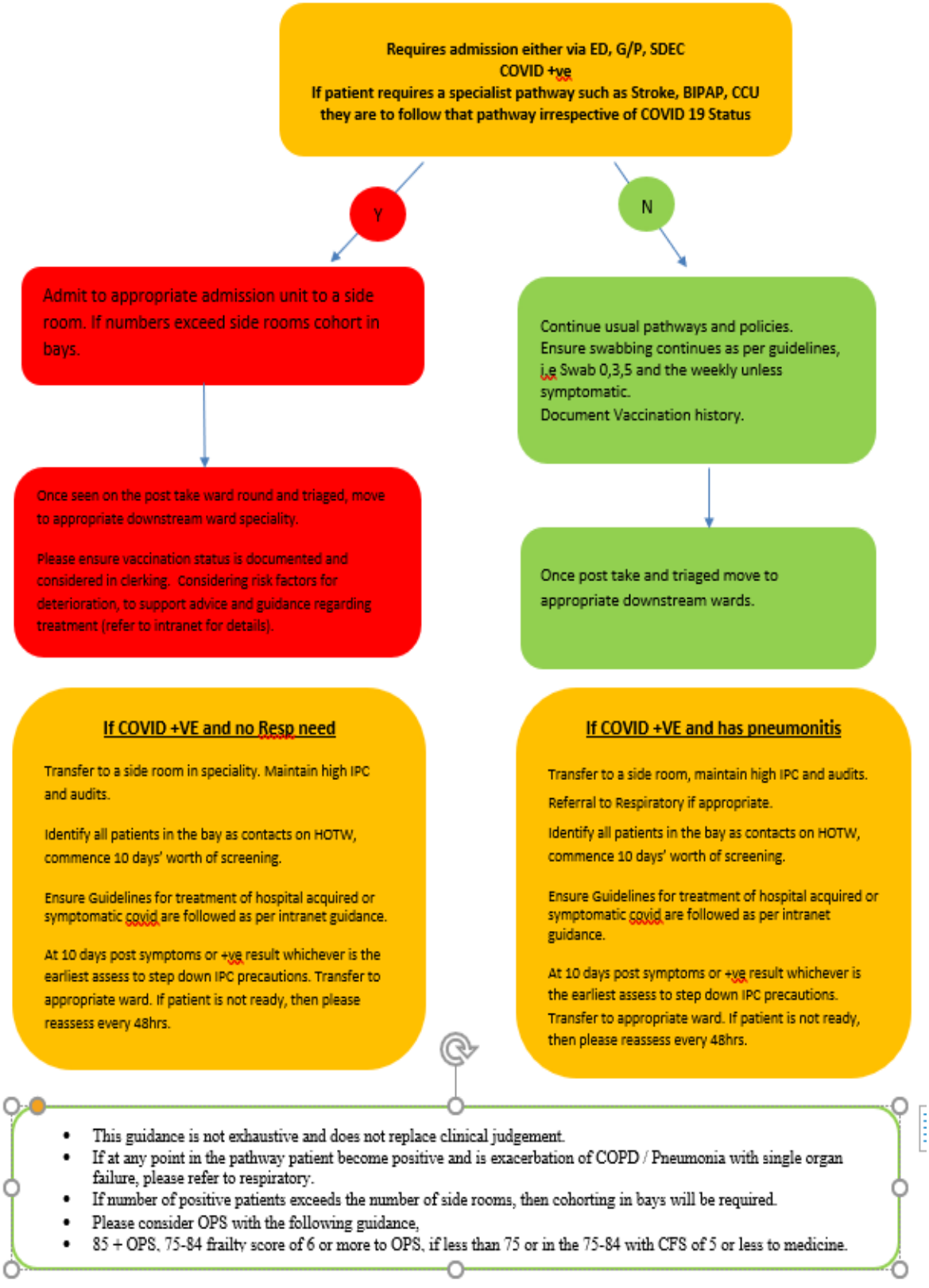
A contact is a patient who has had close contact with someone with confirmed Covid-19.

Table 1 Case definitions:

Community Onset	Indeterminate Onset	Healthcare Probable Onset	Definite Healthcare Onset
On or before day 3 of admission	Between day 4 and 7 of admission	Between day 8 and 14 of admission	On or after day 15 of admission.



Flow chart for management of COVID-19 patients - Medical Care Group



General principles in open wards

Screening: should be completed using swabs that allow for results to be returned within 24 hours. Only contacts to be screened, patients moved into contact bays do not need screening unless exposed to a case.

Ventilation: ensure windows are regularly opened.

Staff LFTs and wellbeing: complete lateral flow test every 72 hours. No one to work with evidence of symptoms, however mild. Use morning huddle to check ‘are we OK?’.

IPC: daily hand hygiene and PPE audit submitted to matrons for review. IPC ward assessment to be completed daily by IPC team.

PPE: ensure ward has staff who have been fit tested.

Cleaning: enhanced cleaning in contact bays and cubicles (twice daily cleaning on all high touch surfaces). Standard cleaning in all other areas. Complete terminal clean of any bed spaces of patients with COVID-19 once left bed space.

Vaccination: ensure that all patients within the ward gave a documented vaccination history and isolate those vulnerable.

Face masks: continue to ask patients (where tolerated) to continue to wear face masks.

Duty of candour: document DOC clearly within patient notes the level of risk and current pressure in the Trust.

Visiting: visiting can continue in line with the current guidance. We do not prevent visiting for patients with COVID-19 or if a contact, however visitors should be informed.

Cleaning for bay or ward closures

Ward closures for Covid-19 should be planned at the beginning for how cleaning will take place. This starts with a rapid de-clutter of the ward environment.

Bay cleaning guidance - updated

During the outbreak a regular and thorough clean of the environment will help reduce any onwards transmission of cases.

> Terminal clean any vacated bed space. No further terminal cleans for the bay are required unless evidence of symptoms in other patients/ further hospital onset cases.

Ward cleaning guidance - updated

Covid-19 transmission from the environment to the patient at this point is highly unlikely given the survival time of the virus.

> Terminal clean ward environments, including staff areas, if a deep clean has been completed in the last 12 months. Terminal cleans should not be undertaken within 72 hours of the last case in a bay (but can be done post-discharge from a bay).

Patient cohorts considered at highest risk from COVID-19 and to be prioritised for treatment with nMABs and antivirals

Appendix 1: Patient cohorts considered at highest risk from COVID-19 and to be prioritised for treatment with nMABs and antivirals

The following patient cohorts were determined by an independent advisory group commissioned by the Department of Health and Social Care (DHSC)[8].

Cohort	Description
Down's syndrome	All patients with Down's syndrome
Patients with a solid cancer	• Active metastatic cancer and active solid cancers (at any stage) • All patients receiving chemotherapy within the last 3 months • Patients receiving group B or C chemotherapy 3-12 months prior (see Appendix 3) • Patients receiving radiotherapy within the last 6 months

Patients with haematological diseases and stem cell transplant recipients	• Allogeneic haematopoietic stem cell transplant (HSCT) recipients in the last 12 months or active graft vs host disease (GVHD) regardless of time from transplant (including HSCT for non-malignant diseases)
	• Autologous HSCT recipients in the last 12 months (including HSCT for non-malignant diseases)
	• Individuals with haematological malignancies who have
	  ○ received chimaeric antigen receptor (CAR)-T cell therapy in the last 24 months, or
	  ○ radiotherapy in the last 6 months
	• Individuals with haematological malignancies receiving systemic anti-cancer treatment (SACT) within the last 12 months except patients with chronic phase chronic myeloid leukaemia (CML) in molecular response or first or second line tyrosine kinase inhibitors (TKI).
	• All patients with myeloma (excluding MGUS) or chronic B-cell lymphoproliferative disorders (e.g. chronic lymphocytic leukaemia, follicular lymphoma) or myelodysplastic syndrome (MDS) who do not fit the criteria above.
	• All patients with sickle cell disease.
	• Individuals with non-malignant haematological disorder (e.g. aplastic anaemia or paroxysmal nocturnal haemoglobinuria) receiving B-cell depleting systemic treatment (e.g. anti-CD20, anti-thymocyte globulin [ATG] and alemtzumab) within the last 12 months.

[8] For paediatric/adolescent patients (aged 12-17 years inclusive), paediatric multi-disciplinary team (MDT) assessment should be used to determine clinical capacity to benefit from the treatment

Cont'd…

Patients with renal disease	• Renal transplant recipients (including those with failed transplants within the past 12 months), particularly those who:
	  ○ Received B cell depleting therapy within the past 12 months (including alemtuzumab, rituximab [anti-CD20], anti-thymocyte globulin)
	  ○ Have an additional substantial risk factor which would in isolation make them eligible for nMABs or oral antivirals
	  ○ Not been vaccinated prior to transplantation
	• Non-transplant patients who have received a comparable level of immunosuppression
	• Patients with chronic kidney stage (CKD) 4 or 5 (an eGFR less than 30 ml/min/1.73m2) without immunosuppression

Patients with liver disease	• Patients with cirrhosis Child's-Pugh class B and C (decompensated liver disease). • Patients with a liver transplant • Liver patients on immune suppressive therapy (including patients with and without liver cirrhosis) • Patients with cirrhosis Child's-Pugh class A who are not on immune suppressive therapy (compensated liver disease)
Patients with immune-mediated inflammatory disorders (IMID)	• IMID treated with rituximab or other B cell depleting therapy in the last 12 months • IMID with active/unstable disease on corticosteroids, cyclophosphamide, tacrolimus, cyclosporin or mycophenolate. • IMID with stable disease on either corticosteroids, cyclophosphamide, tacrolimus, cyclosporin or mycophenolate. • IMID patients with active/unstable disease including those on biological monotherapy and on combination biologicals with thiopurine or methotrexate
Immune deficiencies	• Common variable immunodeficiency (CVID) • Undefined primary antibody deficiency on immunoglobulin (or eligible for Ig) • Hyper-IgM syndromes • Good's syndrome (thymoma plus B-cell deficiency) • Severe Combined Immunodeficiency (SCID) • Autoimmune polyglandular syndromes/autoimmune polyendocrinopathy, candidiasis, ectodermal dystrophy (APECED syndrome) • Primary immunodeficiency associated with impaired type I interferon signalling • X-linked agammaglobulinaemia (and other primary agammaglobulinaemias)

Cont'd…

	• Any patient with a secondary immunodeficiency receiving, or eligible for, immunoglobulin replacement therapy
HIV/AIDS	• Patients with high levels of immune suppression, have uncontrolled/untreated HIV (high viral load) or present acutely with an AIDS defining diagnosis • On treatment for HIV with CD4 <350 cells/mm3 and stable on HIV treatment or CD4>350 cells/mm3 and additional risk factors (e.g. age, diabetes, obesity, cardiovascular, liver or renal disease, homeless, those with alcohol-dependence)
Solid organ transplant recipients	All recipients of solid organ transplants not otherwise specified above
Rare neurological conditions	• Multiple sclerosis • Motor neurone disease • Myasthenia gravis • Huntington's disease