Guidance to support scaling back up acute hospital services

V1.0 23/06/2020

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Introduction

This document contains a compilation of updated versions of 7 documents issued previously as separate documents by HSE Acute Operations. The documents have been reviewed and updated to take account of experience and feedback since the initial documents were issued. They have been compiled into a single document for convenience.

Further updates on this guidance are likely to be required. Please ensure that you are using the latest version of guidance. If you have comments or suggestions for improvement of the documents please contact any member of the Antimicrobial Resistance and Infection Control Division of the Health Protection Surveillance Centre.

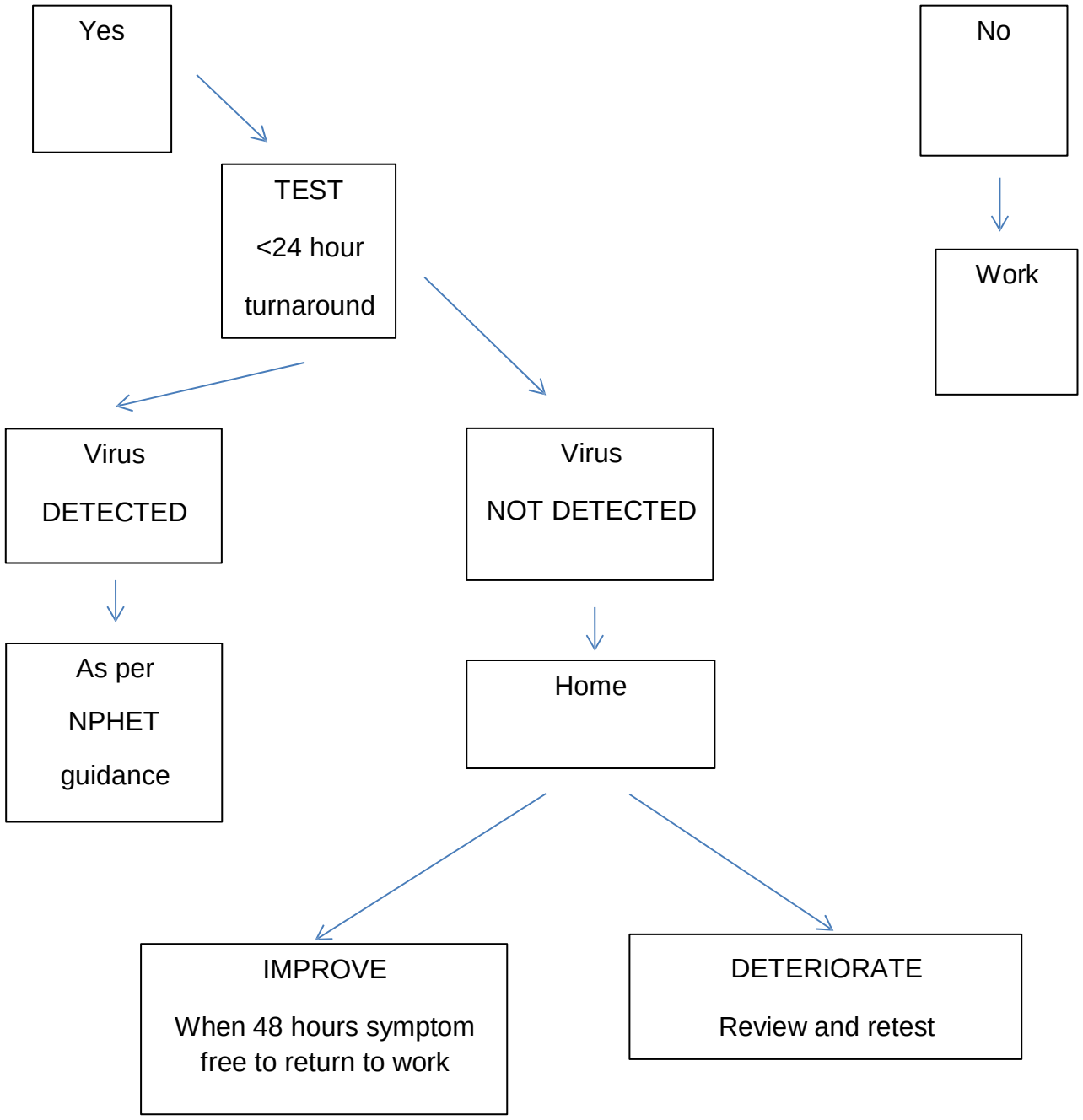
Scope

The document is intended to support all those involved in scaling back up clinical services in acute hospitals over the coming weeks.

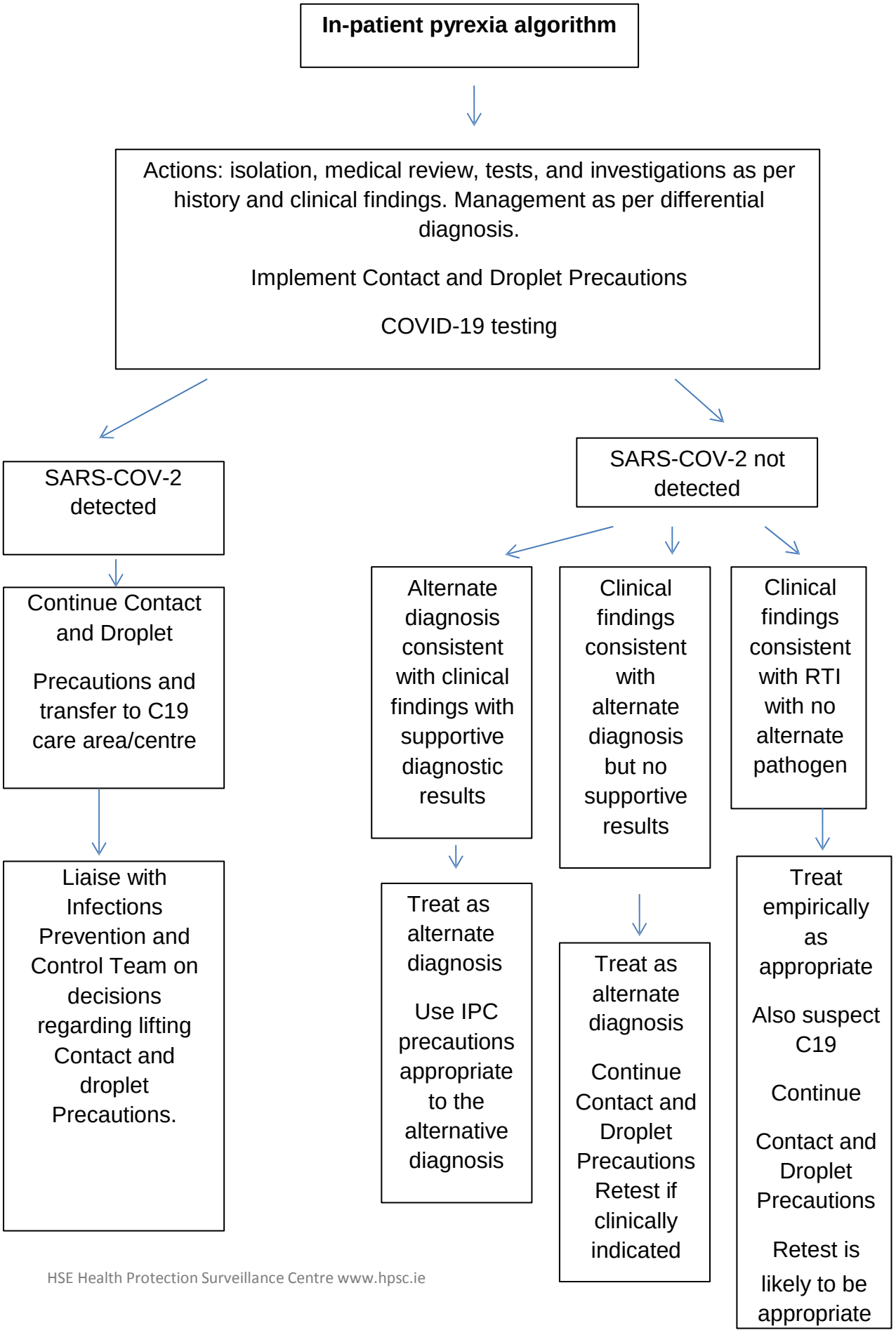
Item 1

Healthcare Worker Algorithm **Pre-work check** **Most common:**		
Cough	Shortness of breath	Myalgia
Fatigue	Fever >38.0°C[Note]	Loss of taste / smell
Less common:		
Anorexia	Sputum production	Sore throat
Dizziness	Headache	Rhinorrhoea
Conjunctival congestion	Chest pain	Haemoptysis
Diarrhoea	Nausea / vomiting	Abdominal pain

Note: Fever may be subjective report if measured with a thermometer >=38.0



Item 2


In-patient pyrexia algorithm
Actions: isolation, medical review, tests, and investigations as per history and clinical findings. Management as per differential diagnosis.
Implement Contact and Droplet Precautions
COVID-19 testing
SARS-COV-2 detected
Continue Contact and Droplet
Precautions and transfer to C19 care area/centre
Liaise with Infections Prevention and Control Team on decisions regarding lifting Contact and droplet Precautions.
SARS-COV-2 not detected
Alternate diagnosis consistent with clinical findings with supportive diagnostic results
Treat as alternate diagnosis
Use IPC precautions appropriate to the alternative diagnosis
Clinical findings consistent with alternate diagnosis but no supportive results
Treat as alternate diagnosis
Continue Contact and Droplet Precautions
Retest if clinically indicated
Clinical findings consistent with RTI with no alternate pathogen
Treat empirically as appropriate
Also suspect C19
Continue
Contact and Droplet Precautions
Retest is likely to be appropriate

Item 3

Interim pre-assessment, triage and review of patients in outpatient care settings (new and return patients)

Clinician & Clinic actions

There is a requirement for service re-design (systems engineering) to ensure lean principles/ flow processes are applied. Need for a risk management and quality assurance/improvement process to underpin service re-configuration.

1. Review all planned attendances to OPD in context of option for care provision in primary care settings or integrated care.
2. Review all planned OPD attendees for option to triage to virtual clinic review.
3. Consider mechanisms to support single patient visits where patient is attending multiple providers of having laboratory and radiology tests undertaken ("one stop shop").
4. Deliver OPD services by appointment only.
5. Where possible issue a text reminder not to attend if they have symptoms of COVID-19 in the day or two before the appointment. This may be linked to appointment reminder texts for hospitals that provide this service.
6. If the person has travelled to the hospital by private care and where possible and appropriate to the patients' needs the patient should remain in their car until as near as practical to the time of the appointment. Waiting areas should be arranged to support physical distancing. [Note Waiting stations may need two adjacent seats to accommodate the needs of patients who are accompanied]
7. Pre-review and cohort all required OPD attendees (per specialty criteria) to a designated provider. Clearly record in the OPD appointments system designated clinician per patient and other staff per clinic. Update if changes occur on the day of clinic.
8. Pre-assess all OPD *attendees (with appropriate supports for vulnerable groups) for symptoms: fever, cough, shortness of breath OR lethargy, confusion, loss of appetite, include loss of sense of taste or smell* unexplained change in baseline condition (also enquire symptomatic members or close contact with confirmed cases amongst social circle)
9. Consider split clinics, extended days, extended working hours with workforce planning.
10. Patients who have had COVID-19 and who are 14 days or more post onset of symptoms and with no fever for the last 5 days are regarded as non-infectious. They may attend outpatient services with the same IPC precautions that apply to patients in whom there is no clinical suspicion of COVID-19. Repeat testing is generally not appropriate during the 12 weeks after diagnosis. If there is a specific concern please discuss the patient with a Consultant Microbiologist or Infectious Disease Physician.

Patient actions:

1. Commence social distancing 2 weeks in advance of OPD visit Comply with requirements for assessment for signs and symptoms of COVID-19 to minimise spread
2. Hand sanitize and wear a cloth face covering of face mask in public spaces during visit, if tolerated and if a distance can't be maintained .

Summary:

1. Pre-screen all OPD attendees as above
2. Check all staff when coming on duty with for symptoms
3. All staff to wear surgical masks when caring for patients within 2m or when within 2m of a colleague for more than 15 minutes
4. Please refer to HPSC HCW IPC guidance
5. All patients to wear a cloth face covering of face mask in public spaces during visit, if tolerated and if a distance can't be maintained.

Item 4

Interim Guidance on the Management of Procedures that are Day Case – Involving anaesthesia or potential aerosol generating procedures (AGPs)

This document does not supersede clinical judgment and describes methods to mitigate risks associated with delivering care to patients in whom there is no clinical suspicion of COVID-19 in an environment where SARS-CoV-2 is prevalent. It provides a framework for services that will need to be tailored to local conditions and specialty needs.

Before scheduling the procedure

All patients should have a pre-scheduling engagement that is virtual, by telephone or other suitable means, to ascertain that they are not

1. Suffering from any symptoms or signs of COVID-19
2. Restricting their movements due to being a close contact of COVID-19
3. Suffering from acute infectious disease other than that related to the procedure
4. In direct contact (face to face meeting) with anyone who is suffering from the symptoms or signs of COVID-19.

They should be advised that if they develop symptoms of COVID-19 or are told that they are a Contact of COVID-19 that they should contact the hospital to re-schedule their procedure.

In addition, they need to be advised that they need a means to get to the hospital and a designated individual to stay with them for 12/24 hours after any procedure involving sedation or anaesthesia. It is preferable if the accompanying adult remains in the car but recognised that this may not always be possible. No children are to accompany individuals for procedures.

Pre-procedural evaluation

Pre-procedure evaluation is organised by the hospital. It is not the responsibility of the patients GP to perform the evaluation or arrange testing.

Within the 3 days prior to the procedure, the patient should attend to be assessed for clinical features of COVID-19 (signs or symptoms) and for a COVID-19 test (for example if the procedure is on Monday they should have the test taken on or after Friday). They should not have the procedure until it has been confirmed that their test has been reported not-detected.

Note the requirement for testing does not apply to patients who have had COVID-19 and who are 14 days or more post onset of symptoms and with no fever for the last 5 days. These patients are regarded as non-infectious but may continue to have a positive test. They may have procedures with the same IPC precautions that apply to patient in whom there is no clinical suspicion of COVID-19. Repeat testing is generally not appropriate during the 12 weeks after diagnosis. If there is a specific concern please discuss the patient with a Consultant Microbiologist or Infectious Disease Physician.

Note also in certain in some circumstances, if the hospital has capacity to provide the service, it may be preferable for the person to attend on the day of the procedure with rapid turn-around testing performed before the procedure is performed. In this case the assessment for clinical features (symptoms) should be carried out by telephone or video-link within the 3 days prior to the procedure.

Pre-sedation, anaesthesia assessment

As much as can be should be assessed virtually and additional investigations and/or in person history and examination should be scheduled to occur on the same day as pre-procedural COVID-19 evaluation and testing to minimize the number of hospital visits.

Prior to admission

Patients should be sent an appointment time and asked to wait in their car, where possible and appropriate to their needs, until shortly before their appointment time. Included in this communication should be a patient information leaflet indicating the requirements pertaining to the procedure.

Patients should be reminded of the national recommendation to wear a cloth face covering when in indoor areas where a distance of 2m cannot be maintained. They should wear a face covering when entering the building and while registering or waiting unless they are under 13 years or can't tolerate wearing the face covering. If they do not have a cloth face covering they should be provided with a facemask at reception/registration.

Patients and accompanying person should perform hand hygiene on arrival.

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Once delivered, the accompanying adult will be asked to return to their vehicle and to leave contact details for patient collection unless there is an adequately spacious waiting area or the patient needs them to be present.

Patients will be asked to keep their face covered, if tolerated except when in a clinical space and removal is required to facilitate communication, examination or the procedure. Should it become wet or soiled they should be provided with replacement will be offered.

On admission the patient will be screened for the symptoms and signs of COVID-

19. If any are present the procedure will be cancelled and the person advised to go home, self-isolate and contact their doctor for advice on testing.
If the patients reports that they have had signs of COVID-19 within 14 days of the procedure the procedure will be cancelled and the person advised to go home, self-isolate and contact their doctor for advice on testing

The patient will be admitted to a dedicated elective pre-operative area.

Post procedurally, the patient will be admitted to an area dedicated to planned care and including only patients who have had similar pre-procedural evaluation and testing.

On discharge the patient will be given an information leaflet including the means to contact the hospital or attend for unplanned care due to an unforeseen complication of the procedure e.g. G.P., a virtual clinic, the ASAU or AMAU for clinical examination rather than attending an undifferentiated care pathway (ED).

Item 5

Interim Guidance on the Management of Day Case Procedures – non-aerosol generating procedures (AGPs) e.g. non-invasive radiology, colonoscopy, minor procedures

This document does not supersede clinical judgment and describes methods to mitigate risks associated with delivering care to patients in whom there is no clinical suspicion of COVID-19 in an environment where SARS-CoV-2 is prevalent. It provides a framework for services that will need to be tailored to local conditions and specialty needs.

Before scheduling the procedure

All patients should have a pre-scheduling engagement that is virtual by telephone or other suitable means, to ascertain that they are not

1. Suffering from any symptoms or signs of COVID-19
2. Restricting their movements due to being a close contact of COVID-19
3. Suffering from acute infectious disease other than that related to the procedure
4. In direct contact (face to face meeting) with anyone who is suffering from the symptoms or signs of COVID-19.

They should be advised that if they develop symptoms of COVID-19 or are told that they are a Contact of COVID-19 that they should contact the hospital to re-schedule their procedure.

In addition, they need to be advised that they need a means to get to the hospital and a designated individual to stay with them for 12/24 hours after any procedure involving sedation or anaesthesia. It is preferable if the accompanying adult remains in the car but recognised that this may not always be possible. No children are to accompany individuals for procedures.

Note patients who have had COVID-19 and who are 14 days or more post onset of symptoms and with no fever for the last 5 days are regarded as non-infectious but may continue to have a positive test. They may have day case procedures with the same IPC precautions that apply to patients in whom there is no clinical suspicion of COVID-19. Repeat testing is generally not appropriate during the 12 weeks after diagnosis. If there is a specific concern please discuss the patient with a Consultant Microbiologist or Infectious Disease Physician.

Pre-procedural evaluation

Any pre-procedure evaluation is organised by the hospital. It is not the responsibility

of the patients GP to perform the evaluation.

Prior to admission

Patients should be sent an appointment time and asked to wait in their car, where possible and appropriate to their needs, until shortly before their appointment time. Included in this communication should be a patient information leaflet indicating the requirements pertaining to the procedure.

Patients should be reminded of the national recommendation to wear a cloth face covering when in indoor areas where distance cannot be maintained. They should wear a face covering when entering the building and while registering or waiting unless they are under 13 years or can't tolerate wearing the face covering. If they do not have a cloth face covering they should be provided with a facemask at reception/registration.
Patients and accompanying person should perform hand hygiene on arrival.

Once delivered, the accompanying adult will be asked; to return to their vehicle and to leave contact details for patient collection unless there is an adequately spacious waiting area or the patient needs them to be present.

Patients will be asked to keep their face covered, if tolerated except when in a clinical space and removal is required to facilitate communication, examination or the procedure. Should it become wet or soiled they should be provided with replacement will be offered.

On admission

The patient will be screened for the symptoms and signs of COVID-19. If any are present the procedure will be cancelled and the person advised to go home, self-isolate and contact their doctor for advice on testing.
If the patient's reports that they have had signs of COVID-19 within 14 days of the procedure the procedure will be cancelled and the person advised to go home, self-isolate and contact their doctor for advice on testing

Post procedurally, the patient will recover in an area dedicated to planned care and including only patients who have had similar pre-procedural evaluation. As soon as is reasonably practical and safe they will leave the hospital to return to their home.

Item 6 Interim Guidance on the Management of planned Hospital Admission

This document does not supersede clinical judgment and describes methods to mitigate risks associated with delivering care to patients in whom there is no clinical suspicion of COVID-19 in an environment where SARS-CoV-2 is prevalent. It provides a framework for services that will need to be tailored to local conditions and specialty needs.

It applies to planning for a hospital stay or planned interventions that may impact adversely on the patient outcome in the event that they are incubating or have undetected COVID-19 at the time of the procedure/treatment.
This includes surgery and immunosuppressant treatments such as chemotherapy or radiotherapy. In each case the treating clinician needs to consider the expected benefits of the procedure/treatment, the patients expressed preferences and the strength of evidence that the specific procedure or risk is associated with increased risk in the context of undetected COVID-19. The potential risk of spread of undetected COVID-19 to other patients and to healthcare workers must also be considered.

Note this guidance is not intended to create barriers to access to care. Where of necessity admission for care must be scheduled at shorter notice for practical reasons the approach outlined here may be adapted. For example the patient could be checked for symptoms or history or contact and be tested on the day of procedure/treatment before the procedure/treatment is administered if necessary.
For patients who require frequent scheduled admissions (for example some chemotherapy or radiotherapy regimens) at a minimum the patient could be checked for symptoms or history or contact in all cases. Testing of asymptomatic patients may be waived in some circumstances based on a risk assessment that takes account of current local epidemiology.

Before scheduling the procedure

Engagement 1

All patients should have a pre-scheduling engagement. Where possible this should be 14 days or more before the scheduled procedure. This engagement should be virtual, by telephone or other suitable means, to ascertain that they are not

1. Suffering from any symptoms or signs of COVID-19
2. Restricting their movements due to being a close contact of COVID-19
3. Suffering from acute infectious disease other than that related to the procedure

4. In direct contact (face to face meeting) with anyone who is suffering from the symptoms or signs of COVID-19.

They should be advised that if they develop symptoms of COVID-19 or are told that they are a Contact of COVID-19 that they should contact the hospital to re-schedule their procedure.

In addition, they need to be advised that they need a means to get to the hospital and a designated individual to stay with them for 12/24 hours after any procedure involving sedation or anaesthesia. It is preferable if the accompanying adult remains in the car but recognised that this may not always be possible. No children are to accompany individuals for procedures.

Note patients who have had COVID-19 and who are 14 days or more post onset of symptoms and with no fever for the last 5 days are regarded as non-infectious but may continue to have a positive test. They may be scheduled for hospital admission with the same IPC precautions that apply to patients in whom there is no clinical suspicion of COVID-19. Repeat testing is generally not appropriate. If there is a specific concern please discuss the patient with a Consultant Microbiologist or Infectious Disease Physician.

Reducing risk of acquiring COVID-19 in the pre-procedure period

Each individual, in so far as possible, should minimise their risk of exposure to others during the 14 days prior to admission. It is especially important that they avoid exposure to people with symptoms of COVID-19 but they are advised to limit exposure to others also to avoid risk of exposure to people who may have asymptomatic or pre-symptomatic infection.

The most effective measure is to cocoon for 2 weeks in advance of admission. Where this is not possible, it is recommended that contact is minimized with people outside of their immediate social group to the greatest possible extent and that social distancing, mask wearing and hand washing/ sanitizing is used to minimize infection risk.

If an individual is in a residential care setting, establish if there is COVID-19 transmission in the RCF and if so defer surgery or remove to another setting two weeks prior to admission.

Pre-procedural evaluation

With respect to each attendance at the hospital patients should be reminded of the national recommendation to wear a cloth face covering when in indoor areas where distance cannot be maintained. They should wear a face covering when entering

the building and while registering or waiting unless they are under 13 years or can't tolerate wearing the face covering. If they do not have a cloth face covering they should be provided with a facemask at reception/registration.
Patients and accompanying person should perform hand hygiene on arrival.

Once delivered, the accompanying adult will be asked to return to their vehicle and to leave contact details for patient collection unless there is an adequately spacious waiting area or the patient needs them to be present.

Patients will be asked to keep their face covered, if tolerated except when in a clinical space and removal is required to facilitate communication, examination or the procedure. Should it become wet or soiled they should be provided with replacement will be offered.

In addition, the patient needs means to get to the hospital. It is preferable if the accompanying adult remains in the car but recognised that this may not always be possible. No children are to accompany individuals for admission.
Pre-procedure evaluation is organised by the hospital. It is not the responsibility of the patients GP to perform the evaluation or arrange testing.

Within the 3 days prior to the procedure, the patient should attend to be assessed for clinical features of COVID-19 (signs or symptoms) and for a COVID-19 test (for example if the procedure is on Monday they should have the test taken on or after Friday). They should not have the procedure until it has been confirmed that their test has been reported not-detected.

Note in certain in some circumstances, if the hospital has capacity to provide the service, it may be preferable for the person to attend on the day of the procedure with rapid turn-around testing performed before the procedure is performed. In this case the assessment for clinical features (symptoms) should be carried out by telephone or video-link within the 3 days prior to the procedure.

Anesthesiology pre-assessment clinic

Pre-sedation, anaesthesia assessment

As much as can be should be assessed virtually and additional investigations and/or in person history and examination should be scheduled to occur on the same day as pre-procedural COVID-19 evaluation and testing to minimize the number of hospital visits.

At this time the patient's medical file can be made up and sent to their admission ward which should only care for patients with planned admission who been assessed to manage the risk of inadvertent introduction of COVID-19 as above.

Day of admission

Patients should not attend unless they have been informed that their COVID-19 test indicates “VIRUS NOT DETECTED” and given an attendance time.

On arrival the patient will be screened for the symptoms and signs of COVID-19. If any are present the procedure will be cancelled and the person advised to go home, self-isolate and contact their doctor for advice on testing.

If the patients reports that they have had signs of COVID-19 within 14 days of the procedure the procedure will be cancelled and the person advised to go home, self-isolate and contact their doctor for advice on testing

If there are not indications of COVID-19 the patient will be admitted to a dedicated elective pre-operative are

Post procedurally, the patient should be admitted to an area dedicated to planned care and including only patients who have had similar pre-procedural planning, screening and testing.

On discharge

The patient should be given an information leaflet including the means to contact the hospital or attend for unplanned care due to an unforeseen complication of the procedure whether it be the GP, a virtual clinic or the ASAU/ AMAU rather than attending an undifferentiated care pathway.

If being discharged to another healthcare or long stay residential centre (LSRC) after a stay case the patient should be tested for COVID-19 within 24 hours of discharge and consideration given to ‘cocooning’ on return to the LSRC for 14 days.

Surveillance

It is recommended that patients are reviewed for infection, including COVID-19 and surgical site infection occurs between 2 to3 weeks post discharge. In so far as possible this should be done virtually.

Item 7. Interim Guidance on the Peri-Procedural Period

Note this guidance is intended to support access to care with the lowest possible risk. It is intended that individual hospital and services will consider how the principles are implemented so as to manage risk but in a manner that does not inappropriately impede access to care

Patient having a planned procedure should have had 2 weeks 'cocooning' or social distancing, pre-screening for symptoms and signs and a COVID test with 'virus not detected' within the 3 days before of the procedure as outlined in '**Guidance on the**

These patients should not have significant contact (for example in waiting areas or clinical spaces) with patients who have not had prior similar evaluation to minimise the risk that they are unintentionally exposed to patients with COVID-19.

For theatres that are delivering on scheduled and unscheduled care, procedures should be put in place to avoid overlap between individuals from these patient cohorts.

Standard Precautions should be followed at all times with the additional wearing of surgical masks by healthcare workers within 2m of a patient as per NPHET recommendation.

Note. Guidance on the peri-procedural period for patients recovered from COVID-19 is the same as guidance for the general population. At present there is not sufficient evidence to advise that these patients

Induction

May occur in the anaesthetic room, suggest minimum staff present.
Standard Precautions for induction include surgical mask, non-sterile gloves, eye protection (where there is a risk of splashing) and a barrier such as a plastic apron.
Given the pre-assessment process the risk of undetected COVID-19 is extremely low. Airborne precautions are not routinely required.
Based on an individual risk assessment practitioners may consider use of a respirator mask in place of a surgical mask and a gown in place of a plastic apron.
for

Bag, mask ventilation
Intubation/ extubation
LMA insertion/ removal
Flexible optical intubation
For bronchoscopy – see bronchoscopy guidance
Naso-gastric tube insertion and airway insertion are not Aerosol Generating Procedures associated with an increased risk of infection (AGPs).

Note the use of Perspex barriers /boxes are not supported by evidence and are not recommended. If they are used the institution must have a documented process for decontamination between patients with appropriate traceability.

Transfer to theatre may occur as soon as the patient is ready due to the pre-admission risk mitigation actions.

In the theatre

In general Standard Precautions for an operative procedure are appropriate. There is no requirement for routine addition of additional precautions such as LMA removal in theatre, specified periods for air change in the theatre after each procedure or for any cleaning or decontamination beyond what is standard in an Operating Room.

Based on an individual risk assessment practitioners may consider use of a respirator mask in place of a surgical mask and a gown in place of a plastic apron

Post-operatively

Patients should be transferred to a dedicated area with patients who have undergone a similar pre-screening and testing process.