
Guidance to support scaling back up acute adult (non-maternity) hospital services
Coronavirus
OUT-PATIENTS
AUGUST 2020 v2

Contents

This document is the result of collaboration between the following organisations:

- Health Protection and Surveillance Centre
- National Clinical Adviser and Group Lead (Acute Operations)

Introduction

This guidance contains a compilation of updated versions of a set of documents previously issued separately by HSE Acute Operations for adult (non-maternity) services. They have been compiled into a single document for convenience. Paediatric and maternity services are outside the scope of this document.

In this document version, any guidance related to surgical services has been removed and incorporated into a separate new document – 'Guidance on the resumption of scheduled surgical services during the COVID-19 era'. This can be viewed on the HSE repository under the surgery section or by clicking here.

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 (AMRIC) Division of the Health Protection Surveillance Centre (HPSC).

Scope

The document is intended to support all those involved in scaling back up clinical services in acute hospitals over the coming weeks and is specific to the adult (non-maternity) setting.

Definitions of terms

COVID-19 testing	A laboratory test for SARS-CoV-2 RNA. The testing should be PCR for RNA, not serology for antibodies. If testing is required, swabbing should take place within three days of admission, the results of which must be available prior to admission.
COVID-19 risk assessment (Appendix 1)	A series of questions designed to assess symptoms or exposure to COVID-19, these may be in the form of a questionnaire, telephone or virtual health assessment. COVID assessment needs to take place; • virtually at 14 days prior to admission/procedure • virtually 7 days prior to admission/procedure (where practical) • within three days prior to any hospital attendance • on arrival at the hospital
Minimising exposure risk (Cocooning)	Minimising exposure risk is achieved by limiting interactions with individuals outside of a person's household and good infection prevention and control practices. The purpose of minimising exposure risk (cocooning) prior to a scheduled admission or procedure is to minimise the risk of acquiring COVID-19 in the community. Minimising exposure risk and testing for SARS-CoV-2 (where appropriate), minimises the risk of a patient having a scheduled admission or procedure with undetected COVID-19 and thus minimises the risks associated with peri-procedure COVID-19. In this regard, it is a patient safety strategy. It also reduces the risk of exposure of healthcare

	workers to undetected COVID-19. More details can be found at: https://www2.hse.ie/conditions/coronavirus/cocooning.html
Non-COVID pathway	For patients who have undergone assessment for COVID-19 and who: • have not shown any signs or symptoms of COVID-19 in the last 14 days • have not been identified as a COVID-19 contact AND where applicable • have had a 'virus not detected' result on a sample taken within the three days prior to attendance
National Risk Designation	National risk designation, Yellow status <20 cases / 100,000 population* – TEST GENERALLY NOT REQUIRED Orange / Amber / Red ≥ 20 cases / 100,000 population* – TEST GENERALLY REQUIRED This will be determined by a 14 day cumulative review of incidence, local clusters and outbreaks in community and hospital settings and will be issued to hospitals Monday to Friday Yellow, orange, amber or red may be overlaid by local information and result in enhanced measures. *European Centre for Disease Control (ECDC) (August 2020)
Virtual clinic	A non face-to-face method of clinical review that can either be by telephone or video. An information technology platform can be used which allows for video interaction between health care worker and patient. It is imperative to document the platform used in the patients' clinical notes and that consent has been obtained for this type of consultation.

Section 1. Healthcare worker (HCW) algorithm

Daily Self-Assessment for Staff

Healthcare Worker Algorithm
Pre-work check for COVID-19

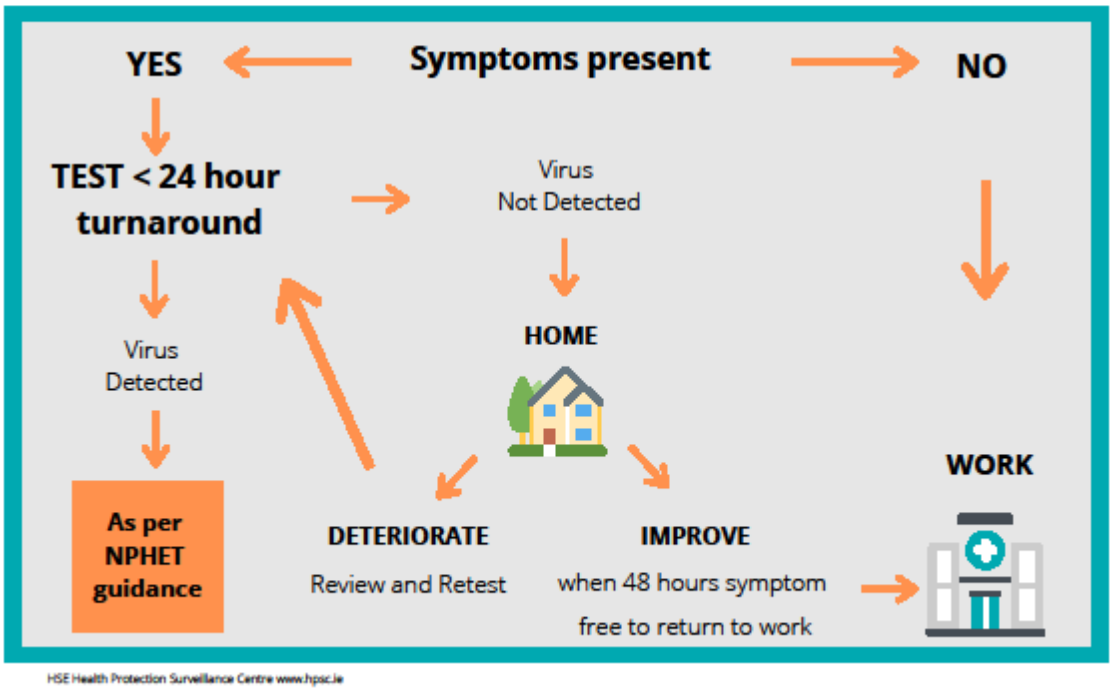
Most Common Symptoms

- Cough
- Fatigue
- Shortness of Breath
- Fever >38.0C
- Myalgia
- Loss of Taste / Smell

Less Common Symptoms

- Anorexia
- Dizziness
- Conjunctival Congestion
- Diarrhoea
- Sputum Production
- Headache
- Chest Pain
- Nausea / Vomiting
- Sore Throat
- Rhinorrhoea
- Haemoptysis
- Abdominal Pain

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



In-patient pyrexia and /or new signs or symptoms of COVID-19 algorithm

Consider possibility of COVID-19
Incubating but not evident on admission or health care associated infection

Actions:

- Clinical review
- Tests and investigations as per history and clinical findings
- Management as per differential diagnosis
- Implement Contact and Droplet Precautions
- Take COVID-19 swab for SARS-CoV-2 testing

SARS-CoV-2 Detected

Continue Contact and Droplet precautions and transfer to C19 care area / ward

Refer to Acute Hospital IPC Guidance for a suspected case of hospital acquired COVID-19 in an inpatient.

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

Suspect C19

Continue Contact and Droplet precautions

Retest is likely to be appropriate

Section 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 or having laboratory and radiology tests undertaken ("one stop shop").
4. Deliver OPD services by appointment only.
5. Where possible, in the day or two before the appointment, issue a text reminder to the patient that they should not attend if they have symptoms of COVID-19. 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 car and where possible and appropriate to the patient's 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 by a carer
7. Pre-review and cohort all required OPD attendees (per specialty criteria) to a designated provider. For each clinic, document in the OPD appointments system the designated clinician for each patient and other staff. Update if changes occur on the day of clinic.
8. At the time of arrival or check-in, pre-assess all OPD attendees (with appropriate supports for vulnerable groups) for symptoms of COVID-19: fever, cough, shortness of breath OR lethargy, confusion, loss of appetite, include loss of sense of taste or smell, unexplained change in baseline condition and also enquire whether the patient has been told they are a contact of a person with COVID-19 in the past 14 days

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 five 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 in people with a previous confirmed diagnosis of COVID-19 unless there is a specific clinical indication. If there is a specific concern, please discuss the patient with a Consultant Microbiologist or Infectious Disease Physician.

Staff Vaccination Programme

Hospitals should actively promote the seasonal influenza vaccine uptake and facilitate in-hospital clinics and allocated time.

Patient actions:

1. Further information available at: https://www2.hse.ie/conditions/coronavirus/protect-yourself-and-others.html
2. Do not attend for the outpatient visit if new symptoms of COVID-19 are present.
3. Patients and their carers should be actively encouraged to have the seasonal influenza vaccination.
4. Patient information leaflets can be downloaded from https://hse.drsteevenslibrary.ie/c.php?g=679077&p=4872978

Section 4: Testing for SARS-CoV-2 prior to scheduled admission or admission for a procedure involving an AGP

Testing is only recommended for patients who are to undergo an aerosol generating procedure or a planned admission and only when the patient is from an area of high prevalence.

In this iteration of the guidance, control is given to the hospital to determine its risk level using data provided centrally and, based on local prevalence, to decide whether testing is required to be part of the patient pathway. In general, the recommendation is that, in the absence of local or specialty-based needs, in a low prevalence environment (14-day cumulative new <20 cases/100,000 population) testing would not be required unless there were local epidemiological pressures and that in the higher prevalence environment i.e. ≥20 new cases/100,000/14 days testing would be included as part of the pathway.

The risk assessment of the hospital and its environment should be done in a regular and structured way with a multidisciplinary team including infection prevention and control, clinical director, management and nursing with clear communications lines. The data used to inform this decision would include the HPSC 14-day epidemiology report, Health Atlas COVID cases map and hospital local epidemiological information.

- A national risk designation will be determined by a 14-day cumulative review of incidence, local clusters and outbreaks in community and hospital settings and will be issued to designated contacts in hospitals and acute operation programme leads regularly, as determined by local risk assessment team
- Each hospital should have a multi-disciplinary team with representation from clinical leads in Microbiology/ID/IPC and a clinical director, with representation from management and nursing that will govern the review the national risk designation to determine requirements for COVID-19 testing prior to scheduled admission or admission for procedures involving AGPs
- It is suggested that this team meet twice weekly (Monday and Thursday) in the first instance and then as epidemiologically indicated, to review the latest information and have an effective communication mechanism to ensure the information is easily accessible for departments scheduling admissions and procedures.

National risk designation

	National risk designation			
	Yellow status	Orange,	Amber	Red
Data	<20 cases / 100,000 population/14 days	20.0 – 59.9 Orange 60.0 – 119.9 Amber ≥120.0 Red cases / 100,000 population/14 days		
Requirements	COVID-19 risk assessment required Pre-procedure SARS-Cov-2 RNA TEST not required unless locally indicated	COVID-19 risk assessment required **PLUS** Pre-procedure SARS-Cov-2 RNA TEST REQUIRED unless there is an up-to-date risk assessment justifying an exception		
	Yellow, orange, amber or red may be overlaid by local epidemiological information and result in enhanced measures			

***Status Yellow Definition:* <20 cases / 100,000 population/14 days**

- All patients should have a COVID-19 risk assessment carried out
- Patients generally DO NOT REQUIRE pre-procedure SARS-Cov-2 RNA TEST unless locally indicated

Summary: There is no national recommendation to test patients for SARS-CoV-2 unless the risk assessment determines that there is a risk due to geographical location or presence of symptoms. However, local adaptations for specific services may apply.

***Status Orange, Amber or Red Definition:* ≥ 20 cases / 100,000 population/14 days**

- All patients should have a COVID-19 risk assessment carried out
- If the patient is living in an area of higher COVID-19 incidence, then a pre-procedure test for SARS-CoV-2 is generally required for all patients who require an aerosol generating procedure, whether a day case or planned admission. Exceptions should be justified by up-to-date risk assessment
- If a procedure is delayed but is carried out within the same day, then COVID-19 test remains valid
- If a procedure is delayed and will not take place that day then the test will need to be repeated if the interval between testing and rescheduled admission is more than three days
- If a situation arises where pre procedure testing was indicated but was not carried out, or the result is not available, these cases should be risk assessed on a case-by-case basis to

determine if the procedure can go ahead and whether PPE needs to be escalated to that of a COVID-19 unknown case.

- 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 the 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 after diagnosis. If there is a specific concern, please discuss the patient with a Consultant Microbiologist or Infections Disease Physician

Summary: Where local prevalence rates are ≥ 20 cases / 100,000 population/14 days *it is recommended nationally to carry out a COVID-19 risk assessment* ***AND*** *test patients for SARS-CoV-2 prior to scheduled admission*

Section 5. – Interim guidance on the management of day case procedures that may or may not involve 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.

Guidance specifically related to surgical services is also provided in a separate new document – 'Guidance on the resumption of scheduled surgical services during the COVID-19 era'. This can be viewed on the HSE repository under the surgery section or by clicking here.

Guidance specifically related to endoscopy services is provided in a separate document. This can be viewed on the HSE repository here.

Before the procedure

- Pre-procedure evaluation is organised by the hospital. It is not the responsibility of the patient's GP to perform the evaluation or to arrange COVID (SARS-CoV-2) testing, where it is indicated
- Within three days prior to procedure date, the patient should be telephoned to confirm they have not been exposed to COVID-19 within their social circle and currently have no clinical features for COVID-19, using the COVID-19 assessment questionnaire (Appendix 1)
- COVID-19 assessment questionnaire must be repeated on the day of the procedure
- They should be advised that if they develop symptoms of COVID-19 or are told that they are a contact of a person with 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 or returns to collect the patient afterwards, but recognised that this may not always be possible. No children are to accompany individuals for procedures

For certain day case procedures that involve general anaesthesia or other aerosol-generating procedures (AGPs), pre-procedure testing for SARS-CoV-2 may be required based on the epidemiological situation, as described earlier in this document. If a pre-procedure test is required it should be carried out within the three days prior to the procedure and ideally at the same visit, the COVID assessment questionnaire can be performed.

Sampling and testing for COVID-19 may be carried out elsewhere, but COVID testing results must be available prior to patient admission.

A local protocol outlining the pathway for swabbing must be established. It must detail where COVID testing will be performed, by whom and the appropriate pathway for communication with and transportation of specimens to the laboratory. The protocol should also outline how these results will be communicated to the team and how the team will communicate with the patient. This protocol must also accommodate the return of test results for scheduled procedure following the weekend and a bank holiday

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 five of those 14 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 in people with a previous confirmed diagnosis of COVID-19 unless there is a specific clinical indication. If there is a specific concern, please discuss the patient with a Consultant Microbiologist or Infectious Disease Physician.

Pre-sedation or pre-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 (where indicated) to minimize the number of hospital visits.

Procedure day

- A specific time for attendance should be given to the patient in advance to assist with social distancing
- If patients have travelled by car, they should wait in the car until just before their appointment time

- If patients are travelling using public transport, it is mandatory that they wear a face covering
- Patients and accompanying adult should wear a face covering in public spaces if social distancing cannot be maintained. They will be provided with one if they do not have one. Should the face covering become wet or soiled a replacement will be offered. Touching face covering or face is not recommended
- Patients and accompanying adult should be offered the opportunity to clean their hands with alcohol-based hand rub when entering hospital or after touching face covering
- If accompanied by a friend or relative, this person should wait outside of the hospital, where possible until it is confirmed that the procedure will go ahead as scheduled
- On arrival, the patient will undergo a repeat COVID-19 assessment questionnaire. If any symptoms are present the patient should have appropriate assessment and if appropriate, the procedure may be deferred
- If the procedure is deferred, due to the patient having symptoms of COVID-19 then immediate care should be arranged and appropriate follow-up from the clinical team must be arranged
- In the event of deferral of a procedure, the patient must be advised to follow HSE guidelines on COVID-19 including contacting their GP

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

On discharge the patient will be given an information leaflet, including the contact information for the hospital or advised where to attend for in the event of any complication of the procedure (e.g. GP, a virtual clinic, the ASAU or AMAU and only in the case of an emergency, to the Emergency Department).

Section 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.

Guidance specifically related to surgical services is also provided in a separate new document – 'Guidance on the resumption of scheduled surgical services during the COVID-19 era' This can be viewed on the HSE repository under the surgery section or by clicking here.

This guidance 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 immunosuppressant treatments, such as chemotherapy or radiotherapy. In each case, the treating clinician needs to consider the expected benefits of the procedure/treatment, the patient's 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 accessing care. Where necessary, if admission for care must be scheduled at shorter notice for practical reasons, the approach outlined here may be adapted.
For patients who require frequent scheduled admissions (for example some chemotherapy or radiotherapy regimens), at a minimum the patient should 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 the admission or procedure

Once the patient has been deemed to require inpatient admission, a member of staff must inform the patient of the admission date and the requirement to minimize exposure to risk of COVID-19 (cocooning) prior to admission. For more information, refer to;
https://www2.hse.ie/conditions/coronavirus/cocooning.html

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 admission. It is not the responsibility of the patient's GP to perform pre-admission evaluation.
Within 14 days prior to admission, the patient should be telephoned to confirm that they are following advice to minimize exposure risk and to confirm they have not been exposed to COVID-19 within their social circle have currently have no clinical features for COVID-19.

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.

For certain admissions, pre-procedure testing for SARS-CoV-2 may be required based on the epidemiological situation as described earlier in this document. If a pre-admission test is required it should be carried out within the three days prior to the scheduled admission and ideally at the same visit, the COVID assessment questionnaire can be performed.

Where testing for COVID-19 is required, patients should be specifically advised to self-isolate between having their pre-procedure SARS-CoV-2 test and coming into hospital for their procedure

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 five of those 14 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.

Day of admission

- A specific time for attendance should be given to the patient in advance to assist with social distancing
- If patients have travelled by car, they should wait in the car until just before their appointment time

- If patients are travelling using public transport, it is mandatory that they wear a face covering

- Patients and accompanying adult should wear a face covering in public spaces if social distancing cannot be maintained. They will be provided with one if they do not have one. Should the face covering become wet or soiled a replacement will be offered. Touching face covering or face is not recommended
- Patients and accompanying adult should be offered the opportunity to clean their hands with alcohol-based hand rub when entering hospital or after touching face covering
- If accompanied by a friend or relative, this person should wait outside of the hospital, where possible until it is confirmed that the admission will go ahead as scheduled
- On arrival, the patient will undergo a repeat COVID-19 assessment questionnaire. If any symptoms are present the patient should have appropriate assessment and if appropriate, the admission may be deferred
- If the admission is deferred, due to the patient having symptoms of COVID-19 then immediate care should be arranged and appropriate follow-up from the clinical team must be arranged
- In the event of deferral of an admission, the patient must be advised to follow HSE guidelines on COVID-19, including contacting their GP

Appendix 1 COVID-19 Assessment Questionnaire

HOSPITAL LOGO

COVID-19 Risk Assessment

Patient Details

Affix Patient Label or Complete

Patient Name:_____ DOB: _____

Consultant:_____ Patient MRN: _____

Risk Assessment Form Completed

Date: _____

Planned attendance / admission

Date:_____

COVID-19 Exposure Risk

1. Has the patient been diagnosed with COVID-19 in the last 14 days ?	**Yes / No**
2. Has anyone in the patient's family, work or social circle tested positive for Coronavirus in the last 14 days?	**Yes / No**

If the answer is Yes to any of the above questions, recommend deferring procedure for 14 days and provide advice on following public health advice. If answer is No to both questions above, proceed to Question 3

3. Has the patient been physical distancing / cocooning?	**Yes / No**

If the answer is No, provide advice on the importance of cocooning and proceed to assessing COVID-19 signs and symptoms

COVID-19 Signs and Symptoms

Has the patient had an acute onset of any of the following signs or symptoms in the last 14 days? Tick if present ☑

Fever / Chills		Dizziness*		NOTES
Dry Cough		Diarrhoea*		
Shortness of breath		Sputum Productions +/ - Blood staining*		
Fatigue / muscle tiredness		Abdominal Pain*		
Sudden loss of smell or taste		New Confusion**		
Nausea/ Vomiting*		Lethargy**		
Chest Pain*		Loss of Appetite**		
Sore Throat*		Unexplained change in baseline**		

*Less Common Symptoms ** More likely in an older populations

If the patient has experienced an acute onset of any of the above symptoms, recommend deferring the procedure due to the suspiscion of COVID-19. Advise patient to follow public health advice, isolate and contact GP.

PAGE 1 of 2

Please complete the reverse side of this form.

(COV- AHO COVID Screening) 4.8.20 DV 8

HOSPITAL
LOGO

COVID-19 Risk Assessment

Affix Patient Label or Complete

Patient Name:_____ DOB: _____

Consultant:_____ Patient MRN: _____

COVID-19 Advice on when to test

A. If the patient is living in an area of low prevalence i.e. Status Yellow, then there is no need to test for Coronavirus. If they are living in an area of Amber or Red prevalence status, then testing is recommended for all patients who require an aerosol generating procedure, whether a day case or planned admission

B. The requirement for testing does not apply to patients who have had COVID-19 (lab confirmed) and who are 14 days or more post onset of symptoms and with no fever in the last 5 days. These patients are regarded as non-infectious but may continue to have a positive test. Repeat testing is generally not appropriate.

C. There is no national recommendation to test patients if there is low exposure risk and no acute symptoms. However, local adaptations for specific services may apply

Is the patient living in an area of low prevalence (Yellow status)?	Yes / No

If **YES**, then testing is not required due to a low exposure risk
If **NO**, then organise testing for Coronavirus within three days of attendance at hospital

CORONAVIRUS Test Information

TEST NOT REQUIRED ❒	TEST REQUIRED ❒
Procedure to go ahead	Date Sample taken: _____
NOTES	Date of Result: _____
	TEST RESULT
	VIRUS DETECTED ❒
	VIRUS NOT DETECTED ❒
	INDETERMINATE ❒
	Note: If the result is INDETERMINATE, recommend repeat

Result of COVID-19 Risk Assessment

Proceed ❒ Defer Procedure ❒ Results/Information Pending ❒

Completed by: _____ **Signature:**_____

Date : _____ **Time:** _____ **PIN/IMC:**_____

(COV- AHO COVID Screening) 4.8.20 DV 8

References

European Centre for Disease Control: (2020) **Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK – eleventh update: Resurgence of cases**. Available from: **https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-rapid-risk-assessment-20200810.pdf/ Accessed 24th August 2020.**