Coronavirus Disease (COVID-19) Interim Policy

Site	Service/Department/Unit	Disciplines
SCGH	Hospital-Wide	All Staff

Contents

Introduction

Coronaviruses are a large group of viruses that can cause illnesses ranging from a mild common cold to severe disease such as Severe Acute Respiratory Syndrome (SARS). The novel coronavirus disease (COVID-19) was recently identified in December 2019 and is caused by the newly identified SARS CoV-2 virus.[1]

Policy principles

This policy provides details on the infection prevention and management for COVID-19.

This policy relates to all staff involved in the management of patients with COVID-19 at SCGH.

Note: This policy does not apply to the COVID Clinic, separate guidelines are available for this area.

This policy is based on current available knowledge of the transmission of coronaviruses and may change as more evidence becomes available specifically regarding COVID-19.

1. Patient assessment

A risk assessment of travellers returning from overseas within the last 14 days with an acute respiratory illness who present to the Emergency Department (ED), are directly admitted, or attend an outpatient appointment should be performed immediately. The Communicable Diseases Network of Australia (CDNA) National Guidelines for Coronavirus Disease 2019 (COVID-19) (external link) define suspect cases according to clinical and travel history.[2] Assessment of patients presenting to SCGH should be based on the latest guidance from CDNA or WA Department of Health.

The differential diagnosis of acute respiratory illness in a traveller includes common viral aetiologies such as seasonal influenza that also occur locally. If the risk assessment determines that the patient does not have suspected COVID-19, they should be managed in accordance with the SCGH Infection Prevention and Control Influenza-like Illness Policy #08.

2. Patient management

Patients presenting to the Emergency Department (ED)

Patients presenting with symptoms suggestive of respiratory tract infection (e.g. cough, fever) should be given a surgical mask to wear immediately, regardless of travel history. The triage assessment should be completed, including obtaining a travel and contact history. If the patient meets the suspect case definition, they will require transmission-based precautions in the ED.

Patients are to be admitted to an Airborne Infection Isolation Room (AIIR), if available. If the number of suspected or proven COVID-19 patients is in excess of the available AIIRs in ED then patients with mild symptoms, who do not require aerosol-generating procedures AGPs), may be placed in a designated COVID-19 assessment area in ED on contact and droplet precautions for further assessment.

Contact and airborne precautions must be implemented for patients who are critically unwell or with symptoms suggestive of pneumonia (e.g. fever and breathing difficulty or frequent, severe or productive coughing episodes), or who are likely to require aerosol-generating procedures (AGPs). Refer to Appendix 2 for details on AGPs.

Any person entering the room must don personal protective equipment (PPE). Refer to section 9.

Conduct a medical assessment and collect respiratory specimens as outlined in Section 10 and Appendix 3.

If a patient is determined to be a suspect case (i.e. the patient is being tested for COVID-19), but does not require admission, advise the patient to self-isolate at home, if not already, and minimise contact with other people. Provide the patient with the Australian Government "*Home Isolation Guidance when unwell (suspected or confirmed cases)*" fact sheet available on the Department of Health website. Ensure patient is aware that further testing may be required if they deteriorate or the illness persists beyond 72 hours and no other cause is found.

Ensure arrangements are in place for the patient to be contacted with the test result.

If the patient requires admission, the Infection Prevention and Control (IP&C) unit **must be notified immediately** during working hours (8am-4.30pm Monday-Friday). After hours, the on-call clinical microbiologist must be notified.

Transporting patients from ED to the ward
The patient should wear a surgical face mask during transportation if possible. Patients on oxygen therapy should be changed to nasal prongs, if safe to do so, and wear a surgical face mask.

Accompanying staff must wear a long sleeve fluid repellent gown, surgical mask, disposable full face visor and gloves (ensure the gloves cover the cuffs of the gown sleeve). Refer to Section 9. A new set of clean PPE must be donned prior to transporting the patient.

Transfer the patient to the ward via the Gold lifts. **Ensure no visitors or other staff are in the lift during transfer.**

Direct admissions to SCGH
The Infection Prevention and Control Unit **must be notified immediately** during working hours (8.00am-4.30pm Monday-Friday). After hours, the on-call clinical microbiologist must be notified.

Persons accompanying patient / Visitors
In general visitors would be restricted. If this is unavoidable for medical reasons the accompanying person(s) must be trained to wear personal protective equipment (PPE) as per Section 9.

3 In-patient management

Patient placement

Patients are to be admitted to an AIIR, if available. In determining the placement of patients the following principles will apply. Discuss the case with the IP&C unit or the on-call clinical microbiologist if unsure.

Patients with mild symptoms, who **do not** require aerosol-generating procedures, may be placed on droplet precautions after discussion and approval by the IP&C unit and/or the on-call clinical microbiologist.

Contact and airborne precautions are to be implemented for patients who are critically unwell or with symptoms suggestive of pneumonia (e.g. fever and breathing difficulty or frequent, severe or productive coughing episodes), or who are likely to require aerosol-generating procedures. If an AIIR is not available discuss patient placement with the IP&C unit or the on-call clinical microbiologist. Refer to Appendix 2 for details on AGPs.

In-patients requiring airborne precautions
Patients with symptoms suggestive of pneumonia e.g. fever, difficulty in breathing, or frequent, severe, productive cough are to be nursed in an AIIR.

- Place a blue ‘airborne precautions’ sign on the door outside the AIIR. The door must be kept closed and negative pressure activated.
- Non-essential staff must not enter the AIIR (refer to full list of staff restrictions in Section 18)
- Personal Protective Equipment (PPE) for airborne precautions must be worn - Refer to Table 1
- For correct donning and doffing of PPE refer to Appendix 1.

In-patients requiring droplet precautions
The use of droplet precautions for patients with suspected or confirmed COVID-19 must be discussed with and approved by the IP&C unit and/or the on-call clinical microbiologist

- Contact and droplet precautions are recommended for routine care of the patient suspected or confirmed to have COVID-19 with mild illness or no symptoms
- Admit patient to a single room with the door closed. Place a green ‘droplet precautions’ sign on the door
- No aerosol-generating procedures are to be performed
- Non-essential staff must not enter the room (refer to full list of staff restrictions in Section 18).

4 Cohorting of in-patients

If the number of patients being admitted with suspected or confirmed COVID-19 exceeds the AIIR or single room capacity, it may be necessary to cohort patients. Cohorting of patients must only be undertaken under the direction of the IP&C unit and/or the on-call clinical microbiologist. Patients with COVID-19 are not to be cohorted with patients who have NOT been diagnosed with COVID-19.

5 Duration of transmission-based precautions

Transmission based precautions should only be discontinued on advice from the IP&C unit or a clinical microbiologist.

Criteria for release of a proven COVID-19 patient from isolation are included in the CDNA Guidelines[2]

6 Visitors

In general no visitors would be allowed. If this is unavoidable for medical reasons the accompanying person(s) must be trained to wear personal protective equipment (PPE) as per Section 9.

7 Transporting patients / transfer to other departments/HCFs

- Interdepartmental transfers should be restricted unless patient management will be compromised (e.g. admission to intensive care, dialysis or procedural investigations)
- The receiving department must be notified prior to transfer
- The patient should wear a surgical face mask during transportation if possible. Patients on oxygen therapy should be changed to nasal prongs, if safe to do so, and wear a surgical face mask for transport.
- The HCW accompanying the patient must don a new set of PPE prior to transfer, so they are not wearing the same PPE they had on in the patient room, The HCW is to wear a long sleeve fluid repellent gown, surgical mask, disposable full face visor and gloves (ensure the gloves cover the cuffs of the gown sleeve).
- Ensure no visitors or other staff are in the lift during transfer
- HCWs must remove PPE prior to leaving the receiving department and perform hand hygiene
- A disinfection clean of the area and equipment used on the patient is required once the patient has left the room.
- Transfers to other HCFs should be limited unless necessary for medical care. If the patient is being transferred to a different health care facility the receiving facility must be notified prior to transport.

8 Cough etiquette

- Encourage the patient to cover their nose and mouth with a tissue when coughing
- Promptly dispose of used tissues into the waste bin
- Perform hand hygiene after contact with respiratory secretions.

9 Personal protective equipment

Standard precautions, including the 5 moments for hand hygiene are to be implemented for all patients in conjunction with the following transmission-based precautions:

- **Contact** and **droplet** precautions are recommended for **routine care** of the patient with **mild illness or no symptoms** and who do not require aerosol-generating procedures. The following PPE to be donned prior to entering the patient's room: long sleeved gown, surgical mask, full face visor or goggles and gloves

- **Contact and airborne** precautions are recommended when managing a patient:
  - with symptoms suggestive of pneumonia (e.g. fever and breathing difficulty or frequent, severe or productive coughing episodes),
  - who requires frequent interventions outside the Intensive Care Unit (ICU)
  - likely to require aerosol-generating procedures (AGPs).

The PPE required includes long sleeved gown, P2(N95) mask (fit check required), full face visor or goggles and gloves.

- Patients admitted to ICU with severe COVID-19 are likely to have a high viral load. Contact and airborne precautions are required. The use of the powered air purifying respirator (PAPR) may be considered for comfort and visibility if the HCW is anticipating care for long periods of time e.g. greater than one hour.

Table 1: Guidance for PPE use by HCWs providing direct patient care

	Asymptomatic patients meeting home isolation criteria	COVID-19 is suspected or confirmed in patient with mild symptoms	COVID-19 is suspected or confirmed in patient with symptoms of pneumonia
Inpatient precautions	Contact & Droplet	Contact & Droplet	Contact & Airborne
Room type	Single room with ensuite, door closed	AIIR preferred, if not available single room with ensuite, door closed	AIIR
PPE	Surgical mask Long sleeved gown, protective eyewear, gloves	Surgical mask Long sleeved gown, protective eyewear, gloves	P2 (N95) mask Long sleeved gown, protective eyewear, gloves
Specimen collection	Surgical mask Long sleeved gown, protective eyewear, gloves	Surgical mask Long sleeved gown, protective eyewear, gloves	P2 (N95) mask Long sleeved gown, protective eyewear, gloves
Aerosol generating procedures	P2(N95) mask Long sleeved gown, protective eyewear, gloves Perform in AIIR	P2(N95) mask Long sleeved gown, protective eyewear, gloves Perform in AIIR	P2 (N95) mask Long sleeved gown, protective eyewear, gloves Perform in AIIR

See Appendix 1 for donning and doffing sequence and fit checking procedure
See Appendix 2 for Aerosol Generating Procedures

10 Specimen collection

When collecting respiratory specimens from patients with suspected or confirmed COVID-19, transmission-based precautions must be observed whether or not respiratory symptoms are present.

For most patients with mild illness, collection of upper respiratory specimens is a low risk procedure and should be performed using a single room with the door closed and **contact** and **droplet** precautions.

Where patients have severe symptoms suggestive of pneumonia, then contact and airborne precautions should be observed.[2]

Note: Testing for other endemic respiratory viruses should also be included.
Samples for testing may include:

a) Upper respiratory tract samples – nasopharyngeal and/or oropharyngeal flocked swabs or nasal wash/aspirates

b) Lower respiratory tract samples (must be collected using contact and airborne precautions in an AIIR) – sputum, bronchoalveolar lavage, tracheal aspirate, pleural fluid
c) Serum – to be stored pending serology availability

Refer to Appendix 3 for specimen collection guidelines.

Specimens should be transported directly to Central Specimen Reception Area (CSRA) by a HSA. **DO NOT** use the pneumatic tube system.

11 Linen management

- Standard precautions apply to the handling of all soiled linen from patients with confirmed or suspected COVID-19
- The linen skip is to be lined with a red soluble plastic bag and kept inside the patient room.
- Ensure both soluble red bag and the cloth linen bag are securely tied prior to transporting from the patient room to collection area.
- Wear gloves when transporting soiled bagged linen to the dirty linen trolley
- Perform hand hygiene after removal of gloves after contact with soiled linen and laundry
- There is no need to wear surgical or P2 (N95) masks or protective eyewear when handling soiled bagged laundry
- Stockpiling supplies of linen in the patient rooms is not to occur and any unused linen is to be sent for laundering and not returned to general use.

12 Catering

- Catering staff must not enter the rooms. Nursing staff are to deliver and collect the patient's meal tray, crockery and cutlery and **must wear PPE** as per Section 9.
- Standard precautions should be used when handling used crockery and cutlery.
- Crockery and cutlery may be returned to the kitchen in the usual way. The combination of hot water and detergents used in the automatic dishwashers is sufficient to decontaminate these items
- Disposable crockery and cutlery are not required
- Unopened food items or food waste is to be discarded into general waste.

13 Patient care equipment

- Keep equipment in the rooms to a minimum
- Disposable, single-use patient care equipment should be used when possible and disposed of into appropriate clinical waste after use
- Dedicate non-critical equipment to the room e.g. stethoscope, tourniquet
- Patient charts must be left outside the room. If patient is in an AIIR the charts may be left in the anteroom
- Reusable medical devices/equipment, e.g. pulse oximeter is to be cleaned with surface cleaner or detergent wipes followed by disinfection with alcohol impregnated wipes and allowed to dry before removal from the room. A combined 2 in 1 disinfectant wipe may also used

- Unused disposable items e.g. dressings, kidney dishes to be discarded on patient's discharge
- If any equipment is to be returned to Sterilisation Services place return in the usual way. If equipment cannot be returned to Sterilisation Services contact the Infection Prevention and Control Nurses for advice
- ICU must ensure mechanical ventilation equipment is protected with viral filters and utilisation of inline suction systems.

14 Environmental cleaning

Staff performing daily and terminal cleaning must wear PPE as per Section 9.

Daily cleaning
A daily disinfection clean with a combined detergent and disinfectant e.g. Chloradet is required. An increase in cleaning frequency may be advised by IP&C unit

Terminal cleaning
Airborne Isolation Infection Rooms – Airborne precautions
On patient discharge maintain negative pressure for 30 minutes prior to commencing cleaning and disinfection processes.

Single rooms - Droplet precautions
The room can be cleaned directly after the patient has been discharged from the room

- Follow Standard Operating Procedure COVID-19 Daily and Discharge cleaning guidelines for isolation room.
- All disposable items in the room are to be discarded on discharge
- A hydrogen peroxide disinfection clean (Nocospray®) **is not required** on discharge
- The rooms can be used following completion of cleaning once all surfaces are dry.

15 Disposal of waste

- Standard precautions apply
- All waste shall be bagged and securely sealed prior to exiting from patient room
- Dispose of all waste into the clinical waste bin.

16 Management of the deceased

Staff must wear PPE as per Section 9. In the event of death a surgical face mask is to be placed on the deceased prior to movement of the body and the patient placed in a body bag, this must be completely sealed. Inform the mortuary prior to transfer of patients if the patient is suspected or confirmed to have COVID-19.

17 Patient discharge

If the patient is discharged prior to meeting the criteria for release from isolation (CDNA National Guideline), ensure the patient and family members are instructed on appropriate home isolation guidance until cleared. The Australian Government Department of Health Fact sheets must be provided *Home Isolation Guidance when*

unwell (suspected or confirmed cases) and *Isolation Guidance* for their close contacts. Latest fact sheets are available on the Department of Health website.

18 Healthcare worker management

General

- Only essential staff should enter the patient's room

- Where possible, dedicated staff should manage the patient suspected or confirmed with COVID-19.

The following HCWs must not care for a suspected or confirmed case of COVID-19;

- pregnant women
- individuals with chronic respiratory conditions including asthma, chronic obstructive pulmonary disease (COPD)
- morbidly obese
- persons with chronic illness predisposing to severe disease such as:
    - cardiac disease, excluding simple hypertension
    - diabetes mellitus
    - chronic renal disease
    - haemoglobinopathies
    - immunosuppression, including that caused by cancers, medications or by HIV/AIDS infection
    - chronic neurological conditions

HCW surveillance

- A register of all HCWs entering the room of a suspected or confirmed case of COVID-19 will be kept by the Nurse Manager (Refer to Appendix 4.) to allow for monitoring of potential IP&C breaches and contact tracing. A copy of the register must be sent to the Department of Occupational Safety and Health (OSH)

- In the event of unanticipated patient contact without proper PPE contact OSH or the on-call clinical microbiologist

- HCWs must self-monitor for fever and other symptoms for 14 days
- Exposed staff who develop symptoms of a respiratory illness must:
    - Immediately exclude themselves from the workplace
    - report the illness to their supervisor (who should inform the Infection Prevention and Control Unit and Occupational Safety and Health)
    - present for COVID-19 testing

The period of exclusion from work will be determined in individual cases.

- HCWs working across multiple sites must inform all their line managers they have been caring for a patient with suspected or confirmed COVID-19

- HCWs who have taken recommended IP&C measures, including the correct use of PPE, while caring for a confirmed case of covid-19 are not considered close contacts unless there has been a breach of PPE.

19 Contact management

Due to the emerging information regarding the infectivity and transmission of COVID-19 refer to the National Guidelines for Coronavirus Disease 2019 (COVID-19) (external link). for definitions of contacts and the management of contacts. Contact tracing will need to be undertaken by the IP&C unit for inpatients and Occupational Safety & Health for HCWs.

Close contacts require self-quarantine for 14 days. An Australian Government Department of Health fact sheet for close contacts on Isolation Guidance must be provided. If a contact is required to seek medical care for any reason they must telephone their GP, clinic or hospital emergency department prior to presenting.

20 Management of patients who are under 14-day self-isolation

Refer to Appendix 5.

Related documents

- SCGH IP&C Standard and transmission-based precautions #02
- SCGH IP&C Influenza-Like Illness Policy #08
- AS/NZS 1716:2012 Respiratory Protection Devices.

References

1. Coronavirus Disease (COVID-19). Infection, Prevention and Control in the Hospital Setting, Government of Western Australia, Department of Health. https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Infectious%20diseases/PDF/Coronavirus/Infection%20Prevention%20and%20Control%20in%20Hospitals.pdf

2. National Guidelines for Coronavirus Disease 2019 (COVID-19) (external link) The Communicable Diseases Network of Australia (CDNA) National Guidelines for public health units. Australian Government Department of Health

Authorisation

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Standards Applicable:					

Appendix 1: Personal Protective Equipment

General

- PPE is to be available outside the patient room or in the anteroom
- Donning of PPE should occur in the anteroom or outside the single room
- HCWs must be diligent not to touch their eyes, nose, mouth or hair while wearing PPE. Loose hair must be tied back securely prior to donning PPE
- Wearing gloves is not a substitute for hand hygiene. Hand hygiene must always be performed on glove removal
- Hand hygiene products and gloves must be available in the room to facilitate compliance with the 5 Moments for Hand Hygiene
- When gloves are worn, avoid touching environmental surfaces such as light switches and door handles to minimise environmental contamination
- Doffing of PPE should occur in the anteroom or at the door of the single room, just prior to leaving. Eyewear and masks are to be removed outside the room followed by hand hygiene.

Protective eyewear

- Designated protective eyewear (full face visor or goggles) are to be worn
- Eyewear should be single use where possible

  Personal prescription spectacles are inadequate and must be used in conjunction with a face shield or goggles designed for use over spectacles
- If reusable eyewear is used it must be cleaned and disinfected after use
- Eyewear is to be worn on entering a patient room.

Gowns

- Long sleeve fluid repellent cuffed gowns must be worn by all HCWs.
- Gowns are to be worn once and then discarded in clinical waste
- Gowns must be changed between each patient.

Masks

- Masks used include surgical and P2(N95) disposable respirator masks
- Surgical masks are currently recommended for HCWs for most contacts with suspected or confirmed COVID-19 cases EXCEPT P2(N95) masks must be used

where there is a risk of airborne transmission e.g. when undertaking AGPs or when attending a patient with symptoms of pneumonia.

- Masks should be removed when damaged, soiled, become moist or when it is difficult to breathe through

P2 (N95) respirator mask
All staff working with suspected or confirmed COVID-19 cases must undertake a competency assessment for donning, fit checking and doffing of a P2 (N95) respirator mask competency.
Refer to HealthPoint/Infection Prevention and Control/Education/Other resources – Donning, fit checking and doffing of a P2 (N95) respirator mask competency.

A fit check must be performed prior to entering the AIIR or patient's room and every time a new P2 (N95) mask is worn. Refer to the instructions on the poster displayed in the anteroom of the AIIR or outside patient's room.

Do not re-adjust mask once in the patient's room. Staff who are unable to achieve the correct fit (e.g. due to facial hair or other problems with fitting the respirator) must not enter the AIIR.

If the respirator is damaged, soiled or become moist leave the room and change the respirator;

- remove gloves
- apply alcohol based hand rub to hands,
- remove the respirator by the straps
- apply alcohol based hand rub to hands
- put on the new respirator
- put on clean gloves.

Powered air purifying respirator (PAPR)
The use of the powered air purifying respirator (PAPR) are not routinely used but could be considered, if available, for additional comfort and visibility of the wearer if the HCW is anticipating care for long periods of time if the HCW is unable to satisfactorily achieve a fit check with a P2 (N95) respirator mask.

Training in the use of the PAPR is required - refer to PAPR guidelines for use in SCGH Infection Prevention and Control Manual.

Table 2: Donning and doffing PPE

Donning PPE		**Doffing PPE**	
Prior to entering patient's room or in the anteroom		**In the anteroom or at the door of the patient's room**	
↓	**Hand hygiene**	↓	Gloves – turn inside out by cuff; discard into clinical waste
	Long sleeve fluid repellent gown		**Hand hygiene**
	Surgical mask Or P2 (N95) respirator mask (perform fit check)		Gown- turning inside itself, discard into clinical waste
			Hand hygiene
			Remove outside room Full face visor (disposable), discard into clinical waste
	Protective eyewear (full face visor) **Recheck mask**		**Hand hygiene**
	Gloves		Remove outside room Surgical mask Or P2 (N95) respirator mask handle straps/ties only, discard into clinical waste
			Hand hygiene

NOTE: of reusable goggles are worn, clean and disinfect after each use.

Appendix 2: Aerosol-generating procedures (AGPs)

Aerosol generating procedures (AGPs) are those that stimulate coughing and promote the generation of fine airborne particles (aerosols) resulting in the risk of airborne transmission. Procedures include nebulised medication, endotracheal intubation, mechanical ventilation, airway suctioning or opening a ventilator circuit, bronchoscopy, diagnostic sputum induction, positive pressure ventilation via face mask (non-invasive ventilation), and high frequency oscillatory ventilation. High flow nasal oxygen has a much lower risk of generating aerosols compared to other AGPs.

- AGPs must not be undertaken on suspected or confirmed COVID-19 patients unless strictly necessary and authorised by the Medical Consultant.
- Any procedures undertaken on cases that may produce aerosols (e.g. nebulisation, suctioning) must be performed with full respiratory precautions in the AIIR (staff to wear P2 (N95) respirator mask, full face visor, gloves, and a long sleeve fluid repellent gown).
- Limit the numbers of HCWs in the room when AGPs are performed
- Administration of medication via nebulisers is not recommended, use spacers where possible.

Table 3: Classification of respiratory specimens as APGs (add reference)

Specimen type	**Patients with no fever and mild or no respiratory symptoms**	**Patients with fever and mild symptoms e.g. mild cough and/or rhinorrhoea**	**Patients with fever and symptoms of pneumonia**
Nasopharyngeal swab	No	No	Yes
Oropharyngeal swab	No	No	Yes
Sputum (not induced sputum)	No	No	Yes
Nasal wash/aspirate	No	No	Yes
Bronchoalveolar lavage	Yes	Yes	Yes
Induced sputum	Yes	Yes	Yes
Non-invasive ventilation	N/A	No	Yes
High flow intranasal oxygen	N/A	No	Yes

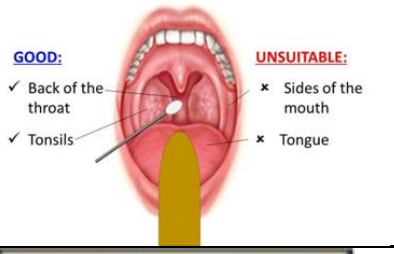
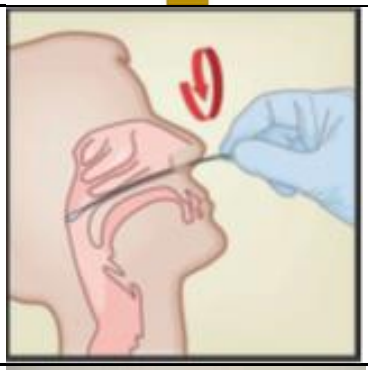
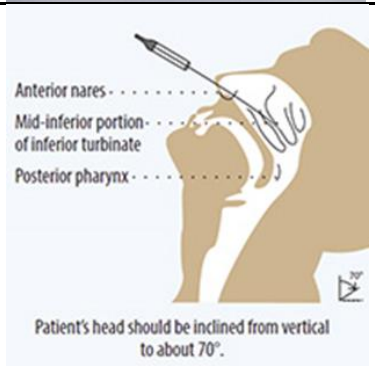
Appendix 3: Collection of specimens

HOW TO COLLECT OROPHARYNGEAL/THROAT AND NASOPHARYNGEAL SWABS USING A SINGLE FLEXIBLE SHAFT SWABS:

1. Perform hand hygiene before donning PPE. Refer to Section 10 and Appendix 1.
2. Remove the flexible nasopharyngeal swab from its packaging.
3. Stand slightly to the side of the patient to avoid exposure to respiratory secretions, should the patient cough or sneeze.
4. **Oropharyngeal swab:** Ask the patient to open their mouth and stick out their tongue. Use a wooden tongue depressor to press the tongue downwards. Firmly swab the posterior pharynx and the tonsillar arches, rotating the swab twice while holding it against the tonsillar fossa at the side of the pharynx. Withdraw the swab, which should be thoroughly wet with throat secretions.
5. **Nasopharyngeal swab: Using the same swab,** tilt the patient's head back. Gently insert the nasopharyngeal swab into one nostril, then gently insert it along the floor of the nasal cavity parallel to the palate until resistance is encountered. This is approximately half to two-thirds of the distance between the anterior nares and the ear. Rotate gently for 10-15 seconds, then withdraw, and repeat the process in the other nostril with the same swab, to absorb secretions.
6. Place the swab into the UTM containers, flocked end first, and snap the shaft at the indicated snapping point, using the rim of the UTM tube for leverage if required.
7. Close the UTM container with the flocked end of the swab inside, discarding the remainder of the shaft.
8. Ensure that the UTM container is closed correctly and is not leaking – the swab is usually slightly bent within the tube.
9. Follow steps 5 – 7 above.

If flexible swabs are not available, use the standard rigid PCR swabs (orange capped metal shaft swab or white capped plastic shaft swab) but

- Do **not** attempt to collect a nasopharyngeal swab.
- Collect oropharyngeal/throat swab as above
- **Mid turbinate samples: Using the same swab** tilt the patient's head back to about 70^{o}, and gently insert the swab into one nostril until you feel resistance (Figure 5). Leave it in place for 10-15 seconds to absorb secretions, then remove and repeat via the other nostril. Place the swab back into its original container.

Figure 1: Flocked swab with UTM	
Figure 2: Collection of throat sample	
Figure 3: Collection of nasopharyngeal swab	
Figure 4: Dry rigid PCR swab	
Figure 5: Collection of mid-turbinate nasal sample	

SPECIMEN TRANSPORT

1. Complete a pre-printed PathWest Request Form.
2. Label the specimens and place the swab into the sealed section of a dual compartment biohazard bag. Place the request form in the outer compartment.
3. Transport specimens **directly** to Central Specimen Reception Area (CSRA) by a HSA. **DO NOT** use the pneumatic tube system.

Appendix 4: Staff and Visitor Register

All staff/visitors entering the patients room to complete register.

***Staff contact number e.g. ward extension/pager/DECT phone**

***Visitor contact number e.g. mobile/home phone**

Patient label

DATE	FULL NAME	HCW DESIGNATION	TIME IN Shift start	TIME OUT Shift finish	*CONTACT NUMBER (VISITORS ONLY)

Appendix 5: Guidance for patients requiring urgent surgery or medical care who are under 14-day self-quarantine

Context

The following people are required to self-isolate due to the risk they may have been exposed to COVID-19:

- All incoming travellers who have returned from overseas in the last 14 days
- Those who have been in close contact with a confirmed case of COVID-19 in the last 14 days (they must isolate themselves for 14 days after the date of last contact with the confirmed case)
- Those who are awaiting test results after attending the COVID clinic.

General patient management

Patients who meet the criteria for self-isolation, and who now require urgent hospital admission for issues not related to COVID-19, must not be refused appropriate medical/surgical care.

These patients must be immediately given a surgical mask to wear and admitted on droplet precautions whether respiratory symptoms are present or not for assessment.

The patient must then be assessed for symptoms consistent with COVID-19, including shortness of breath, cough or sore throat with or without fever.

The Healthcare worker (HCW) undertaking the assessment is to wear appropriate personal protective equipment (PPE) including disposable fluid resistant gown, gloves, surgical mask, and eye protection while reviewing the patient. Refer to Appendix 1.

Patient management for urgent scheduled treatments e.g. chemotherapy, should be discussed with the treating medical doctor to determine if treatment should be continued or deferred until the 14-day isolation period has ended. Onset of COVID-19 illness is likely to complicate the patient's admission.

Following the clinical assessment, management will depend on whether the patient has respiratory symptoms

No respiratory symptoms

- Specimen for testing for COVID-19 is not required
- Patient to remain on contact and droplet precautions, in a single room with ensuite facilities, throughout their admission, or until they have completed the 14-day isolation period
- HCWs are to wear appropriate PPE, that includes disposable fluid resistant gown, gloves, surgical mask, and eye protection, when providing care . Refer to Appendix 1.
- Patient is not required to wear a surgical mask whilst isolated in their single room but must wear a surgical mask when leaving the room for any reason. Patients are to be discouraged from leaving the room for non-clinical reasons.
- Continue monitoring for symptoms consistent with COVID-19 throughout duration of admission.

Respiratory symptoms consistent with COVID-19

- Immediately notify Infection Prevention and Control Unit or the on-call clinical microbiologist.
- Follow the Infection Prevention and Control –Coronavirus Disease (COVID-19) Policy

Visitors

Visitors should be discouraged for patients admitted under the 14-day isolation. If essential and patient has no symptoms of COVID-19 the visitor should wear a surgical mask. If the patient has symptoms, discuss with the IP&C unit.

Advice on emergency surgery

If the patient requires emergency surgery during the 14-day isolation period:

- The patient is to wear a surgical mask while being transported to and from the operating or procedural room and whilst in the surgical holding bay prior to surgery
- Airborne precautions should be implemented for all members of the operating team, in addition to standard precautions in the operating room. This includes wearing a P2 (N95) face mask (fit checked) and ensuring eye protection is worn
- Airborne precautions are to be continued on completion of surgery. This may include recovering the patient in the operating room or transferring the patient to a segregated bay or single room in the post anaesthesia area
- All members of the post-operative recovery team are to wear P2 (N95) masks which have been properly fit checked, in addition to disposable fluid resistant gowns, gloves and eye protection.
- Patient can be cared for under contact and droplet precautions once extubated and there is no further risk of aerosolisation of virus.