Immediate management of a suspected case of CoV 2019(Wuhan) or Avian influenza for acute sites GG&C

Jan 26 2020-For paediatric and primary care see separate guidelines

PLEASE USE THE MOST RECENT VERSION OF THIS INFORMATION AVAILBLE-IT IS SUBJECT TO RAPID CHANGE

Full details on each potential illness with current information can be found at Health Protection Scotland’s website

https://www.hps.scot.nhs.uk/

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Introduction

Novel coronavirus 2019 (nCoV 2019) or Wuhan virus was found to be the cause of a rapidly spreading respiratory illness first identified in Wuhan city in Dec 2019. At the time of writing cases are predominately in China but sporadic case have been identified elsewhere (26/01/2020).

Avian Influenza (bird flu) is rare and only rarely transmitted human to humans. Currently Avian influenza A(H7/N9) requires a travel history of travel to China in the last 10 days(26/01/2020)

It is important to take a clear travel history from any patient presenting with a febrile or symptoms of respiratory tract infection to ensure prompt isolation and infection control procedures are put in place as required. PPE FOR THESE CONDITIONS IS THE SAME AS FOR MERS-COV

Follow the site specific guidelines for patient triage and isolation for acute sites.

The patient should only be moved to a different site due to clinical need. This needs full agreement of the Infection Control Consultant, the Infectious Diseases Consultant and the Public Health Consultant and will usually require a PAG (problem assessment group).
Specific responsibilities for possible case of NCOV2019/AVIAN influenza

Reception staff
- Display flag sign (appendix 1)
- Ask the question about travel history if a patient presents with respiratory symptoms (sore throat, cough, shortness of breath) and/or temperature
- Ask patient to put on a surgical mask if the travel history is disclosed and inform Nurse in Charge immediately.

Nurse in charge
- Informs Consultant in charge
- Coordinates move of the patient to appropriate location
- Ensures staff assessing patient have PPE available and only staff familiar with PPE are entering the room
- Initiates recording of names of all staff entering the room where patient is located
- Ensures staff have access to appropriate guidance and documents
- Coordinates transport of samples to virology
- Ensures all Infection control precautions are followed
- Exclude visitors where possible and where necessary show how to use respiratory PPE

Consultant in charge
- Must make sure the protocol is followed and has responsibility for the patient.
- Discusses the case with the infectious diseases Consultant on call
- Ensures the initial set of samples is obtained
  - For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
- Ensures all infection control precautions are followed

Infectious disease on call must ensure contact has been made with

a. On call virologist
b. Public Health
c. On call Infection Control Doctor(Consultant Microbiologist on call if out of hours)

DO NOT DO A FLU POINT OF CARE TEST
DO NOT DO Blood gases
DO NOT do a BMT/Finger prick Glucose test
Infection control

Detailed information on resp PPE including doffing, decontamination of rooms and equipment and waste and linen disposal can be found at


Respiratory Personal Protective Equipment=resp PPE

<table>
<thead>
<tr>
<th>Personal Protective Equipment (PPE)</th>
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<tbody>
<tr>
<td>To be worn by <strong>ALL</strong> staff</td>
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<tr>
<td>• Long-sleeved, fluid-resistant disposable gown.</td>
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<tr>
<td>• Non-sterile disposable gloves.</td>
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<tr>
<td>• An FFP3 respirator conforming to (EN149:2001): Fit testing must be undertaken prior to using this equipment and fit checking must be performed each time an FFP3 respirator is worn.</td>
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<tr>
<td>• Eye protection compatible with the FFP3 respirator (prescription glasses do not provide adequate protection against droplets, sprays and splashes).</td>
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It is vital that the PPE described above is worn for all airway management, including intubation.

Cleaning and decontamination

<table>
<thead>
<tr>
<th>Decontamination of affected clinical areas in ED</th>
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<tbody>
<tr>
<td>Following transfer and/or discharge of patient(s) resp PPE must be worn to clear and decontaminate the area.(Note, this also applies to Domestic Service staff)</td>
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<tr>
<td>The room/area should be decontaminated using a combined detergent disinfectant solution at a dilution (1000ppm av.cl.);</td>
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<tr>
<td>All staff working with these patients should be trained in resp PPE and fit tested.</td>
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For **NCOV2019** infectious

- **linen** should be stored/quarantined in a secure area until testing results are confirmed. If confirmed dispose of as Category A waste, contact local waste officer to initiate this process
- **waste** should be stored/quarantined in a secure area until testing results are confirmed. If confirmed waste will be disposed of as Category A waste.
nCoV2019 (Wuhan)

Full details at
https://www.hps.scot.nhs.uk/a-to-z-of-topics/wuhan-novel-coronavirus/

As this is all rapidly moving please use the most up to date case definition and clinical information as it appears on the HPS web link above.

Respiratory PPE is as per MERS.

Infection control and patient placement is as per the MERS information and detailed for each Acute Site.

Please note the sampling is different at present. Please use the information below which is correct as of 27/01/2020

DO NOT DO A FLU POINT OF CARE TEST
DO NOT DO Blood gases
DO NOT do a BMT/Finger prick Glucose test

For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
Avian influenza

Full details at
https://www.hps.scot.nhs.uk/a-to-z-of-topics/avian-influenza/

Respiratory PPE is as per MERS.

Infection control and patient placement is as per the MERS information and detailed for each Acute Site.

Sampling. Discuss with virology. They will require a viral gargle/nose/throat swab and sputum or ET aspirate.

Samples should be sent with Category B packaging (i.e. what we use for MERS). This can then be sent to the lab by taxi.

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For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
A) QEUH

QEUH ED triage

Patient identifies foreign travel to reception staff

Book in patient and note presenting complaint.
Inform triage nurse immediately

Move patient to Room A in reception. Ask them to put on a surgical mask and await triage

Inform Triage and CIC on phone 82828
QEUH ED triage

1. Keep the patient in the room they are in when the diagnosis is first suspected. Keep the door closed.

Specific Examples

1. Triage Room A or B – isolate in room and quarantine both Triage Rooms A & B (this is to allow the unaffected ‘Clean’ Triage room to be used for staff changing)

2. Ambulance queue move patient to Major Procedures Rooms 4 or 8 in Resus

3. Ambulance—remain in ambulance until move to Procedure room/HDU/ITU.

If reception highlight a potential patient then move them to Room A in Reception for Triage (flow chart attached for Reception staff)

2. Put surgical mask on patient (as per flow chart for Reception staff) or once concern has been raised by assessing staff

3. Apply full PPE including FFP3 mask, eye protection and fluid repellent gown to anyone assessing the patient once concern has been raised

4. Inform Nurse-in-Charge and Consultant-in-Charge as soon as concern is raised.

Emergency Department Dos and Don’ts

- The patient should not be moved anywhere through the department without consultation with the ED consultant in charge in conjunction with the Infection Control Consultant on call.

- Unless the patient has an emergent airway issue ALL intubations should be performed in a respiratory isolation rooms in ITU. If intubation is required for an airway issue in-extremis in ED it should be performed in one of the Procedures Rooms.

- Under no circumstances should the Decontamination Room be used to assess and treat unwell patients with ? MERS/Avian flu/NCOV2019 (or VHF).

- CXR if required should be done as a portable in HDU/ITU with radiographers who are PPE trained. A patient with possible MERS/ Avian flu/NCOV2019 should not be X-rayed in the radiology department

- If Infectious disease team decide the patient requires admission they will identify room. Once designated room is ready then the patient (wearing surgical mask) should be moved using the route with minimal patient contact through ED and up to HDU using core lifts G or C as appropriate. Liaise with the clinical coordinator and facilities staff to ensure the corridors affected by the patient journey are closed to the public during transfer.
QEUH IAU triage

Patient presents with a history of fever/respiratory illness

Triage nurse identifies foreign travel that fulfils risk criteria

Patient fulfils case definition

Nurse puts on respiratory PPF and puts FRSM on patient

Senior medical staff urgently called and contact infectious diseases team on call

ID confirms meets case definition and identifies location to transfer patient to

Significant delay in moving the patients? Move patient to ARU1 for respiratory isolation

**All Staff managing patient should be familiar with PPE and be FFP3 mask fitted**

**DO NOT MOVE patient into any other area in IAU**

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**DO NOT DO A FLU POINT OF CARE TEST**

**DO NOT DO Blood gases**

**DO NOT do a BMT/Finger prick Glucose test**

For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
QEIH IAU triage

1. Keep the patient in the triage area they are in when the diagnosis is first suspected.

2. Put surgical mask on patient once concern has been raised by assessing staff.

3. Apply **full** PPE including FFP3 mask, eye protection and fluid repellent gown to anyone assessing the patient once concern has been raised.

4. Inform Nurse-in-Charge and Consultant-in-Charge as soon as concern is raised.

**IAU Dos and Don'ts**

- The patient **should not be moved anywhere** through the department without consultation with the IAU consultant in charge and in conjunction with the Infection Control Consultant on call and not until a bed has been identified and prepared in HDU.

- If no bed is available within a reasonable timeframe in HDU or onward ward (as agreed by Infection Control consultant) then the patient should be moved to a room in ARU1 as a temporary measure.

- Unless the patient has an emergent airway issue **ALL** intubations should be performed in a respiratory isolation rooms in ITU.

- **CXR** if required should be done as a portable with radiographers who are PPE trained. A patient with possible MERS/ Avian flu/NCOV2019 should not be X-rayed in the radiology department.

- If Infectious disease team decide the patient requires admission they will identify the admission location, likely HDU or 5D. The ID on call team will ensure that the room has been cleared and prepared before the patient can be moved.

- Once a room is ready then the patient (wearing surgical mask) should be moved using the route with minimal patient contact and up to HDU using core lifts G or 5th floor using core lift C. Liaise with the clinical coordinator and facilities staff to ensure the corridors affected by the patient journey are closed to the public during transfer.

**DO NOT DO A FLU POINT OF CARE TEST**

**DO NOT DO Blood gases**

**DO NOT** do a BMT/Finger prick Glucose test

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C GRI

ED Triage

1. If patient reports history of travel to one of the affected countries move to ‘clean prep room’ from reception or triage. If patient has been in triage this room should be cleaned with 1000 ppm av.CI by domestic staff wearing full respiratory PPE prior to being used again.

2. If patient requires resus level care this can be provided in the clean prep room

3. Keep both doors closed.

4. Commode to be provided.

5. Place screens outside corridor door of clean prep room to create a bay for equipment storage and staff changing.

6. Put surgical mask on patient.

7. Apply full respiratory PPE to anyone assessing the patient once the concern has been raised.

8. Inform nurse-in-charge and consultant-in-charge and IPCT (consultant microbiologist on call if out of hours) as soon as concern is raised.

9. If fulfils case definition as a POSSIBLE case patient should be transferred to a negative pressure room in ITU or respiratory. Once a room is ready patient should be moved using a route to minimise contact with other patients. Liaise with the clinical coordinator and facilities staff to ensure the corridors affected by the patient journey are closed to the public during transfer.

. Patient should wear a surgical mask during this transfer.

10. Record the names of those who were in the waiting room with the patient

    DO NOT DO A FLU POINT OF CARE TEST

    DO NOT DO Blood gases

    DO NOT do a BMT/Finger prick Glucose test

For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
GRI MAU triage

1. If GP requests on the phone review of a patient and reports risk suggesting nCoV 2019 or Avian flu 2020, request that they direct telephone query to ID consultant on call for consideration of direct admission to QEUH.

2. If patient reports travel to one of the affected countries move from MAU triage to ‘clean prep room’ in ED.

3. Ongoing nursing care will be provided by ED staff.

4. Ongoing medical care will be provided by MAU staff.

5. For further detail see ED triage notes.

Emergency department dos and don’ts.

- The patient should not be moved anywhere through the department without consultation with the ED consultant in charge in conjunction with the consultant on call for infection control.
- Unless the patient has an emergent airway issue all intubations should be performed in a respiratory isolation room in ITU.
- CXR should be done as portable, by radiographers who are PPE trained. A patient with MERS/Avian flu/NCOV2019 needing to visit the radiology department should be discussed with IPCT.

DO NOT DO A FLU POINT OF CARE TEST

DO NOT DO Blood gases

DO NOT do a BMT/Finger prick Glucose test

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DO NOT DO A FLU POINT OF CARE TEST
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For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
Suspected MERS/Avian flu/NCOV2019 - Immediate ED Actions

Move patient to the designated room

Patient identified by Reception staff

- Move patient to the Resus 5 single room
- Quarantine both Resus 5 single room and Resus Bed 4 (this is to allow the unaffected ‘Clean’ Resus Bed 4 to be used for staff changing)

Ambulance queue

- Move patient to the Resus 5 single room
- Quarantine both Resus 5 single room and Resus Bed 4 (this is to allow the unaffected ‘Clean’ Resus Bed 4 to be used for staff changing)

Patient is identified during assessment in ED and is in the bay area

- Ask the patient to put on surgical mask
- Move patient to the Resus 5 single room
- Quarantine both Resus 5 single room and Resus Bed 4 (this is to allow the unaffected ‘Clean’ Resus Bed 4 to be used for staff changing)

Apply full respiratory PPE to anyone assessing the patient once concern has been raised.

Emergency Department Dos and Don’ts

- The patient should not be moved anywhere through the department without consultation with the ED consultant in charge in conjunction with the Infection Control Consultant on call
- If intubation is required for an airway issue in-extremis in ED it should be performed in Resus 5 single room
- CXR should be done as a portable with radiographers who are PPE trained. A patient with possible MERS/Avian flu/NCOV2019 should not be X-rayed in the radiology department
- If Infectious disease team decide the patient requires admission the most appropriate option for admission has to be agreed by clinical team with ID specialists and ICT
- If the decision is to admit patient to ITU they have to be taken by the shortest route, using lift to ITU and placed in isolation room. Patient wears surgical mask where possible.
RAH

Suspected MERS/ Avian flu/NCOV2019 immediate actions in MAU

- Keep the patient in the room they are in when the diagnosis is first suspected
- Put surgical mask on patient once concern has been raised by assessing staff
- Inform Nurse-in-Charge and Consultant-in-Charge as soon as concern is raised
- Apply full respiratory PPE to anyone assessing the patient once concern has been raised

MAU Dos and Don’ts

- The patient should not be moved anywhere through the department without consultation with the consultant in charge and in conjunction with the Infection Control Consultant on call
- Consultant in charge should discuss the most appropriate option for admitting patient with ID consultant and Infection Control Doctor
- Unless the patient has an emergent airway issue ALL intubations should be performed in a respiratory isolation rooms in ITU
- CXR should be done as a portable with radiographers who are PPE trained. A patient with possible MERS/ Avian flu/NCOV2019 should not be X-rayed in the radiology department.
- If the decision is to admit the patient to RAH they should be managed in a respiratory isolation room in ITU. The consultant in charge must inform ITU about the patient transfer
- Once a room in ITU is ready then the patient (wearing surgical mask if possible) should be moved to ITU by the shortest route, using lift to ITU and placed in isolation room.

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For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
Patient identifies foreign travel to reception staff

Book patient in and note presenting complaint. Discuss with nurse in charge immediately

Patient meets case definition

Move patient to resus step down room 1. Ask patient to put on a surgical mask and wait urgent clinical review

Inform consultant in charge

DO NOT DO A FLU POINT OF CARE TEST
DO NOT DO Blood gases
DO NOT do a BMT/Finger prick Glucose test

For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
Suspected MERS/Avian flu/NCOV2019 - Immediate ED Actions

Patient identified by Reception staff

- Move patient to the Resus Step Down 1 room
- Quarantine **both** Resus Step Down 1 and Resus Step Down 2 (this is to allow the unaffected ‘Clean’ Resus Step Down 2 to be used for staff changing)

Ambulance queue

- Move patient to the Resus Step Down 1 room
- Quarantine **both** Resus Step Down 1 and Resus Step Down 2 (this is to allow the unaffected ‘Clean’ Resus Step Down 2 to be used for staff changing)

Patient is identified during assessment in ED and is in the bay area

- Ask the patient to put on surgical mask and immediately inform Nurse-in-Charge and Consultant-in-Charge
- Move patient to the Resus Step Down 1 room, quarantine **both** Resus Step Down 1 and Resus Step Down 2 (this is to allow the unaffected ‘Clean’ Resus Step Down 2 to be used for staff changing)

Apply full respiratory PPE to anyone assessing the patient

Emergency Department Dos and Don’ts

- The patient **should not be moved anywhere** through the department without consultation with the ED Consultant in Charge in conjunction with the Infection Control Consultant
- If intubation is required for an airway issue in-extremis in ED it should be performed in Resus Step Down 1 room
- CXR should be done as a portable with radiographers who are PPE trained. A patient with suspected MERS/Avian flu/NCOV2019 should not be X-rayed in the radiology department.
- If Infectious disease team decide the patient requires admission the most appropriate option for admission has to be agreed by clinical team with ID specialists and ICT.
- If the decision is to admit patient to IRH ITU they have to be taken by the shortest route, using theatre lift to ITU and placed in isolation room.
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DO NOT DO Blood gases

DO NOT do a BMT/Finger prick Glucose test

For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
DO NOT DO A FLU POINT OF CARE TEST

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DO NOT do a BMT/Finger prick Glucose test

For guidance regarding testing, please go to testing guidelines in the IPC Manual (icon on desktop)
VOL

Suspected MERS/ Avian flu/NCOV2019- Immediate MAU Actions

Patient identified by Reception staff

- Ask the patient to put on surgical mask
- Inform Nurse in Charge for Medical Assessment Unit (MAU) and Minor Injuries Unit (MIU). MAU Nurse in Charge to inform the Consultant in Charge for MAU
- MAU Nurse in Charge to escalate to the CSM/Lead nurse and Physician of the week in hours and escalate to the Clyde duty manager and on call medical consultant in the OOHs period
- Patient to be transferred to a bay in MIU
- Make sure all patients are transferred out of Minor Injury Unit and all non-essential equipment has been removed from the area
- MIU to move all work to the Fracture Clinic
- Transfer the patient to the MIU bay and await triage
- Use adjacent bay as “clean anteroom” for staff changing and for decontaminating the equipment
- Keep the MIU entrance doors closed

Ambulance service- informs the unit about possible MERS/Avian flu/NCOV2019 case in advance and move patient to MIU

Patient is identified during assessment in MAU and is in the bay area

- Ask the patient to put on surgical mask
- Immediately inform nurse-in-charge and consultant-in-charge
- Do not move the patient out of the bay
- Nurse-in-Charge to discuss with senior management the most appropriate placement for the patient. Issues to consider will include:
  - occupancy of the MAU and MIU
  - availability of domestic staff to carry out terminal clean of the unit
  - predicted stay of the patient at the VoLH
  - senior management will consider a divert of all SAS calls to another site
  - In OOHs period – NHS24 informed. Consideration by SMT of all OOHs GP calls to be diverted to other OOHs centres

If it is possible within a reasonable timeframe to carry out terminal clean of MAU then the patient should be transferred to MIU (see actions above for the move of workload of MIU) and terminal clean of MAU should be carried out before normal work of MAU can be resumed.

In case it is not logistically feasible to carry out a terminal clean of MAU within reasonable timeframe then the patient should be cared for at the MAU bay and all the other MAU work should be transferred to MIU area.
VOL

Patient is identified at the Out-of-Hours GP Clinic

Keep the patient in the GP clinic room in clinical situation allows this and follow the actions as for “Patient identified by Reception Staff” pathway

Apply full respiratory PPE to anyone assessing the patient once concern has been raised

MAU Dos and Don’ts

- The patient **should not be moved anywhere** through the department without consultation with the MAU consultant in charge in conjunction with the Infection Control Consultant

- **CXR** should be done as a portable with radiographers who are PPE trained. A patient with possible MERS/Avian flu/NCOV2019 should not be X-rayed in the radiology department

- If Infectious disease team decide the patient requires admission the most appropriate option for admission has to be agreed by clinical team with ID specialists and ICT.

- If the decision is to admit patient to ward 3 (AMRU) they have to be taken by the shortest route, using the AMRU lift and placed in isolation room 6. Close the corridors affected by the patient journey to the public until area has been appropriately cleaned.

**Actions if a suspected MERS/Avian flu/NCOV2019 patient is admitted/identified on ward 3 (AMRU)**

**Suspected MERS/ Avian flu/NCOV2019 patient is identified on ward 3**

- Immediately inform Nurse in Charge and Consultant in Charge.

- Move patient to isolation room 6. Make sure room is prepared and all the non-essential equipment has been removed from the room

- Vacate the adjacent room 5 and use this as “clean anteroom” for staff changing and decontamination of the equipment

- All staff and visitors have to apply full PPE when entering the room.

**It has been decided to admit a suspected MERS/ Avian flu/NCOV2019 patient from MAU/MIU**

- MAU Nurse in Charge has to inform the ward 3 Nurse in Charge in advance and coordinate transfer of the patient. Please follow the actions described above.
Has the patient travelled to any of these countries in the last 2 weeks? Inform the triage nurse/nurse in charge.

- Bahrain
- Jordan
- Iran
- Iraq
- Kingdom of Saudi Arabia
- Kuwait
- Oman
- Qatar
- United Arab Emirates
- Yemen
- China