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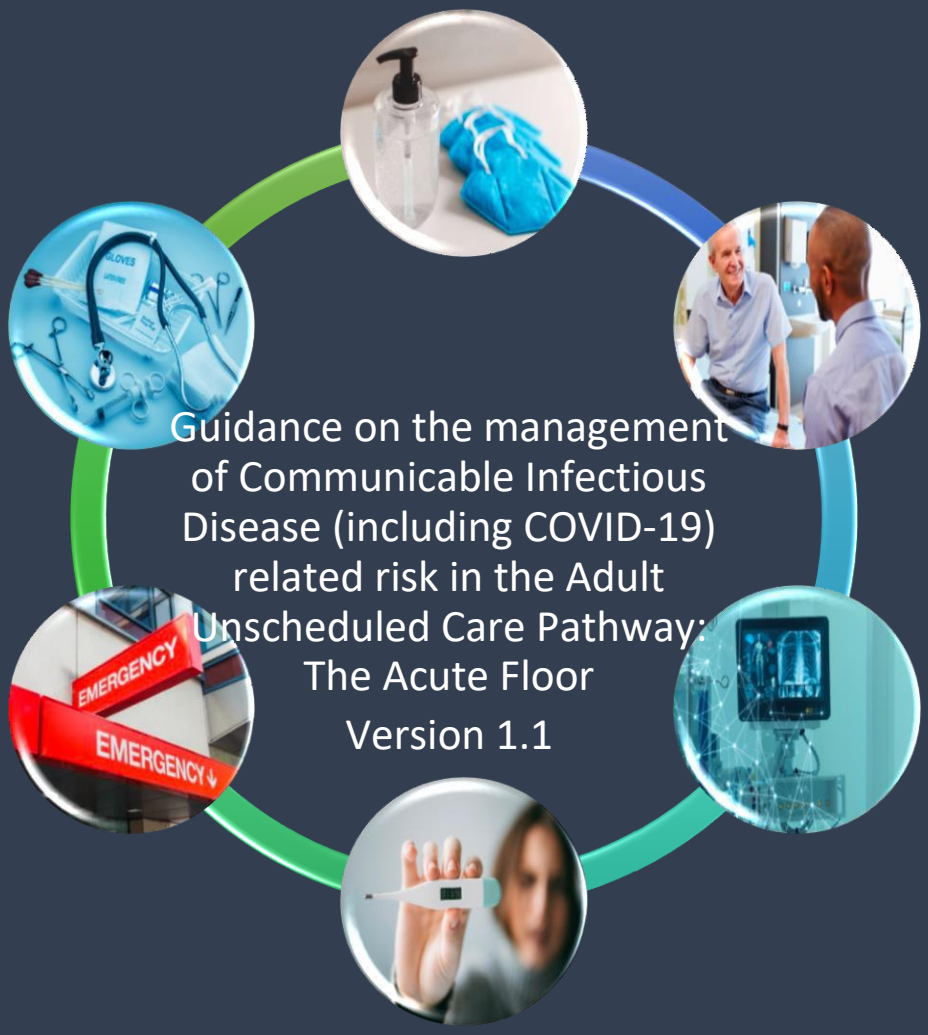
This document replaces "Guidance on the management of COVID-19 related risk in the Adult Unscheduled Care Pathway; The Acute Floor Version 1.5



Guidance on the management of Communicable Infectious Disease (including COVID-19) related risk in the Adult Unscheduled Care Pathway: The Acute Floor

Version 1.1

March 2022 V1.0

ALERT

New variants SARS-CoV- 2 and other non-endemic Communicable Infectious Disease (CID)

Affected population:
There is may be a risk of introduction of new SARS-CoV-2 variants or other non-endemic CIDs associated with all individuals who have recently travelled outside of Ireland (in the previous 14 days is a useful general guide)

Assessment of Risk
As part of the initial evaluation process, recent travel history (within 14 days) must be taken into account.

A high index of suspicion for new variant SARS-CoV-2 or other non-endemic CID should apply to patients presenting with symptoms of an acute infectious disease including COVID-19 symptoms with recent travel from other countries. The risk is generally greater for those who have travelled outside of the European Union and other more developed regions

Patients with symptoms of COVID-19 or other CID presenting within 14 days of arrival from another country: These patients should receive priority for placement in single room or cubicle... Any specimen from such a patient that has SARS-CoV-2 detected should be sent for characterisation

Haemodialysis
Patients travelling from another country within 14 days and availing of holiday access haemodialysis should be managed with contact and droplet precautions, including isolation in a single room if available, even in the absence of symptoms suggestive of COVID-19. A person who requires dialysis at a time when they are subject to travel related restricted movements should be tested for SARS-CoV-2 in advance of attending for dialysis if practical to so within the time frame within which haemodialysis is essential.

The Following Working Group Contributed to "Guidance on the management of COVID-19 related risk in the Adult Unscheduled Care Pathway; The Acute Floor Version 1.0" on which this document is based	
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Glossary of Words & Terms	
AFIS	Acute Floor Information System
ANP	Advanced Nurse Practitioner
AMAU	Acute Medical Assessment Unit
ASAU	Acute Surgical Assessment Unit
CGA	Comprehensive geriatric assessment
CID	Communicable Infectious Disease
ECDC	European Centre for Disease Prevention and Control
ED	Emergency Department
FAST	Facial drooping, Arm weakness, Speech difficulties and Time used to educate the public on detecting symptoms of a stroke
FITT	Frailty Intervention Therapy Team
HPSC	Health Protection Surveillance Centre
ICU	Intensive Care Unit
ITU	Intensive Therapy Unit
IPC	Infection Prevention and Control
LRTI	Lower respiratory tract infection
MDRO	Multi Drug Resistant Organisms
NAS	National ambulance service
NCEPOD	National Confidential Enquiry into Patient Outcome and Death Classification
OOH	Out of hours
OPD	Out Patient Department
OT	Occupational Therapist
PET	Patient Experience Time
PPE	Personal Protection Equipment
RSV	Respiratory syncytial virus
USC	Unscheduled Care
VIP	Variable Indicative of Placement risk
Acute Floor	Composed of ED, AMAU, ASAU
Minimum physical distancing	1m
Senior decision makers	Senior decision makers are defined here as those who have undergone appropriate training to make independent decisions around patient admission and discharge: Registrar grade and above or ANPs.
Communicable Infectious Disease Assessment	Communicable infectious patient assessment is a hands off assessment to identify if patients have clinical features that indicate that they are suspect cases for COVID-19 or other CID.

Covid-19 testing for current infection	An appropriately sensitive test for detection of the SARS-CoV- 2 virus in a respiratory sample. If testing is required, swabbing should take place as soon as practical after the decision to admit is made. The result should be available as soon as is practical and in any case, within 12 hours of sample collection for a patient with a clinical suspicion of COVID-19 and within 24 hours of sample collection for all other patients who require testing. Urgent decisions on patient placement or treatment should not be delayed until the test result is reported.
Surveillance testing	This refers to testing for infection in people with no clinical suspicion of COVID-19 and who are not COVID-19 contacts. It may be required to control the risk of introduction of asymptomatic infection in certain higher risk settings.
Virtual clinic	This refers to a method of clinical review that can be by telephone or video, where the patient does not attend the clinical setting in person. 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. **As with face-to-face clinics, for required diagnostics including phlebotomy and SARS-CoV-2 testing, it is essential to ensure patient follow up has appropriate clinical governance and follow-through within the hospital services.**

Version 1.1

This version replaces the original version issued in February 2022
Key changes are
Reference to quality management of test results
Discharge letters should also issue others involved in continuing care in the community in addition to the GP
Reference to the Assisted Decision Making (Capacity) Act 2015
Inclusion of a template checklist for assessing risk of communicable infectious disease at presentation
Some editorial changes

High Level Principles:

- This advice applies to Unscheduled Care Patients who usually fall into different risk categories than Scheduled Care Patients.
- It constitutes a brief framework document to provide support and recommendations to the Acute Floors in Ireland.
- The guidance/ recommendations should be considered by individual hospitals within their Governance framework including local COVID-19 Preparedness Committees, and IPC or ARMIC committee and taking account of circumstances and resources available to that institution.
- Clinical judgment should always be exercised when utilising guidance documents as these

cannot anticipate the clinical context of each case or circumstance.

- The protection of patients and staff are central tenets of the framework.
- Infection prevention and control guidance should not be a barrier to the access of timely, appropriate care, particularly in an emergency. In such circumstance, for example a poly-trauma patient requiring resuscitation or a patient with respiratory failure requiring immediate advanced airway support, the patient should be managed with the protections as if they have a CID including COVID-19 until it is assessed by a senior decision maker that this is not required.
- It is essential to consider what is likely to be implementable and infrastructure.

Executive Summary

For the purposes of managing risk of healthcare associated infection to patients and staff there are broadly speaking two categories of patients presenting to the acute hospital for unscheduled care.

1. Patients with clinical features consistent with CID including COVID-19

and

2. All other patients;

In addition to categorisation for infection risk triage based on severity to ensure timely care and best outcome is required.

On arrival at the Acute Floor (ED/AMAU/ASAU) it is recommended that all patients be assessed by a senior decision maker to determine if (1) suspected or confirmed CID (including COVID-19).

This is the principle function of the immediate assessment on arrival. Each hospital may have a different approach to how this is delivered and a different suite of pathways for care following the initial assessment depending on the services offered in the acute hospital and surrounding community.

Recommendations

1. **It is recommended that the hospital use a structured risk assessment form to facilitate the initial assessment of patients presenting for unscheduled care as early as practical after presentation (see appendix 1).**
2. **It is recommended that each acute hospital identify processes of care for patients with suspected and confirmed COVID-19 or other CID. These processes should be clearly communicated within the hospital and externally to local primary care, NAS and the general community.**
3. **It is recommended that HSE-AMRIC guidance is followed for infection prevention and control and the use of personal protective equipment aligned with the risk status of the patient and the task being performed.**
4. **It is recommended that hospitals receiving undifferentiated patients have on-site quality managed testing for SARS-CoV-2 that is appropriate to their needs**
5. **Requirements for testing of patients for COVID-19 are outlined in Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting** https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/

InfectionPreventionandControlPrecautionsforAcuteSettings.pdf

6. **It is recommended that patients, once designated for admission, are not boarded on the Acute Floor on the basis that results of testing for a CID including COVID-19 is not yet available.**
7. **It is recommended that Ambulances NOT be used to house patients pending assessment.**
8. **It is recommended that the senior decision maker/s assigned to the AMAU/ ASAU and to ensure the Patient Experience Time (PET, time from registration to discharge or decision to admit) is optimised and patient flow maintained.**
9. **It is recommended that at least one dedicated emergency theatre be available for admitted acute surgical patients 24/7.**
10. **It is recommended that timely access to intervention/care not be delayed if SARS-CoV-2 test results or risk assessment are not available.**
11. **It is recommended that access to care pathways, COVID-19 be communicated to the local GP and OOHs services and the public informed of local hospital pathways and practices.**
12. **It is recommended that discharge letters be sent to GPs for patients who have attended and received treatment and discharge from the acute floor. Where possible this should be via Healthlink. Discharge letters should also be provided to others who need this information to provide continuing care including residential care services and other community base services.**

Table of Contents

1 Introduction

The purpose of this document is to guide the delivery of unscheduled care in the context of the current risk of COVID-19 and other Communicable Infectious Disease. The aim of this guidance is support delivery of service with the lowest practical risk. Each hospital solution will vary based on its infrastructure, staffing and services. The implementation of the USC should be through each hospitals Governance and Accountability Framework supported by a group that includes representation from Emergency Medicine, Acute Medicine, Surgery, Critical Care/ Anaesthesiology, Clinical Microbiology and/or Infectious Disease, Infection Prevention and Control, Nursing and Hospital Patient Flow Managers.

Each acute hospital should document and implement its USC service and monitor it for effectiveness. The pathway to access care should be communicated to local GPs, ambulance services and the local population.

USC is provided through a number of services and the patient is directed to the relevant service by a senior decision maker who performs the initial assessment. The suite of services and pathways will vary depending on the services offered.

Overcrowding is a significant risk to providing the required care and infection prevention and control interventions. Assessment and allocation to services should aim to keep the time to admission or discharge decision (Patient Experience Time) as short as possible and to direct patients to the appropriate place for their care.

2 Infrastructure

The place or places where initial assessment is performed needs to be identified as well as the patient pathways available. These may include ED, AMAU, ASAU, Community COVID-19 assessment Hub, GP, Older Persons acute services, Rapid access clinics etc. Processes for directing people to designated locations for suspected and confirmed COVID-19 or other CID patients need to be identified and communicated clearly.

3 Senior Decision maker availability

Senior decision makers being immediately available to patients on the Acute Floor is key to effective management. Senior decision makers are defined here as those who have undergone appropriate training to make independent decisions around patient admission and discharge: Registrar grade and above or Advanced Nurse Practitioners.

3.1 Guidance on Assessment /Allocation to Service Areas

- Where possible, the most senior decision makers should be available on the Acute Floor.
- Admission avoidance should be strongly considered in each case.
- Where referral onto another discipline is required it should be conducted by the most senior decision makers (at least registrar or equivalent) to another assessment area in a 'refer forwards' principle.
- Disagreements around acute patient governance must be discussed by the attending consultants of the day and if no resolution escalated through relevant Clinical Director pathways.
- Unit components of the Acute Floor should have a senior decision maker available at all opening times to minimize delays to patient assessment and decision-making.

3.2 Streaming Guidance 2:

- Patients should be risk assessed for COVID-19 or other CID by a senior decision maker as soon as is practical after presentation. This includes all patients regardless of the referral pathway.
- Ambulatory patients whose condition is best managed in the community should be referred directly to the appropriate service provided it is available and using clinical judgment.
- Waiting areas for those who have not been assessed should allow adequate space for 1m distance between patients
- Patients with suspected or confirmed COVID-19 or other CID should be fast-tracked to appropriate space to manage the IPC risk
- Accompanying persons should be facilitated as appropriate to the needs of the patient.
- Boarding admitted patients in any assessment space should be avoided to the greatest extent possible. Patients designated for admission should be immediately transferred to the ward or an identified and appropriately staffed area pending admission that allows for necessary patient care and IP&C practices and does not impede patient assessment and management in the Acute Floor.
- Where restrictions on admissions to ward recommended to manage outbreaks or other infection related are contributing to accumulation of patients in assessment space a careful assessment of the relative risks is required
- Testing should be employed to support patient flow as outlined in Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/InfectionPreventionandControlPrecautionsforAcuteSettings.pdf–
- When circulating influenza rates rise above the ECDC threshold for influenza season, influenza should be included in the testing of patients who will require admission and who have presented with clinical features suggestive of influenza.

4 Presentation

It is recommended that the hospital use a structured risk assessment form to facilitate the initial assessment of patients presenting for unscheduled care as early as practical after presentation. A template for such assessment is included as Appendix 1.

It is recommended that each acute hospital identify processes of care for patients with suspected and confirmed COVID-19 or other CID. These processes should be clearly communicated within the hospital and externally to local primary care, NAS and the general community.

It is recommended that HSE-AMRIC guidance is followed for infection prevention and control and the use of personal protective equipment aligned with the risk status of the patient and the task being performed.

4.1 The patient pathway to the hospital Acute Floor follows a number of routes:

4.1.1 Patient Assessment and Allocation

For the purpose of allocation to appropriate space, patients are designated to COVID-19 or other CID processes or to pathways and processes for all other patients.

4.1.1.1 GP referral (GP surgery, OOHs, Community hub)

- Patients referred by primary care should be identified by the referring doctors as suspected of confirmed COVID-19 or as other patients.
- This should be clearly documented in the referral letter or pre-alert. Referrals should be

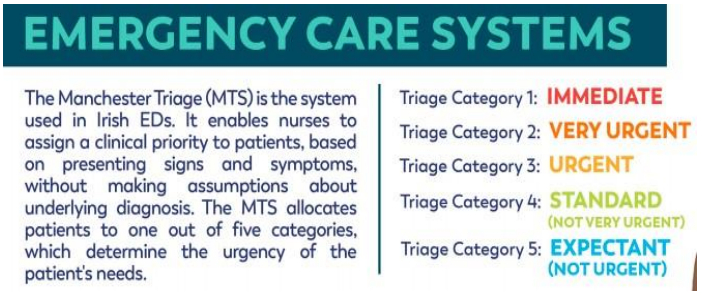
electronic via Healthlink where appropriate.

4.1.1.2 NAS emergency transfer

- Resuscitation patients should be pre-alerted where feasible and IPC managed as 'COVID-19 or other CID until risk assessed and streamed.
- Patients who are known categorised, as 'COVID-19 or other CID' should be communicated by NAS to the hospital ideally in advance of their arrival to the ED.
- Holding patients in ambulances after arrival at the Acute Hospital is not an acceptable means of dealing with patient flow.

4.1.1.3 Self-Presentation

- Patients self-presenting to the ED should undergo a formal risk assessment for COVID-19 or other CID by a senior decision maker.
- Category 5 patients (Manchester Triage System) may be referred to community / primary care services for assessment, diagnosis and management based on the clinical judgement of the senior decision maker.



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- Ambulatory suspect COVID-19 patients, who self-present, will generally be re-directed to the GP/Out of Hours services for testing to be organised in the community unless there are indications for hospitalisation or other specific circumstances.

4.1.1.4 Review clinic

Any review clinic that is held in the Acute Floor should include assessment on attendance for features of COVID-19 or other CID on arrival or in advance of arrival

4.2

4.2.0 Emergency Department

Post initial assessment for COVID-19 or other CID risks, a more formal Manchester Triage process may be undertaken, to ensure that the clinical risk is effectively managed within this service.

The ED deals with "undifferentiated" patients who become suddenly and acutely unwell or suffer injury that requires hospital attendance. Currently, all patients who attend an ED are triaged by an experienced and appropriately trained nurse to allocate them into one of five categories of urgency using a standardised system (Manchester Triage System). These categories decide the clinical urgency of the presentation, ranging from needing immediate resuscitation (category one –triage and treatment are simultaneous) to non-urgent from a clinical perspective (category five – s).

Two priorities guide ED care:

- To consider and diagnose or out rule serious acute illness or injury as a cause for a patient's condition and administer appropriate initial resuscitation, treatment and comfort measures as appropriate.
- To determine whether that patient should be treated within the emergency department and discharged home, or whether they need to be referred elsewhere for further investigation or treatment. From the moment patients arrive at the emergency department to the point of their disposition, senior clinical decision makers systematically organise patient care into a series of activities sequentially driven to achieve these outcomes.

4.2.1 AMAU

The AMAU provides senior medical assessment and management for undifferentiated medical presentations to the Acute Floor

It is recommended that senior decision maker/s are assigned to the AMAU/ ASAU,to ensure the Patient Experience Time (PET, time from registration to discharge or decision to admit) is optimised and patient flow is maintained.

When setting up the Acute Floor services, consideration should be given as to where best care for this patient cohort will be provided and once organised, communicating this to the GPs and local community.

4.2.2 ASAU & Surgical Patients in ED

The Acute Floor is where the majority of acute surgical admissions occur. Other streams such as outpatient admissions and direct ward transfers do occur but form the minority of admissions.

Acute surgery, in its many sub disciplines, is a service delivered by historic on call rotas that vary site to site in the 26 acute adult emergency receiving hospitals across Ireland. There is significant variability of services and staffing across hospital sites and regions, which has largely grown organically over time.

The ASAU/ acute surgical team must be available to all acute surgical patients presenting to other areas of the Acute Floor.

Every effort must be made to reduce PET on the Acute Floor. For those candidates not for outpatient/ ambulatory care, the decision to admit should be made early. In addition, efforts to reduce length of in-hospital stay should also be undertaken.

It is recommended that at least one dedicated emergency theatre must be available for admitted acute surgical patients 24/7.

Those patients who may require additional resources on discharge (such as frailty team, social supports, public health nursing) should be identified early in the admission. Discharge planning should occur as soon as possible and any necessary resources applied in a timely fashion.

4.2.3 Acute (Unscheduled) Operative pathway

Individuals with COVID-19 or other CID may present to surgical services. If COVID-19 or other CID is a suspected part of the presentation, then patients should be treated with appropriate IPC precautions and testing. The surgical team can manage this unless medical advice on clinical management is required.

Unscheduled acute surgical patients should be managed on the perioperative pathways based on admission risk assessment.

The clinical priority and timing of the operation should be decided by the admitting surgical team, in consultation with the anaesthesiology service.

Clinical priority for those needing surgery should be decided at the earliest juncture, ideally at time of admission. Risk stratification using a risk scoring system such as a modified NCEPOD classification may be used (8). These are Immediate (surgery needed within minutes), Urgent (within a few hours), Expedited (12-48 hours) and Elective (maybe booked at a suitable time).

All surgical unscheduled care patients should have a clinical priority assessment at admission (or the earliest appropriate juncture) by the admitting team. (Immediate, Urgent, Expedited, Elective)

Where category Immediate or Urgent is assigned, patients should not be delayed by waiting for a test result. This cohort should be transitioned through the theatre complex as COVID-19 detected or suspected patients.

5 Inpatient process

Once the decision to admit is taken, local hospital protocols should be followed regarding the location and cohorting of patients who either are suspected or confirmed COVID-19.

Patients should not be boarded in the Acute Floor.

6 Specific diagnoses and their pathways

- ED/Ward and Critical Care Staff Educational PowerPoint Presentations: These presentations are available for hospital based education programmes and are regularly updated. https://hse.drsteevenslibrary.ie/Covid19V2/emergencydepartment
- Clinical Decision Support for Suspect Adult COVID-19 for Acute Hospitals: https://hse.drsteevenslibrary.ie/Covid19V2/clincialassessment

6.1 The patient with respiratory failure:

All patients presenting with respiratory failure are required to be managed with Transmission-based precautions and patients should be tested for SARS-CoV-2 RNA and other relevant CID. IPC requirements for patients who require respiratory support are described in

Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/InfectionPreventionandControlPrecautionsforAcuteSettings.pdf

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6.2 The 'viral' patient presenting unwell with possible or probable COVID-19 or other CID:

COVID-19 presentations are variable and can mimic other conditions, such as other respiratory viral infections (seasonal influenza A or B, RSV, rhinovirus) etc. It can present as acute delirium in the older patient, as a pyrexial illness without an obvious source, abdominal pain or gastroenteritis. It can mimic bacterial sepsis. This makes diagnosis challenging and puts pressure on isolation facilities, infection prevention and control practice and laboratory testing capacity. These patients should be tested for SARS-CoV-2. A single sample reported as not detected does not exclude a diagnosis of COVID-19.

6.3 FAST + and chest pain presentations

It is recommended that timely access to intervention/care not be delayed if SARS-CoV-2 test results or risk assessment are not available.

6.4 Management of Orthopaedic Injuries

Patients may be encouraged to attend Injury Units either directly or after prior assessment for risk of COVID-19 or other CID. Injury Units are often capable of performing diagnostic tests and initiating management.

Many patients can be further managed in an outpatient setting. Expansion of the Trauma Assessment Clinics will mean that many of these patients can be managed remotely without further visits to hospital. If they do need to attend, the fracture clinics are remote from the acute floor and are often self-contained reducing the risk of unnecessary patient interaction.

Some patients will require operative management that can be performed in a planned fashion. The Planned Trauma Care arrangements will differ in different places but where possible the aim is to reduce the need for patients to be admitted through the ED. Day-case facilities, including elective Orthopaedic hospitals and independent sector facilities, can be used for ambulatory trauma. Patients can then be admitted on the day of surgery and discharged as soon as clinically appropriate (often on the same day).

Management of traumatic injuries via Injury Units, Trauma Assessment Clinics and Planned Trauma Care requires appropriate communication mechanisms to allow transmission of clinical information, including clinical photographs and x-rays to decision makers and to the sites of final disposition.

Some patients with will not be suitable for assessment in Injury Units because of the nature of the injury or co-morbidities and will need to be admitted from the ED and. These should be assessed for features suggested of COVID-19 or other CID and managed in terms of testing and IPC requirements as outlined in Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting.

The care of patients with hip and femoral fractures remains urgent and a surgical priority.

Staffing: Every effort should be made to ensure that patients with orthopaedic injuries are nursed by a cohort of nurses experienced in trauma orthopaedic nursing. Health and Social Care Professionals are key members of the multidisciplinary team and aid rehabilitation and speedy discharge. Resilience should be built in to all staff rosters to allow for likely absences.

Theatre resources: There should be a regular appraisal of available resources. All should have a clear understanding of the issues facing their own specialty prior to the meeting, including workload, relevant clinical details, ICU bed status, sickness absence and redeployment of staff. Resource allocation and patient prioritisation should be agreed.

7 Special groups

7.1 Frailty

Older persons, aged 70 years and older who present to the Acute Floor should be assessed for frailty using a rapid assessment tool, for example the VIP tool. If deemed frail, they should be assessed, investigated and treated expeditiously, if possible, in a separate area and by a frailty team during the usual working hours for completion of the Comprehensive Geriatric Assessment (CGA).

Presentations of frailty to Out Of Hours services should be referred to the Frail Intervention Therapy Team service as soon as possible for CGA.

This service should be led by a consultant geriatrician and an appropriately resourced team (Ideally include Advanced Nurse Practitioners, Clinical Nurse Specialist, Occupational Therapy, Speech and Language therapists, Pharmacy, Dietitians, Medical Social Workers and Physiotherapists).

The focus should be on ambulatory care with enhanced community supports (for example Community Intervention Team). If admission is required, this should be prioritized to avoid any unnecessary delay in the Acute Floor as this is associated with adverse outcomes.

Particular attention should be paid to the atypical presentations of COVID-19 in the older person

7.2 Cystic Fibrosis

People with CF who need admission out of hours.

These patients normally require testing for SARS-CoV-2 and other relevant pathogens, if they have respiratory symptoms.

In hospitals with a specialist CF Centre, people with CF who present out of hours should be assessed and treated by the team on call. They should be transferred to the CF Team the following day.

In hospitals without a specialist CF Centre, they should be assessed and treated at the hospital where they present. The CF Centre where they attend should be informed of their admission the following day. If appropriate and, if safe to do so, they may then be transferred to their CF Centre; that may or may not be necessary if they present with a short-term medical issue unrelated to CF.

7.3 Acute critical care patients

All patients reviewed for critical care admission have the potential for rehabilitation and recovery and their care wishes taken into consideration prior to admission. Where possible treatment aims and limitations should be discussed with the individual. Where this is not possible treatment goals and expectations should be discussed with the relevant individual. Please refer to information on the Assisted Decision Making (Capacity) Act 2015 on the HSE website.

https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/assisteddecisionmaking/assisted-decision-making.html#:~:text=The%20Assisted%20Decision%20Making%20(Capacity,be%20commenced%20in%20June%202022.

These goals and expectations should be revisited based on the patients' response to treatment.

All unscheduled care admitted patients, where there is a likelihood of a need for ICU admission should be assessed for risk of COVID-19 or other CID and have this documented and clearly communicated to the Critical care team.

All unscheduled care patients admitted to ICU should have SARS- CoV-2 testing in accordance with current guidance in Infection Prevention and Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/InfectionPreventionandControlPrecautionsforAcuteSettings.pdf

Critical care management should not be delayed pending test results; rather appropriate IPC precautions should be implemented.

There should be ICU isolation areas for the patients with suspected or confirmed COVID-19 or other CID at all times. Each ICU should have a documented plan for managing any future COVID-19 surges. If ICU resources are stretched beyond normal occupancy, there should be an ICU controller, ideally a consultant intensivist, whose is responsible for coordinating patient flow, triage and strategic planning for additional ICU spaces.

8 Governance

The Governance for the implementation of this guidance rests with the Hospitals and Hospital Groups through the Governance and Accountability Framework.

It is recommended that discharge letters be sent to GPs for patients who have attended, received treatment and been discharged from the acute floor. Where possible this should be via Healthlink. Where patient does not have a GP, efforts should be made to inform alternative community services, such as Safetynet services and services for the homeless if relevant.

This guidance is not intended to supersede clinical judgment rather to guide acute hospitals in the setting up of unscheduled care pathways to manage risk and optimize patient outcome during the COVID-19 pandemic.

9 Selected References

(1) https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/hseinfectionpreventionandcontrolguidanceandframework/
(2) https://www.ecdc.europa.eu/en/publications-data/rapid-risk-assessment-coronavirus-disease-2019-covid-19-pandemic-ninth-update
(3) https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/infographic-emergency-medicine.pdf
(4) https://www.rcsi.com/surgery/-/media/feature/media/download-document/surgery/practice/publications-and-guidelines/models-of-care/minimum-standards-for-acute-surgical-assessment-unites-in-ireland.pdf
(5) Lei et al: Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. 2020 Apr 5:100331.doi: 10.1016/j.eclinm.2020.100331. [Epub ahead of print] https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30075-4/fulltext and https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31182-X/fulltext
(6) https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/june2020/COVID-19_Daily_epidemiology_report_(NPHET)_09062020_v1%20website.pdf
(7) https://www.icnarc.org/Our-Audit/Audits/Current-Audits
(8) https://www.ncepod.org.uk/
(9) https://www.hpsc.ie/

Appendix: Template Checklist for Initial Brief Assessment for Risk of COVID-19 or other Communicable Infectious Disease

Answer of yes to any one of the clinical features warrants initiation of transmission-based precautions pending further evaluation. If clinical features cannot be determined (unknown)

Answer of yes to any one of the context questions increases the need for caution with any person with one of the clinical features

"Recent" is a subjective term. For this purpose, it can be taken to mean in the previous 7 days.

Clinical Feature	**Yes**	**No**	**Unknown**
Fever (temperature of 38◦C of higher)			
Recent onset of cough			
Recent rigors (observed or self-report shivering not readily explained by non-infectious causes)			
Recent acute deterioration of long-standing cough			
Cough productive of blood not explained by an non-infectious condition			
Recent onset of shortness of breath			
Recent acute deterioration of long-standing shortness of breath			
Recent onset of acute upper respiratory symptoms such as sore throat, nasal discharge, sneezing) not readily explained by non-infectious causes such as allergic rhinitis			
Recent onset of diarrhoea (more than 3 liquid stools in 24 hours)			
Recent acute deterioration of long standing diarrhoea			
Recent onset of skin rash not readily attributed to a non-infectious cause			
Recent unexplained loss or alteration of sense of smell or taste			
Skin or mucosal haemorrhage not readily explained by non-infectious causes			
Context			
Travel outside of Ireland in the previous 14 days			
Current high incidence of communicable infectious disease in the community served			
Completed by	Date		Time

Limitations; Completion of this checklist represents a brief assessment at a point in time to identify most patients most likely to have a communicable infectious disease that represents a substantial risk of spread to other patients and to staff. It is not an exhaustive list of clinical features associated with communicable infection. It does not replace clinical judgement. It does not address possible colonisation with antimicrobial resistant organisms

ENDS