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RCEM Coronavirus Infection, Prevention and Control Guidance

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Background

The following recommendations are a re-statement of good infection and control procedures that should be in place in emergency departments (EDs) to protect patients and staff from respiratory infections which are more prevalent in the Autumn and Winter months. The recommendations are primarily focused on Coronavirus but some aspects are also applicable to influenza and to a lesser extent Respiratory Syncitial virus (RSV). The National Infection prevention and control manual for England contains much useful information [1] including basic but fundamental items such as handwashing technique. National guidance regarding staff illness and isolation [2] should be followed to limit nosocomial spread and departments should develop plans to mitigate staff absence due adherence to nationally recommended isolation periods.

- All EDs should have systems in place to identify vulnerable patients on arrival. Vulnerable patients may include patients such as immunocompromised (eg. Chemotherapy) and unvaccinated patients with significant co-morbidities.

- All EDs should have systems in place to identify those patients with Coronavirus (Covid-19) symptoms [box 1] or those that have recently (past 2 weeks) tested positive. EDs should continue to encourage ambulance services to 'pre-alert' those patients who are Covid-19 positive.

- All EDs should have the capability to segregate or cohort patients who are Covid-19 positive or have Covid-19 symptoms. EDs should risk assess, including the ability to socially distance, the areas of their departments where symptomatic patients may congregate, this includes corridors and waiting rooms.

- EDs are encouraged to use rapid point of care testing for patients who will require admission as a means of maximising flow out of the ED. EDs should not become the default testing service for the whole hospital. Patients who are well enough to be discharged and who are likely to have Covid-19 based on symptoms do not require rapid PoCT in the ED.

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- All ED staff who are working with undifferentiated patients or patients who may have Covid-19 should have access to FFP2 masks. Staff should be aware of the PPE requirements when seeing patients with known or probable Covid-19 and in particular ensure they have undergone appropriate testing to ensure FFP3 masks fit appropriately. Staff should also be aware of what constitutes an aerosol generating procedure (AGP) [Box 2] and be aware of the differing PPE requirement. It should be noted that CPR, manual face mask ventilation, NIV, CPAP, HFNO, nebulisation, intubation (non-awake), chest drain insertion, and procedural sedation are not considered AGPs [3].

- All ED staff should be encouraged to have appropriate vaccinations, accepting that not all will be willing or able. Senior leaders in the ED should promote actively vaccination. When assessing patients, especially those in hard to reach and vulnerable communities eg. homeless; staff should encourage vaccination and be able to direct patients to the appropriate community resource.

- ED staff should ensure they either have access to hospital based Covid-19 testing facilities or a supply of lateral flow tests [4] in the event they develop Covid-19 symptoms. RCEM notes that the asymptomatic covid-19 testing programme has been suspended [5] for the majority of NHS staff and no impact assessment of this programme has been published as yet. Asymptomatic testing is still recommended for healthcare staff coming into regular contact with high risk patients groups eg. Immunosuppressed, at the discretion of Hospital organisations. RCEM remains supportive of asymptomatic testing for ED staff whilst awaiting the formal assessment of the impact of this programme.

- RCEM supports the Academy of Medical Sciences policy statement recommending the reporting of nosocomial Covid-19 infections, similar to that required for MRSA.[6]

Box 1. The main symptoms of COVID-19 include [7]

- Fever
- a new and continuous cough
- anosmia (loss of smell) and ageusia (loss of taste).

However examples of other and often more frequently occurring symptoms include:

- Sore throat
- shortness of breath
- fatigue
- loss of appetite
- myalgia (muscle ache)
- headache
- nasal congestion (stuffy nose)
- runny nose
- diarrhoea
- nausea
- vomiting.

Atypical symptoms, such as delirium and reduced mobility, can present in older and immunocompromised people, often in the absence of a fever.

Box 2. Aerosol Generating Procedures [1]

- Bronchoscopy (including awake tracheal intubation), awake*
- Ear, nose, and throat (ENT) airway procedures that involve respiratory suctioning, awake*
- Upper gastro-intestinal endoscopy, awake*
- Dental procedures (using high speed or high frequency devices eg. ultrasonic scalers/high speed drills)
- Induction of sputum
- Respiratory tract suctioning**
- Surgery or post-mortem procedures (like high-speed cutting / drilling) likely to produce aerosol from the respiratory tract (upper or lower) or sinuses.
- Tracheostomy procedures (insertion or removal).

*Awake including 'conscious' sedation (excluding anaesthetised patients with secured airway)

** The available evidence relating to respiratory tract suctioning is associated with ventilation. In line with a precautionary approach, open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current (COVID-19) AGP list. It is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is currently considered an AGP, that is oral/pharyngeal suctioning is not an AGP.

References

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