Portsmouth Hospitals University NHS Trust

GUIDANCE FOR THE SAFE MOVEMENT OF PATIENTS INTO AND ACROSS THE TRUST DURING THE COVID PANDEMIC

This policy is intended to secure the safe placement of patients when admitted to the hospital, or moved within the hospital, to reduce the risk of nosocomial infection in line with the Updated national guidance: Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022

Community Covid prevalence is currently at its highest level since the pandemic began, being driven by the Omicron variant of concern although we are still seeing some Delta variant cases being admitted to the hospital. Owing to demand and numbers of positives currently being seen only those samples from patients who have been admitted or attended ED are being sent for Variant of Concern (VOC) testing. In addition, referred samples MUST have a Ct value below 30 cycles AND have a residual sample volume post testing of 200 ul or more. For those patients who have been admitted and there is insufficient volume, a repeat sample is requested specifically for VOC testing. Hampshire Hospitals in Basingstoke perform the genotyping and then forward the extracted nucleic acid to Porton Down for sequencing.

Genotyping results are usually available 48 hours post the sample being sent (three days after initial testing – so long as a repeat is not required) Sequencing can take up to three to four weeks for the results to be returned.

To reduce the risk of nosocomial infection, whilst maintaining safe flow from the Emergency Department, the Trust employs point of care testing (POCT) in the Emergency Department for all admissions using the Loop-mediated Isothermal Amplification (LAMP) test, ID NOW, or Quadplex testing on the GeneXpert for those with symptoms suggestive of a respiratory viral illness where influenza must also be excluded. The SOP for the use of this test is included as Appendix 1. Based on this our admission pathway have been updated, see page 3.

1. GENERAL PRINCIPLES

a) Minimise patient moves and thereby number of contacts, prioritising direct admissions for POCT positive patients to designated Covid cohorting wards.

b) Perform POCT testing on all admissions ***including those who have had positive PCR tests within the last 90 days and those patients who are re-admitted who have previously tested negative whilst an inpatient or in ED or another assessment area***. These tests should be performed as early in the assessment pathway as possible as soon as the need for an admission is suspected and not waiting for a formal Decision to Admit (DTA) in ED.

c) Patients requiring urgent surgery being admitted via any route require PCR via GeneXpert.

d) Renal-CHOC –due to the vulnerable nature of these patient cohorts we have agreed to prioritise PCR via GeneXpert for admissions from this cohort.

e) For direct stroke admits swabbing: POCT at earliest possibility; Pre-CT for non-thrombolysis patients (ED or Stroke Nurse specialist); en route for the thrombolysis patients to then be taken back to ED barn for processing.

f) The POCT regime requires a duplicate throat and nose swab for laboratory PCR at the same time as those for POCT. Confirmatory PCR results will be available approximately 15 hours post testing on average, but can be expedited though the ops centre (ext. 6909) when clinical or operational urgency requires.

Following positive POCT or positive covid PCR patients should be managed in a side room with en-suite facilities until such time as side room capacity is overwhelmed when cohort bays on designated Covid cohorting wards will be used in line with the published ward escalation plan.

g) Highly vulnerable patients, including the immunocompromised (defined in section 8) should never be moved to a cohort area until proven Covid positive and should be managed in cubicles in the absence of a positive result.

h) Cubicles should be allocated to Level 2 patients (those requiring CPAP, NIV, HFNO, Aerosol Generating Procedures) in the medium and high-risk categories. All Level 2 Covid positive patients should be admitted to G5 (or an expanded O+ area) where possible.

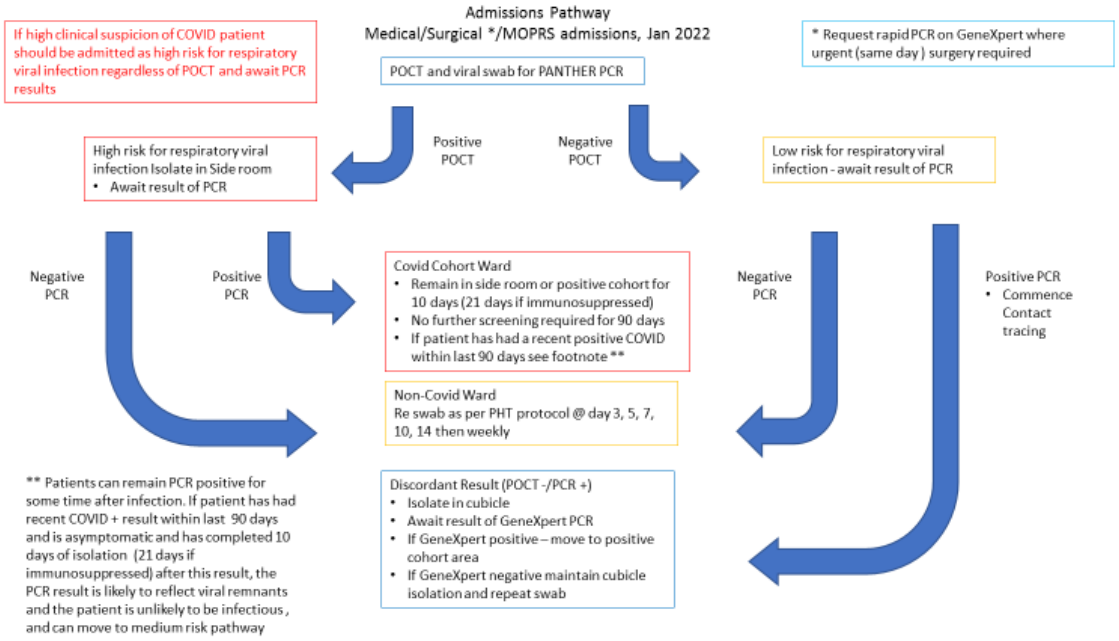
i) Patients being admitted with a positive Covid PCR result within the last 90 days (either community or hospital) will have repeat POCT on admission. Of note the sensitivity of the ID NOW POCT test diminishes significantly from 10-12 days post infection when the viral load has reduced.

j) Continued active decision making is required regarding de-escalation of patients from isolation once the required quarantine period has been completed, that being 10-days for immune competent, non- critical care patients and 21-days for immunocompromised patients and those who have been critically ill.

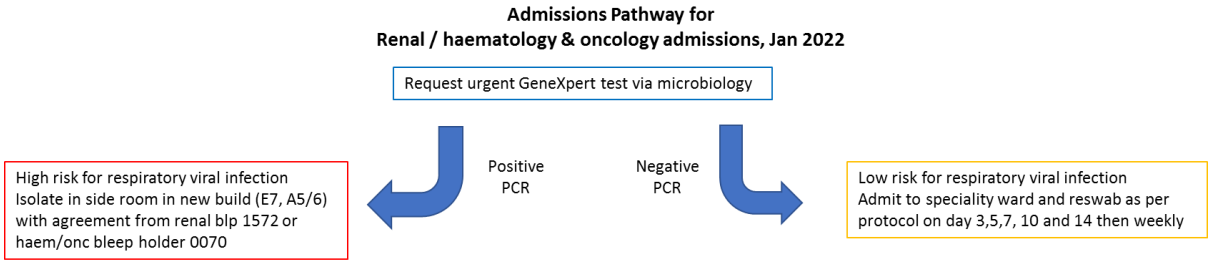
k) All areas require appropriate use of PPE by staff, consistent use of good hand hygiene and decontamination of all high touch surfaces and items multiple times every day. Ensure compliance with the Covid-19 Emergency Admission Screening process (Appendix 3). Encourage patient use of face masks where tolerated and clinically safe to do so (not appropriate for patients with an oxygen requirement). Ensure that windows are opened for 10 minutes every hour on the hour to maximise ventilation.

l) On Covid cohorting wards and contact wards Respiratory Protective Equipment (RPE -FFP3 or equivalent) can be worn by staff in preference to Fluid Resistant Surgical Masks (FRSM) if it is their preference to do so and they have been Fit tested on the available FFP3 masks. This is especially recommended for periods of prolonged contact either in a bay or side room (see guidance in Appendix 2). The use RPE is mandated when caring for patients undertaking Aerosol Generating Procedures (AGP).

2. Admission pathway for medicine, surgery and MOPRS

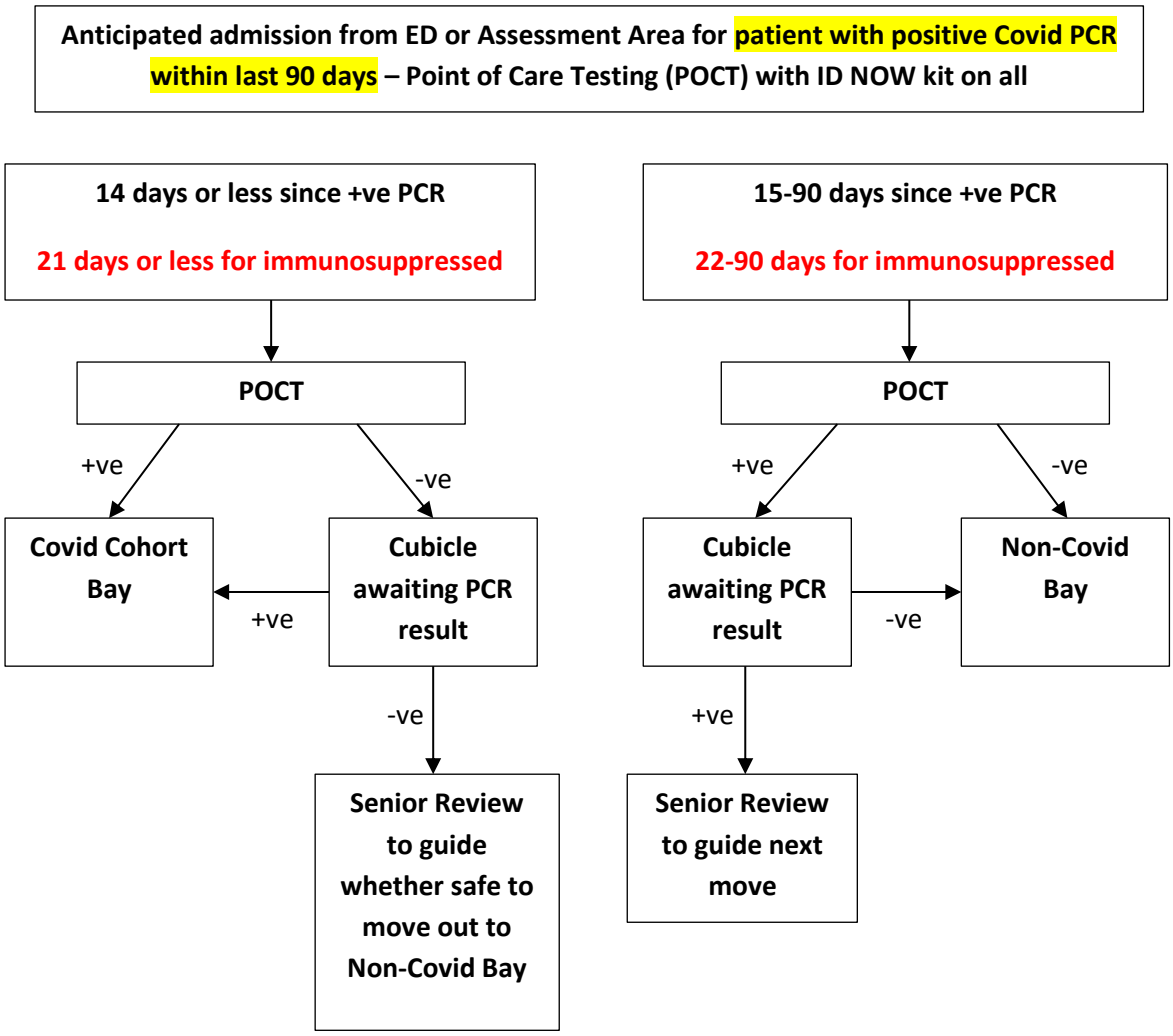


3. Admission pathway for Renal and Haematology/Oncology



** Patients can remain PCR positive for some time after infection. If patient has had recent COVID + result within last 90 days and is asymptomatic and has completed 14 days of isolation (21 days if immunosuppressed) after this result, the PCR result is likely to reflect viral remnants and the patient is unlikely to be infectious and can move to speciality ward

4. Admission Pathway for patients with Positive PCR in the last 90 Days



5. ON ADMISSION

a. Covid Cohorting Wards

Confirmed COVID 19 cases or patients with clinically suspected Covid admitted via any route will be managed through the **Red** area of ED and, if confirmed as having Covid, onwards onto Covid Cohort wards or side room in the hospital. ID NOW POCT results have high specificity for this group and can be used to guide direct movement into **Covid Cohorting wards**.

Suspected COVID 19 patients include the following:

- Those with a clinical picture suggestive of COVID
- Known contact with someone who is COVID positive in last 14 days
- Admissions from care homes **which still have active COVID cases**
- Any travel either within the UK or abroad within last 14 days

Non-Covid Wards

Medical and non-medical patients with and a negative ID NOW POCT result will be moved into Non-Covid bays barring any other individual patient contraindication to do so.

Asymptomatic patients who refuse testing will have to be managed through cubicles until a negative PCR test can be obtained.

6. CONTACT PROTOCOL

a. If patient tests positive in a main bay with other patients who are not positive follow the contact protocol:

- If PCR positive can move into a covid cohorting bay on an a covid cohorting ward if no other contra-indication to do so. If Covid status indeterminate from initial testing move into a cubicle until confirmatory PCR available.
- All new inpatient PCR positive patients routinely have confirmation performed on the same sample via GeneXpert or 6800 for speed in ensuring a confirmed positive plus provision of a threshold cycle (Ct) value.
- Clean vacated space and close to admissions.
- The bay should now be regarded as a Contact Bay.
- Swab remaining patients in bay for Panther PCR test on identification of contact and restart swabbing in accordance with the Covid 19 Emergency Admission Screening process (Appendix 3) **restarting swabbing sequence as if a newly admitted patient** plus add in additional daily lateral flow tests to facilitate rapid detection of infection
- These patients should remain in this bay for 10 days or until discharge, with a risk assessment completed before de-isolation (Appendix 4).
- As remaining patient numbers in bay dwindle it may be required to move these patients into side rooms to free the bay for deep cleaning prior to re-admitting patients normally.
  Deep clean the bay (once all contact patients have moved out or have been discharged) including changing the curtains. Hydrogen Peroxide fogging is not required.

b. For patients in an open bay who develop signs and/or symptoms of COVID, or who are found incidentally to have radiological evidence of possible COVID infection:

- Swab patient and move into side room
  If swab result positive follow actions as above
- If negative can be stepped back down unless there is a very high clinical suspicion and no alternate diagnosis based on a senior clinical review.

c. Mixing Contact patients:

- Evidence from the review of our Nosocomial deaths from the second pandemic wave shows this to be an extremely hazardous activity which should only be considered under exceptional operational circumstances.
- Such a decision would require clinical input; discussion with the IPC team; discussion with a representative of the relevant Divisional team/s; and final Executive Director approval before being enacted.
- If this has to occur exceptionally, our current recommendation, in line with national guidance, is that it should be limited to patients who are 7 days or more post contact with negative PCR on the day of the planned move. Ideally try to match exposure times within 72 hours, and only consolidate contacts on one occasion if possible.
- Individual patients should have no symptoms suggestive of Covid infection when being considered for such a move.
- Urgent GeneXpert (Rapid PCR) testing can be utilised to facilitate these discussions and bed moves if necessary

d. **Adding de-escalated Covid patients**

In line with national guidance Covid recovered immune competent patients can be placed within empty closed contact bay beds after 10 days of isolation has been completed, providing they have symptomatically recovered and have had a clinical risk assessment, see appendix 4.

7. TESTING

a. Methods: Currently the following testing methods are available at QAH:

- Panther- Covid-19 only, high throughput testing system, average TAT 9 hours, samples can be prioritised to give result in 4-5 hours*
- Cobas 6800 – Covid-19 only, back-up, high throughput testing system. This is used during Panther downtime or when excess workload means samples are queuing to be put on the Panther. It is batch-based testing system with a run taking three and a half hours for 94 samples.
- Molecular point of care test (ID NOW) within the Emergency Department – TAT within 15 minutes. This test uses dedicated dry swabs. Currently, four ID NOW platforms are in use in the Emergency Department, giving a capacity of 12 tests per hour.
- GeneXpert - Covid-19 only with an average turnaround time or around 75 minutes.
- GeneXpert – QUADplex has targets for SARS-CoV-2, Influenza A, Influenza B and RSV. Currently based in Microbiology, there is provision for a four-bay platform to be rapidly deployed to the Emergency Department POCT area should case rates for Influenza or RSV rise. Average TAT is one hour, with a combined capacity FOR BOTH Covid-19 only and QUADplex testing currently ten tests per hour.

- QIAstat- Extended respiratory panel covering 23 targets including SARS-CoV-2 with an average TAT 90 minutes (mainly reserved for symptomatic ITU/HDU admissions, paediatric and immunosuppressed patients). Currently, two tests can be run at the same time.
- Covid-19 Ag Test (lateral flow test, antigen detection) - point of care lateral flow test, TAT 15-30 minutes (patients should not be de-escalated on the basis of a negative result). Lateral flow is also being used daily for inpatient contacts and in admission areas for patients unlikely to remain in hospital.

b. Pathway:

The following pathway is for non-elective admission pathways. Patients being admitted electively will be screened prior to admission, so do not require an admission screen, but should follow the pathway from day three onwards.

Testing pathway:

	Possibly Covid Clinically	**Unlikely Covid**
Admission	POCT (ID NOW) and Panther or 6800	POCT (ID NOW) and Panther or 6800[1]
Routine inpatient screening as per as per the Trust's COVID-19 EMERGENCY ADMISSIONS SCREENING PROCESS	Panther (all new positives confirmed by GeneXpert)	
Onset of Covid-compatible symptoms in a previously negative patient.	An urgent test should be requested using either the Panther, GeneXpert, QUADplex or QIAstat- selection is dependent on the clinically/operationally required TAT and whether just Covid-19 testing, limited respiratory viral or a full respiratory screen is required.	
Contact of a positive patient	Swab as soon as identified as a contact, patient should have daily lateral flow tests, continue with routine PCR testing and an additional test is required at day 10 post exposure - Panther.	
Within 48 hours of discharge	Panther	

**** To facilitate a rapid Panther test you must do the following:***
- During working hours (8am-7pm) phone the lab AND mark test as urgent.
- If in doubt as to whether a test is urgent discuss with Ops, IPCT or a consultant microbiologist.
- For quickest results and reliable delivery please hand deliver sample to clinical microbiology reception. It is acceptable to use the POD system but this method of delivery is less reliable
- This specimen will be prioritised and take the next available testing slot using the Panther.
- Results should be available within 4-5 hrs up to 11pm.
- Priority Panther testing is not currently available overnight. Urgent testing overnight should be discussed with the Ops team.

c. Additional Supporting information regarding use of ID NOW POCT:

The ID NOW platform is a Category B point of care test (LAMP technology), has been rolled out as a point of care (POC) test in ED. molecular assays can be divided into 3 categories (A-C). Category A tests do not require confirmation and include the Panther, 6800 and both GeneXpert tests; category B tests require confirmation of negative results. Data from UK users of the ID NOW demonstrates consistent performance as a Category B test.

The positive predictive value of the ID NOW in a low prevalence group is not sufficient to support cohorting of positive patients based on this result alone - as such all positive low risk individuals should be admitted to a side room pending laboratory confirmation using a Category A test.

Confirmation of a negative results:

- 2 x swabs taken by ED staff – one dry for POC, one wet for check PCR in lab (for POC negative tests and low risk only); Dry POC test performed by testing team in ED; the result will be uploaded in real time to Apex and ICE and from there become available on BedView and Minestrone; Validation swab for negative POC results to be transferred to laboratory for Panther or GeneXpert testing.

- For patients who are not admitted – they will be informed of ID NOW result by ED before leaving. Positive patients will be advised to self-isolate as per national guidance.

- For patients who are discharged from ED to a community setting with a positive ID NOW result, the care facility must be informed of the result by telephone prior to discharge and the result included in their discharge documentation. In the exceptional circumstance that the care facility cannot accept receipt of the patient they will need to be admitted pending further planning to be supported by discharge services.

New Variants

As SARS-CoV-2 virus mutates the new variants may escape the protective immunity produced by immunisation or by previous natural infection and cause new onset of infection. The current diagnostic techniques in use in our laboratory detect any of the new variants circulating at present. If a new variant emerges that evades immunity from the vaccine, then all patients will need to be isolated in a cubicle until the genotyping result is back. Currently the predominant variant being seen is Omicron but there are still sporadic cases of Delta being identified within patients.

8. POINTS OF CLARIFICATION WITH REGARD TO ONGOING INFECTIVITY, VULNERABLE AND IMMUNOCOMPROMISED PATIENTS

Patients who have tested positive should remain in a side room or a Covid cohort bay for 10 days, with the exception of those in the groups referred to below. Testing for viral clearance is not required.

Critically ill or immunosuppressed individuals should remain isolated for a period of 21 days as prolonged shedding of infectious virus has been observed in this group (not beyond day 20). Persistent positivity can occur for 90 days in all groups- beyond day 21 this will just reflect detection of non-viable (non-infectious) viral RNA, so testing for viral clearance should not be routinely performed. 21-day isolation should be applied to anyone who falls into one of the following categories;

i. **Severely immunocompromised** - Acute/Chronic leukaemia, lymphoma, lymphoproliferative disorders, cellular immune deficiency, HIV/AIDS, autologous or allogeneic stem cell transplant in last 24 months, immunosuppressive treatment in last 6 months for a malignant/non-malignant disorder or solid organ transplant, immunosuppressive biological therapy in last 12 months, or patients receiving immunosuppressive therapy in last 3 months defined as:

   - Adults and children on high-dose corticosteroids (>40mg prednisolone per day or 2mg/ kg/day in children under 20kg) for more than 1 week
   - Adults and children on lower dose corticosteroids (>20mg prednisolone per day or 1mg/kg/day in children under 20kg) for more than 14 days
   - Adults on non-biological oral immune modulating drugs, for example, methotrexate >25mg per week, azathioprine >3.0mg/kg/day or 6-mercaptopurine >1.5mg/kg/day
   - Children on high doses of non-biological oral immune modulating drugs (as defined in the Green Book on Immunisation)

ii. **Patients receiving critical care**
iii. **Patients receiving renal dialysis**

Appendix 1
Point of Care Testing in the Emergency Department for SARS-CoV-2 and Influenza A & B Viruses

Context

This is a brief guide to describe the point of care testing (POCT) process for samples from patients attending the Emergency Department (ED) and expected GP admissions to Acute Medical Unit (AMU).

It is important to identify patients who are SARS-CoV-2 positive as early as possible in the patient journey; the same applies to patients with symptoms consistent with Influenza. This will aid care, treatment plans and bed allocation for those being admitted to hospital and reduce the risk of nosocomial infections. The development of POCT makes this possible in the Emergency Department without delaying the flow of patients into the hospital.

Standard Inclusion criteria

SARS-CoV-2 Only Testing (ID NOW)
Swab to be taken on arrival to ED, even if they have had a recent positive or negative swab:

- All patients aged 70 years and over
- All patients with an oxygen requirement
- All patients from a care or nursing home
- All patients in the Resuscitation Area
- Patients who on arrival are felt likely to require admission

In addition, all patients who fall outside these criteria but are referred for admission

Influenza A, B, RSV & SARS-CoV-2 (QUADPlex) Testing
Swab to be taken on arrival to ED, even if they have had a recent positive or negative swab:

- All patients with Respiratory Symptoms and are likely to be admitted, including paediatric patients.

Exclusion Criteria

- Patients where time critical treatment is required e.g. CVA, MI
- Patients requiring urgent Surgery, with no respiratory symptoms: these require urgent PCR testing by GeneXpert in the laboratory and not ED POCT using the ID NOW system.
- Patients needing to be admitted to Renal, Oncology and Haematology, again with no respiratory symptoms, these require urgent PCR testing by GeneXpert in the laboratory and not ED POCT.
- Patients where, taking a swab is not possible e.g. facial trauma, significant epistaxis, severe confusion or aggression

Process

Medical technicians are based in the Barn in Majors A 24/7

SARS-CoV-2 Testing

There are 4 ID NOW platforms in the department, and each test takes 15-20 mins to complete, giving capacity for 12 tests per hour.

There are currently 1200 POCT tests available per week for the ID NOW allocated to Portsmouth by the DHSC; this can be increased via Microbiology if required.

Influenza A, B, RSV & SARS-CoV-2 Testing

There are three four bay GeneXpert platforms based in Microbiology, each test takes around one hour to complete; this gives an hourly capacity of ten tests. The laboratory is routinely staffed between 07:00 and 23:00 for Covid-19 testing; access to testing outside of these hours is via Ops and the Microbiology On Call team.

Supply of the QUADPlex GeneXpert Cartridges is currently not constrained but orders can only be placed on a fortnightly basis, on the Thursday prior to the week of delivery. A stock of assay kits is maintained in Microbiology but rapid changes in usage are difficult to accommodate in this new ordering process. These tests are purchased by the Trust and are only partially reimbursed by the DHSC.

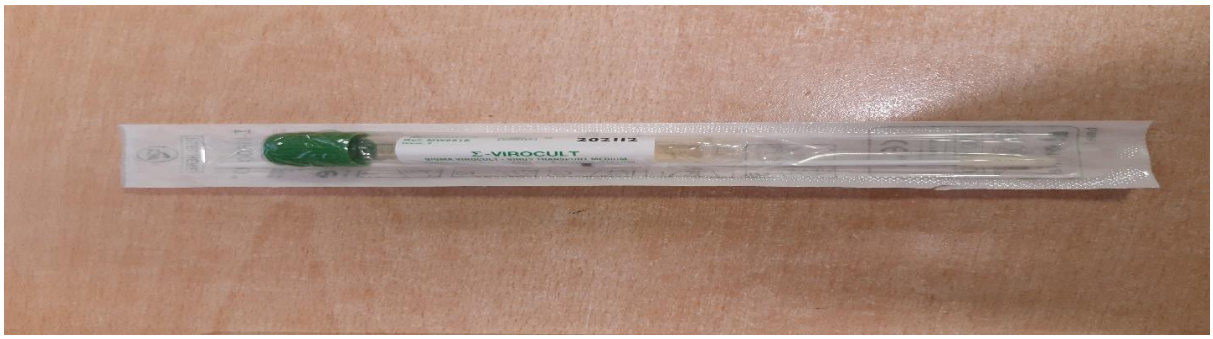
Swabs

SARS-CoV-2 and QUADplex Testing

For patients who have **NO RESPIRATORY SYMPTOMS**, **2 SWABS** are required.

Both swabs will need to be taken from the patient's throat and nasal passages

SWAB A - to be taken to Majors A – the technicians will send this to the lab for either Panther / GeneXpert or QUADplex testing in Microbiology.



SWAB B – to be taken to Majors A for POCT

The average POCT result time will be 15 – 20 mins. A positive result will be sooner.

ICE Requesting for SARS-CoV-2 only Testing

The test code is PCR19P. There are two ways of finding the test code on ICE;

1. After selecting new request,
    a. select the Covid-19 request panel from the top
    b. then select Point of Care from the side

2. Select ward profile and then the Emergency Department page

- The ICE request for POCT will automatically generate a request for a lab request.
- You will not have to re-enter the patient information which you have already given for the POCT request.
- Please ensure that the **DRY SWAB (Swab B)** is labelled and placed in a bag and attached to the **POCT (PCR19P)** request form **AND** that the **VIROCULT – LIQUID SWAB (Swab A)** is labelled and attached to the form being sent to the laboratory.
- Please check that they are the correct way around **BEFORE** entering the POCT testing area.
- Batching of tests must be avoided to prevent a backlog of tests

ICE Requesting for INFLUENZA A / B, RSV AND SARS-CoV-2 Testing for SYMPTOMATIC PATIENTS

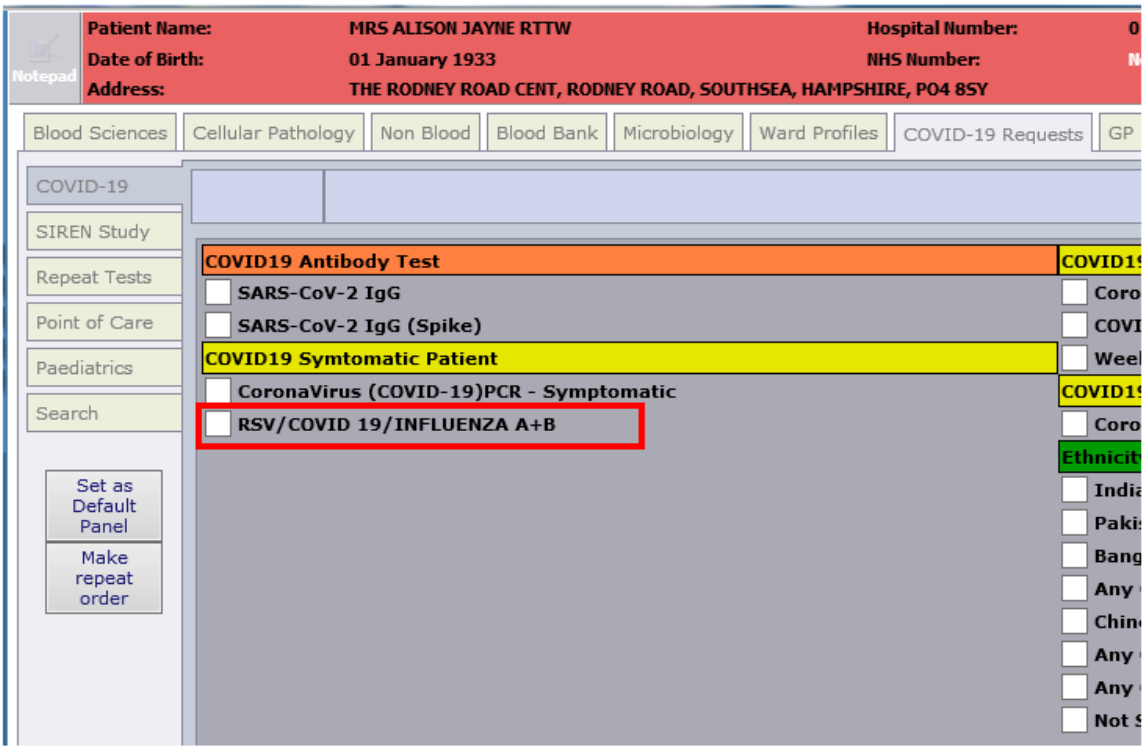
On APEX the over-arching Order Code is QUAD: this will generate four separate test codes for SARS-CoV-2, Influenza A, Influenza B & RSV. On ICE this request can be found by:

Selecting New Request

Select COVID-19 Requests for the tabs at the top

Select COVID-19 from the side

In the list presented select RSV / COVID 19 / Influenza A+B (found under Symptomatic Patient).



Select the Ward Profile

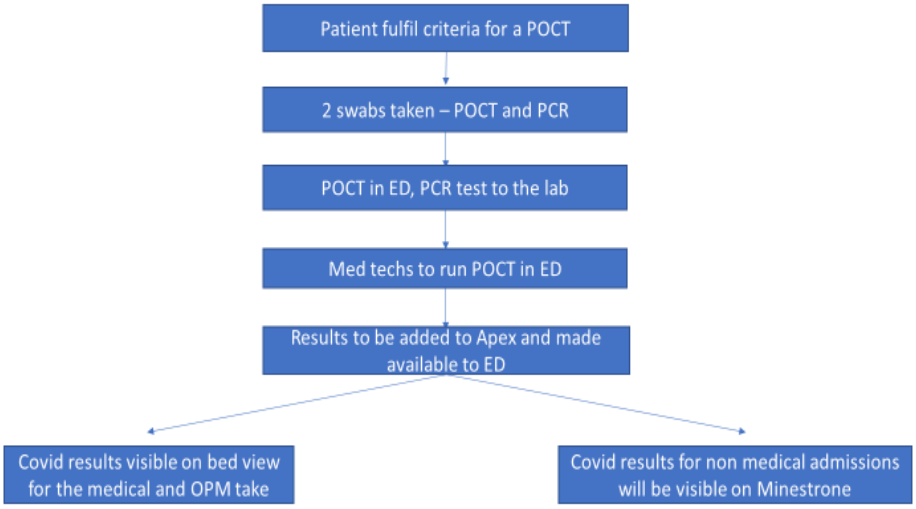
When prompted to enter a Mobile Telephone number: if the patient is admitted onto a ward complete the box with text stating In Patient. If it is likely the patient will not be admitted from AMU or the Emergency Department, please enter the patients Mobile Telephone number to enable them to receive a text message with the result.

The ICE request will be generated.

Remember only ONE SWAB (Type A – with liquid in the vial) will need to be collected.

Please ensure that the swab is labelled, placed in a bag and attached to the printed request form.

Flow Diagram for POCT for SARS-CoV-2 and QUADplex

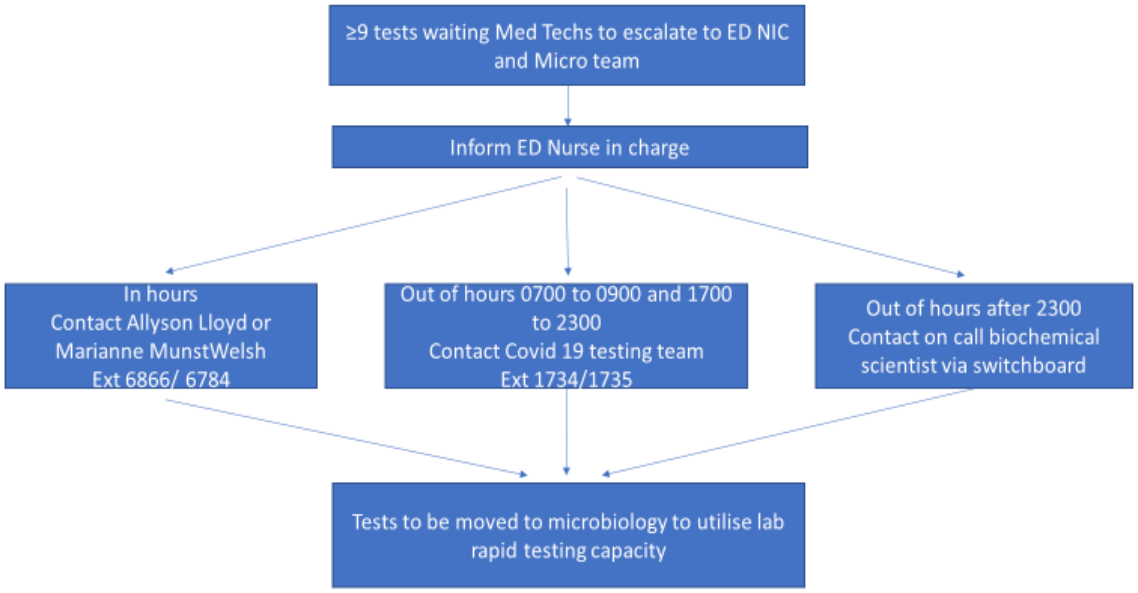


Escalation process for delays in processing POCT

Data suggests there should be enough testing capacity. However, if there are times of increased hourly attendances to ED, there may be a mismatch in demand and capacity leading to a delay in testing.

If there is a **backlog of NINE or more DRY swabs FOR SARS-CoV-2 ONLY testing and / or more than FOUR GREEN TOPPED WET SWABS FOR INFLUENZA A/B, RSV and SARS-CoV-2 TESTING**, this should be escalated by the medical technicians to ED nurse in charge and to Microbiology. POCT should redirected to microbiology laboratory to utilise their rapid testing capacity. It should be noted that whilst the time for the Influenza A, B, RSV & SARS-CoV-2 test will remain the same as that performed by the POCT team the GeneXpert for the SARS-CoV-2 only test will be longer – in excess of 50 minutes.

Flow diagram for escalation



Escalation process for POCT machine failure

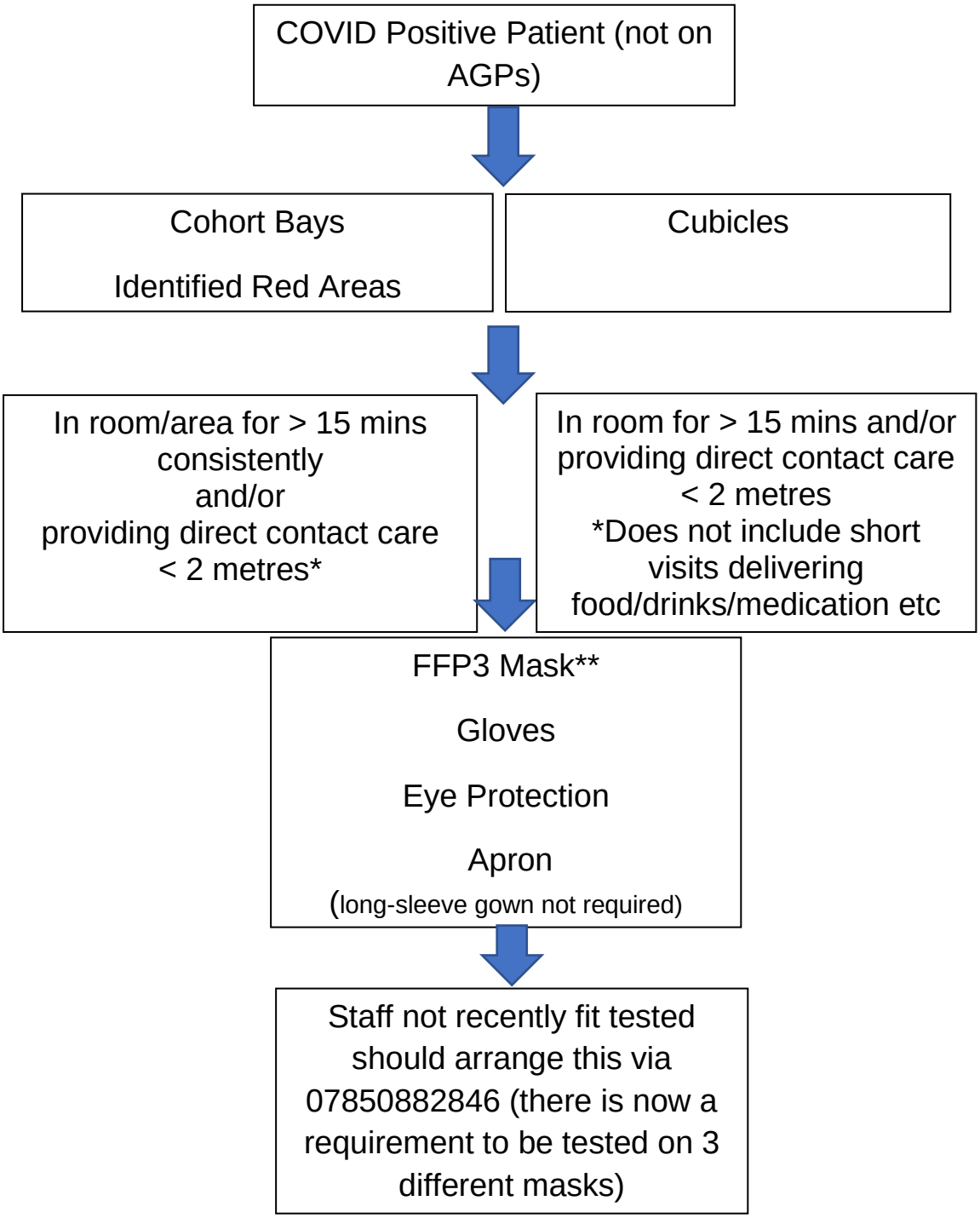
There are 6 ID NOW POCT machines in the Trust, 3 currently in use in ED.

Should one platform in ED fail, the machine will be swapped. This process should take about 45mins, which includes warm-up time and running a control to check performance. Escalate machine failure in the same way as for a testing backlog.

Should a bay fail on the GeneXpert platform the remaining three modules can continue to be used. If performing the self-check routine does not resolve the issue the bay will have to be taken out of use. This will cut testing capacity; therefore, the Nurse in Charge in ED will need to be informed along with Microbiology. It will be increasingly likely that the escalation process will need to be invoked.

Appendix 2

Guidance on when to wear an FFP3 mask instead of a FRSM



Patients having AGPs normal AGP PPE is required – FFP3 Mask, Long-Sleeve Gown, Gloves and Visor

****** If staff decide not to wear an FFP3 Mask this is a personal decision

COVID-19: Guidance for maintaining services within health and care settings

Appendix 3

COVID-19 EMERGENCY ADMISSIONS SCREENING PROCESS

Patients with no Positive result in the last 90 days

DAY 1 – ENTRY TO HOSPITAL

↓

DAY 3

↓

DAY 5

↓

DAY 7

↓

DAY 10

↓

DAY 14

↓

EVERY 7 DAYS WHILST REMAINS AN INPATIENT

↓

WHENEVER **ANY** PATIENT STARTS DISPLAYING SIGNS/SYMPTOMS OF COVID-19

COVID-19 Positive Patients

THERE IS NO REQUIREMENT TO ROUTINELY RESWAB POSITIVE PATIENTS WITHIN 90 DAYS UNLESS THEY ARE BEING TRANSFERRED TO ANOTHER CARE FACILITY. A RE-SCREEN SHOULD BE CARRIED OUT WITHIN 48 HRS PRIOR TO DISCHARGE TO ANOTHER CARE

COVID-19 Contacts

SCREEN CONTACTS ON DAY COVID-19 CONTACT HAS OCCURRED **AND RESTART** SCREENING PROTOCOL ON THE LEFT (ALL CONTACTS SHOULD BE LATERAL FLOW TESTED DAILY IN ADDITION TO ROUTINE SCREENING)

↓

DAY 10 PRIOR TO DE-ESCALATION FROM CONTACT BAY

OR

WITHIN 48HRS PRIOR TO TRANSFER TO ANOTHER CARE FACILITY

Appendix 4

De-escalation of patients with a positive Covid result and PCR negative Covid Contacts

1. Patients with a Positive Covid Result

The course of Covid infection has been shown to differ between immunocompetent, immunosuppressed and critically ill patients. As such the guidance around stepping down Covid precautions following an infection needs to consider these groups separately.

a. Immunocompetent patients

A patient can be stepped down after 10 days of isolation (from the onset of symptoms or their first positive test if they remained asymptomatic throughout) if they meet the following criteria:

- clinical improvement with at least some respiratory recovery
- absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication
- no underlying severe immunosuppression (see appendix A)

b. Severely Immunosuppressed patients

Please see appendix A for a list of patients who should be considered severely immunosuppressed.

A severely immunosuppressed patient can be stepped down after 20 days of isolation (from the onset of symptoms or their first positive test if they remained asymptomatic throughout) if they meet the following criteria:

i. Symptomatic

- clinical improvement with at least some respiratory recovery
- absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication

A GeneXpert PCT test may be requested if clinical concern and need to confirm that Ct value is greater than 35.

ii. Asymptomatic

Asymptomatic patients with a positive PCR test result after 20 days can end their isolation if:

- the Ct value of their PCR test is greater than 35, and
- they have either a positive anti-spike-antibody test or a negative LFD antigen test

c. Critically ill patients

A patient can be stepped down after 20 days of isolation (from the onset of symptoms or admission if this information is not available) if they meet the following criteria:

- clinical improvement with at least some respiratory recovery
- absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication

2. PCR Negative Covid Contacts

A patient can be stepped down after 10 days of isolation (from the date of their contact) if they meet the following criteria:

- No symptoms suggestive of Covid infection
- Absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication
- Negative PCR within 24 hours of de-isolation (if in a contact bay all contacts must also be negative at time of de-escalation)
- No underlying severe immunosuppression (see appendix A)

Appendix A

Severe immunosuppression definitions

Severe immunosuppression is defined in the Green Book on Immunisation as:

- immunosuppression due to acute and chronic leukaemias and lymphoma (including Hodgkin's lymphoma)
- severe immunosuppression due to HIV/AIDS (British HIV Association advice)
- cellular immune deficiencies (such as severe combined immunodeficiency, Wiskott-Aldrich syndrome, 22q11 deficiency/DiGeorge syndrome)
- being under follow up for a chronic lymphoproliferative disorder including haematological malignancies such as indolent lymphoma, chronic lymphoid leukaemia, myeloma and other plasma cell dyscrasias
- having received an allogenic (cells from a donor) stem cell transplant in the past 24 months and only then if they are demonstrated not to have ongoing immunosuppression or graft versus host disease (GVHD)
- having received an autologous (using their own stem cells) haematopoietic stem cell transplant in the past 24 months and only then if they are in remission

- those who are receiving, or have received in the past 6 months, immunosuppressive chemotherapy or radiotherapy for malignant disease or non-malignant disorders
- those who are receiving, or have received in the past 6 months, immunosuppressive therapy for a solid organ transplant (with exceptions, depending upon the type of transplant and the immune status of the patient)
- those who are receiving or have received in the past 12 months immunosuppressive biological therapy (such as monoclonal antibodies), unless otherwise directed by a specialist
- those who are receiving or have received in the past 3 months immunosuppressive therapy including:
    - adults and children on high-dose corticosteroids (>40mg prednisolone per day or 2mg/ kg/day in children under 20kg) for more than 1 week
    - adults and children on lower dose corticosteroids (>20mg prednisolone per day or 1mg/kg/day in children under 20kg) for more than 14 days
    - adults on non-biological oral immune modulating drugs, for example, methotrexate >25mg per week, azathioprine >3.0mg/kg/day or 6-mercaptopurine >1.5mg/kg/day
    - children on high doses of non-biological oral immune modulating drugs