

Interim Infection Prevention and Control Precautions for Possible or Confirmed 2019 novel Coronavirus (2019 nCoV)

Teams will respond to requests for service as usual for patients meeting threshold of Critical Care and are accepted into an (P)ICU. Ward-to-ward transfers of suspected or probable cases are the responsibility of the NAS-IRT

Has the COVID-19 Assessment and testing pathway for use in a HOSPITAL SETTING already been applied to referral? If no, **you must enquire** into the following:

Criteria for COVID-19 parallel stream:

Acute respiratory infection of any degree of severity (including at least one of: fever ($\geq 38^{\circ}\text{C}$), shortness of breath or cough)

OR

Fever ($\geq 38^{\circ}\text{C}$) of unknown cause with no other symptoms

OR

New onset of acute respiratory illness, Influenza-like illness or hypoxic respiratory failure in a previously healthy person

OR

Acute deterioration of existing respiratory disease requiring hospital assessment

OR

Temperature above 38°C or chills in the absence of reasonable evidence of infection at a non-respiratory site

Clinical judgement should be applied in application of these criteria to determine who requires testing. Clinician should be alert to the possibility of atypical presentations in older patients and those who are immunocompromised.

Probable case

A possible case for whom testing for 2019- nCoV is inconclusive (the result of the test reported by the laboratory) or for whom testing was positive on a pan-coronavirus assay.

Confirmed case

A person with laboratory confirmation of 2019-nCoV infection, irrespective of clinical signs and symptoms.

If these Conditions are met, then consider the case definition to have been met, and you must follow the policy below

When do PPE precautions apply?

Apply Standard Precautions to all patients at all times and Contact and Droplet Precautions in addition to Standard Precautions.

Clinical Team

- The clinical team will wear PPE from before patient contact on arrival at the referring centre until completion of the retrieval and decontamination of the equipment.

Ambulance Technician

- The Ambulance Technician will don PPE with the Medical Team and wear until the patient and Team are in the rear of the Ambulance and the doors closed, however at this point he/she would remove their PPE and dispose in order to drive the ambulance back to the receiving hospital.
- The sliding window between the saloon and driver compartment will remain closed at all times in order to keep the driver's compartment decontaminated.
- All communications with the Ambulance Technician during the journey must be via the intercom.

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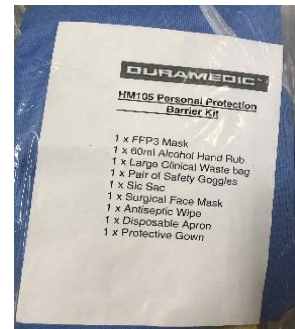
- When he/she arrives at the receiving hospital he/she will don fresh PPE and wear until patient handover is completed and the equipment is decontaminated.

PPE:

- Strict Hand Hygiene.
- Respiratory & Cough Hygiene.
- **NB** Wear PPE as provided **at all times** starting before you enter the patient environment, continuing in the ambulance and until patient handover is completed and you have completed decontamination of the equipment.

PPE equipment available on all NAS-CCRS Ambulances (order in which PPE should be applied)

1. Alcohol gel.
2. Long-sleeved gown +/- shoe covers or Coverall.
3. Respiratory protection – FFP 2/3 mask - method for mask fit:
 - Place mask over nose, mouth and chin
 - Fit flexible nose piece over nose bridge
 - Secure on head with elastic
 - Adjust to fit
 - Inhale – mask should collapse
 - Exhale – Check for leakage around face
4. Eye protection Goggles (if goggles fog up, the respirator is not fitted correctly – adjust and repeat fit check).
5. Gloves.



Respiratory Care

- Avoid Hi-flow oxygen therapy and non-invasive therapy where possible.
- Intubation is recommended to reduce the risk of aerosolisation.
- **NB** Ensure HME filter is attached to ventilation tubing **at all times**.
- Ventilator circuits should not be broken unless absolutely necessary.
- Ventilators must be placed on stand-by when carrying out bagging.
- Nebulisation and Water humidification should be avoided.
- Closed in-line suction recommended at all times (available in Critical Care Vehicle (CCV)).
- Disposable respiratory equipment should be used wherever possible. Re-usable equipment must be decontaminated in accordance with the manufacturer's instructions.
- Transfer patient to negative pressure isolation room or if not available, a neutral pressure side room with a closed ventilator circuit should be used.

Best Practice Intubation Guideline

(Dr Beverley Orse & Dr Salvatore Spadafora for Dept. of Anaesthesiology & Pain medicine, University of Toronto, Canada)

1. Apply full PPE as outlined above prior to patient contact.
2. Most experienced anaesthesiologist/intensivist intubates the patient.
3. Standard pre intubation checks to be completed.
4. Avoid awake fiberoptic intubation if possible (Atomized local anaesthetic may aerosolise the virus).
5. Plan for RSI preceded by 5minutes of pre-oxygenation - mindful that patient may require modification if poor A-a gradient/unable to tolerate 30s apnoea or there is a contraindication to succinylcholine. If manual breathes required – use small tidal volumes.
6. Ensure an HME filter is applied between the ETT/Facemask and the bagging circuit.
7. Following intubation, all reusable equipment used must be sealed in a double zip lock bag and sent for decontamination. All single use equipment should be disposed of.
8. Follow the decontamination protocol as below for decontamination of the patient space.

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Decontamination

- Carefully place all contaminated linen in an alginate bag inside the patient isolation room.
- Disposable equipment should be discarded inside isolation room.
- Move the transport trolley to the ante room if available and wait 20 minutes prior to cleaning trolley and transport equipment (Clearance of any aerosols is dependent on the ventilation of the room. Commonly 12-15 air changes per hour, and so after about 20 minutes there would be less than 1 per cent of the starting level).
- If no anteroom is available, wait in patient room for 20 minutes prior to cleaning the transport trolley and equipment. **NB** Ensure that there is no aerosol generation procedure during this period e.g. disconnection of ventilation circuit, hand bagging patient etc.
- Use a combined detergent disinfectant solution at a dilution of 1000 parts per million available chlorine * (ppnm av.cl.) or a detergent clean followed by disinfection (1000ppm av.cl.) to thoroughly clean the all patient care equipment and transport trolley e.g. Chlor-clean* or Klorsept. Available within the (P)ICUs.
- Clinell wipes are also acceptable for decontamination.
- Pay special attention to frequently touched sites and equipment close to the patient.
- Clean all transport equipment prior to leaving the anteroom/patient's room.

Removing PPE

Following completion of patient handover and equipment decontamination it is safe to proceed with PPE removal:

In the room where equipment decontamination was completed ie patients room/ante room:

While still in the room:

- Remove gloves (avoid touching the outside of the gloves).
- Decontaminate hands.
- Remove goggles.
- Remove gown/apron (avoid touching the front of the gown/apron).

Once in the ante room or directly outside the patient's room:

- Remove mask/respirator by breaking the ties. If ties are elastic, grasp and lift ties from behind your head and pull it away from your face. Avoid touching the front of the mask/respirator and use ties to discard.
- Decontaminate hands.

Pre - Return to Base Huddle

- Clinical Team Responsible for decontamination of equipment as above.
- Ambulance Technician responsible for decontamination of CCV.
- There will be a conversation between Clinical Team Leader and Ambulance Technician to ascertain whether the equipment is clean, and the ambulance is clean before returning to the CCV.
- The team will then return to base as normal.