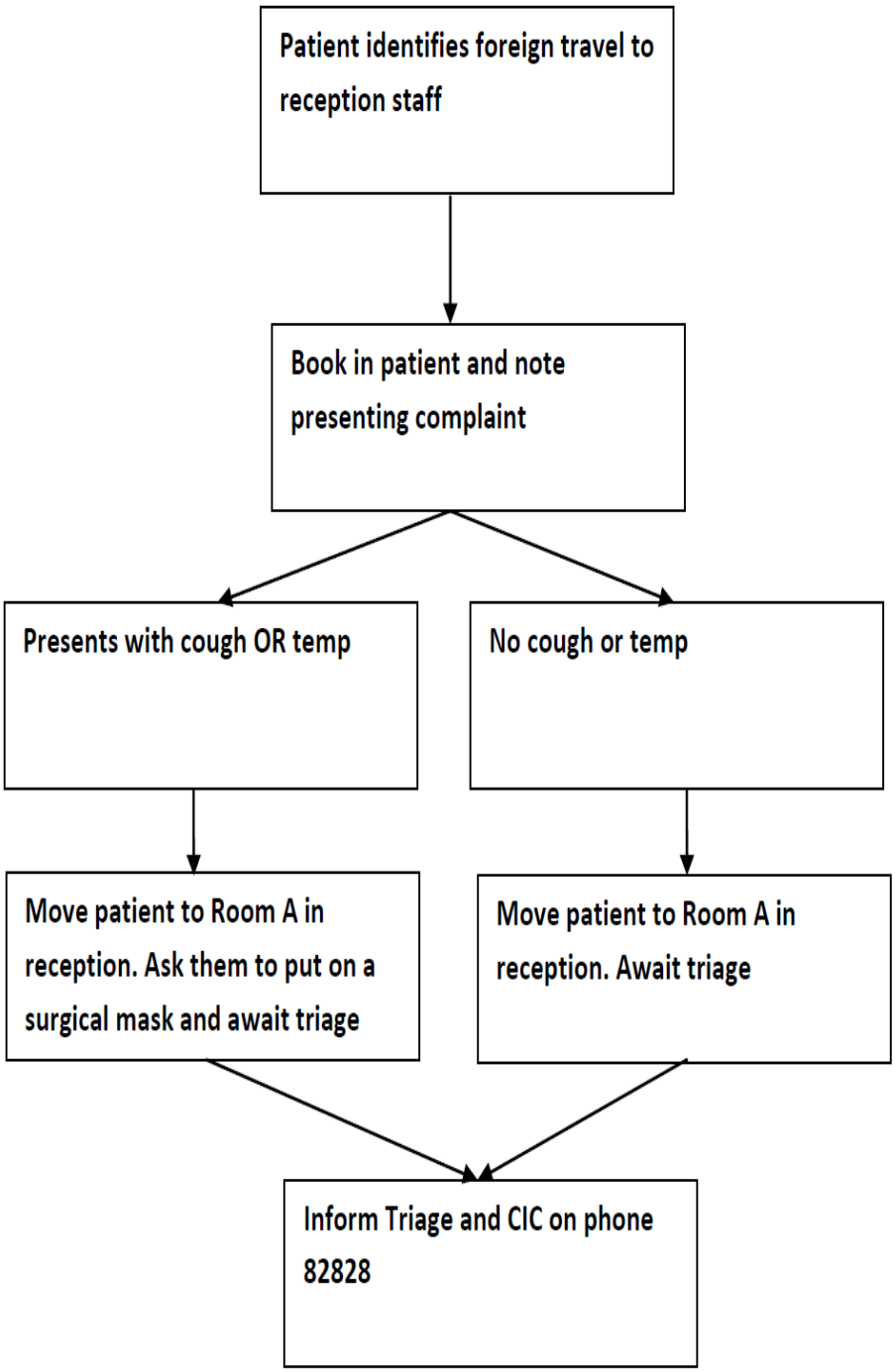
MERS-CoV 2018 Guidance GG&C

A QEUH

QEUH ED triage



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 i.e. Boxes A & B both confirmed.

3. Apply **full** PPE including FFP3 mask, eye protection and fluid repellent gown to anyone assessing the patient once concern has been raised i.e. Boxes A & B both confirmed

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.

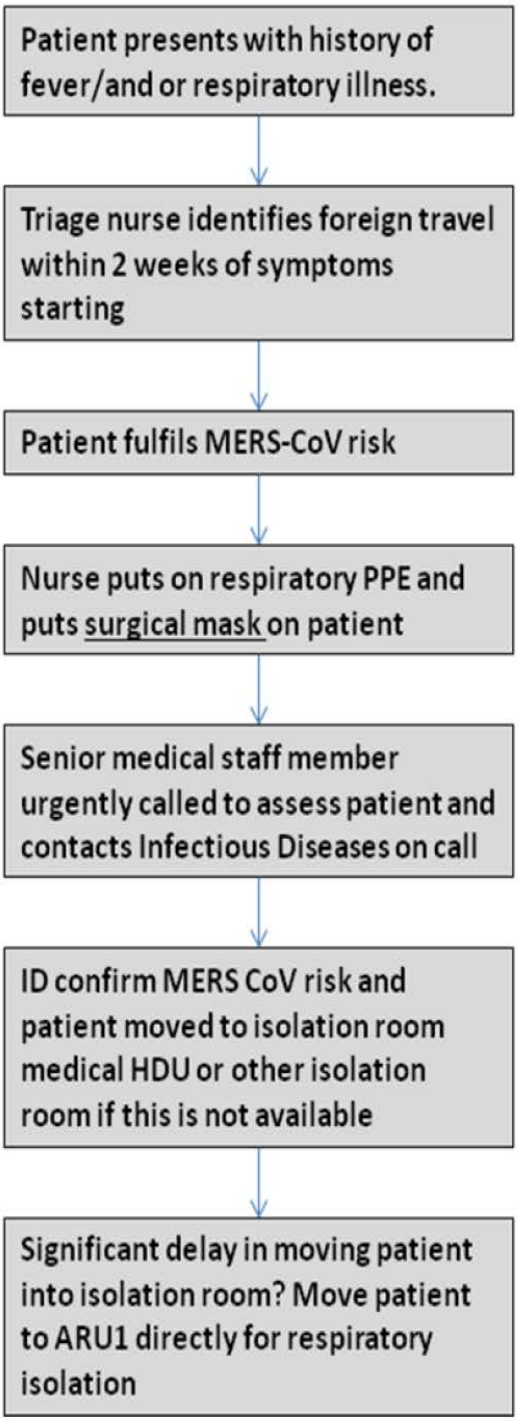
- Unless the patient has an emergent airway issue **ALL** intubations should be performed in a respiratory isolation rooms in **ITU**. If intubation is required for an airway issue in-extremis in ED it should be performed in one of the Procedures Rooms.

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

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

- If Infectious disease team decide the patient requires admission they should be managed in a respiratory isolation room in HDU/ITU. Once a room is ready then the patient (wearing surgical mask) should be moved to HDU using the route with minimal patient contact through ED and up to HDU using *core lifts G*. Close the corridors affected by the patient journey to the public.

QEUH IAU triage



- All staff managing patient should be familiar with PPE and be FFP3 mask fitted
- DO NOT MOVE patient into any other area in IAU.

QEUH 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

   i.e. Boxes A & B both confirmed.
3. Apply **full** PPE including FFP3 mask, eye protection and fluid repellent gown to anyone assessing the patient once concern has been raised i.e. Boxes A & B both confirmed
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 (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** should be done as a portable in HDU/ITU with radiographers who are PPE trained. A patient with possible MERS-CoV should not be X-rayed in the radiology department
- If Infectious disease team decide the patient requires admission they should be managed in a respiratory isolation room in HDU/ITU. The ID on call team must ensure that HDU are aware of the patient and make sure a 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 to HDU using the route with minimal patient contact and up to HDU using core lifts G.