

 NHS Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	1
		Effective From	July 2020
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Review Date	TBC
		Version	3

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

SOP Objective

To ensure that Healthcare Workers (HCWs) are aware of the actions and precautions necessary to minimise the risk of outbreaks and the importance of diagnosing patients' clinical conditions promptly.

This SOP applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts and volunteer & contractors.

KEY CHANGES FROM THE PREVIOUS VERSION OF THIS SOP

- Shielding Guidance updated on Page 9

Document Control Summary

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Distribution/Availability	NHSGGC Infection Prevention and Control Policy Manual and www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/
Lead Manager	Board Infection Control Manager
Responsible Director	Board Executive Lead IPC

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 NHS Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE	Page	2
	CONTROL OF INFECTION COMMITTEE	Effective From	July 2020
	STANDARD OPERATING PROCEDURE (SOP)	Review Date	TBC
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Version	3

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

CONTENTS

1.	Responsibilities	3
2.	Introduction/Scope	4
3.	General Information on COVID 19	4
4.	General Principles of Cohorting	6
5.	Patient Pathways.....	7
6.	Prioritisation of patients for placement in single rooms (SR)	8
7.	Shielded Patients.....	9
8.	Management of contacts of a positive COVID-19 case	10
9.	Opening Wards closed due to COVID 19.....	11
10.	Inter-hospital Transfer	11
11.	Evidence base	11
12.	Appendices.....	12
	Appendix 1 - COVID 19 Cohort in General Ward Cohort Information V.1.6	12
	Appendix 2 - COVID Aide Memoire Cohort	15
	Appendix 3 – Discharge from hospital and stepdown of IPC precautions.....	17
	Appendix 4 – Discharge from Hospital to care home.....	18
	Appendix 5 – General Risk Assessment	19
	Appendix 6: Infection Prevention and Control Risk Assessment.....	20

The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	3
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Effective From	July 2020
		Review Date	TBC
		Version	3

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

1. Responsibilities

Healthcare Workers (HCWs) should:

- Follow this guidance.
- Alert managers and senior clinicians if this guidance cannot be followed.

Managers should:

- Follow this guidance and carry out local risk assessments if this guidance is unable to be followed.

Infection Prevention Control Teams (IPCTs) should:

- Keep this information up to date.
- Advised service on the application of the guidance and complete appropriate risk assessments with service providers.

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 NHS Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	4
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Effective From	July 2020
		Review Date	TBC
		Version	3

The most up-to-date version of this policy can be viewed at the following website:
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2. Introduction/Scope

Prevention of hospital transmission of COVID-19 relies on strict adherence to infection control practices and appropriate patient placement. In situations when single isolation room availability is limited it is accepted that certain patient groups can be cohorted in appropriate areas. This SOP describes general principles of various aspects of cohorting.

It is expected that hospitals will follow these general principles but local adaptation depending on resources available is accepted. Deviation from national guidelines needs to be risk assessed and communicated to the relevant structures of clinical governance.

This guidance provides advice on appropriate cohorting in the context of infection prevention and control precautions for patients who are:

- Positive for COVID 19
- Suspected of having COVID 19
- Contact of a person with COVID 19
- In the category of patients who require to be shielded.

3. General Information on COVID 19

Communicable Disease/ Alert Organism	Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses. COVID 19 is one of this group.
Clinical Condition	<p>Fever, cough or chest tightness, myalgia, fatigue and dyspnoea are the main symptoms reported. A variety of abnormalities may be expected on chest radiographs, but bilateral lung infiltrates appear to be common (similar to what is seen with other types of viral pneumonia).</p> <p>Emerging evidence suggests that there may be atypical presentations reported in older people e.g. delirium (hypo and hyperactive), diarrhoea, lethargy, falls and reduced appetite.</p> <p>https://www.bgs.org.uk/blog/atypical-covid-19-presentations-in-older-people-%E2%80%93-the-need-for-continued-vigilance</p>

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www.nhsggc.org.uk/your-health/infection-prevention-and-control

 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	5
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Effective From	July 2020
		Review Date	TBC
		Version	3

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

Case definitions	<p>Patients who meet the following criteria (inpatient definition)</p> <ul style="list-style-type: none"> • requiring admission to hospital (a hospital practitioner has decided that admission to hospital is required with an expectation that the patient will need to stay at least one night) <p>and</p> <ul style="list-style-type: none"> • have either clinical or radiological evidence of pneumonia <p>or</p> <ul style="list-style-type: none"> • acute respiratory distress syndrome <p>or</p> <ul style="list-style-type: none"> • influenza like illness (fever $\geq 37.8^{\circ}\text{C}$ and at least one of the following respiratory symptoms, which must be of acute onset: new continuous cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing change in sense of smell or taste. <p>Note: Clinicians should consider testing inpatients with new respiratory symptoms or fever without another cause or worsening of a pre-existing respiratory condition.</p> <p>Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.</p> <p>https://www.gov.uk/government/publications/wuhan Novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection</p>
Incubation Period	1-14 days (median 5 days)
Mode of Spread	Droplet and contact According to current evidence, the COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes. In the context of COVID-19, airborne transmission may be possible in specific circumstances and settings in which procedures or support treatments that generate aerosols are performed (AGP).
Period of communicability	Approximately one week from onset of symptoms in mild cases and for longer in those severely affected or immunocompromised.
Persons most at risk	The frail older person
Notifiable disease	Yes

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 NHS Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	6
		Effective From	July 2020
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Review Date	TBC
		Version	3

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www.nhsggc.org.uk/your-health/infection-prevention-and-control

4. General Principles of Cohorting

Prevention of hospital transmission of COVID-19 relies on strict adherence to infection control practices and appropriate patient placement. It is expected that hospitals will follow these general principles but local adaptation depending on available facilities is accepted and should be developed with the advice of the IPCT.

- Deviation from national guidelines needs to be risk assessed and communicated to the relevant structures of clinical governance.
- Minimise patient movement at all times as far as possible.
- Move patients to a new clinical area only if this is a clinical necessity and has been discussed with a senior clinician, or the decision to move the patient is based on a test result.
- Promptly isolate any new positive COVID-19 cases in either in a single room or cohort in a red area.
- Contacts of the same exposure incident (eg contacts to a new positive COVID-19 patient within a 6 bedded bay) should be isolated or cohorted together in an amber (contact) ward/bay and any patient movement should be minimised as much as possible.
- In some situations (bed pressure, low number of contacts etc) contacts of different exposures can be cohorted together in the same area.
- Each group of patients is assigned a colour code to help to visualise patient pathways and the description of each group is summarised in table 1.
- Green Wards should ideally be a combination of side rooms and bays.
- Amber wards should ideally if possible be a combination of single rooms and bay areas. This eliminates the need for cohorting of contacts if any patients test positive. If there are bays then these should be used for 'clusters of contacts' from green wards and patients should not be moved from these until discharged or after 14 days.
- In Red wards there are no specific requirement but consideration should be given to issues such as end of life care.
- Discharge from hospital and stepdown of IPC precautions should be followed when removing patients from red pathway (appendix 3 - Discharge from hospital and stepdown of IPC precautions).

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 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	7
		Effective From	July 2020
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Review Date	TBC
		Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

Table 1

Location	Admission ward/ED			Downstream ward		
Clinical or epidemiological status	Positive COVID 19	? COVID 19	Patients who do not have symptoms of COVID19	Positives	Contacts	Negatives
Colour code	Red	Amber	Green	Red	Amber	Green
Action	Isolated or cohorted	Isolated/cohort Screen and move to green or red area	Enter green area	Isolated or cohorted	Isolated or cohorted	Not isolated

Please refer to appendix 1 & 2 on general principles for setting up a cohort area.

5. Patient Pathways

On admission, patients are divided in three major pathways depending on initial assessment of clinical picture - Green pathway for patients with no symptoms of COVID-19, Amber pathway for those with possible/probable COVID 19 and Red pathway for patients who have COVID-19.

It is expected that each hospital will have to create local pathways to suit their local situation – patient demographics, epidemiological situation, availability of isolation facilities and other factors but general principles should be followed. Any deviation from national guidance should be risk assessed and clinical governance structures should be informed (risk assessment template appendix 5)

An individual patient risk assessment can also be undertaken and a template for this is contained in appendix 6.

Readmission of patients post Covid

<14 days from positive sample. Patient should go into **red** pathway. **Should not be screened again.**

>14 days from positive sample and patient is not immunosuppressed and not presenting with covid like symptoms. Patient can go into **green** pathway. **Should not be screened again.**

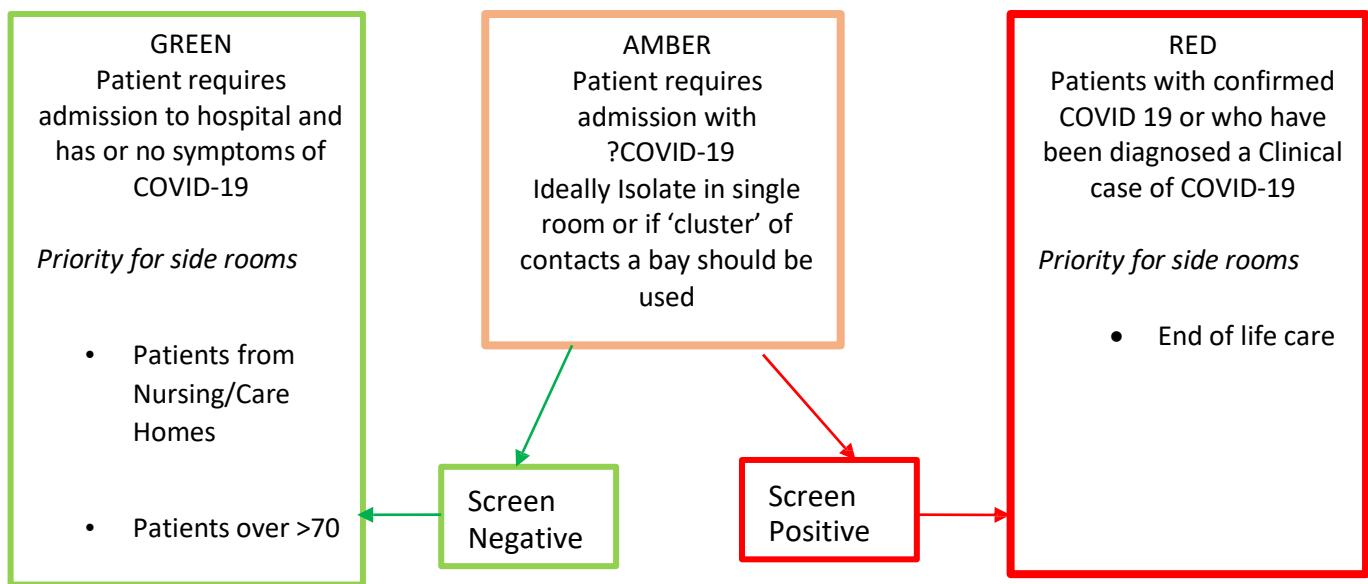
The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE	Page	8
	CONTROL OF INFECTION COMMITTEE	Effective From	July 2020
	STANDARD OPERATING PROCEDURE (SOP)	Review Date	TBC
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

>14 days from positive sample and patient is immunosuppressed, patient should go into **red** pathway until 2 negative screens.

>14 days from positive sample and patient is not immunosuppressed and is presenting with covid like symptoms, patient should go into **red** pathway and should be screened again.



New COVID-19 Patient Identified in Green pathway

- Positive patient to red pathway
- Contacts should go to a single room/bay in amber pathway (should stay in the same cohort for 14 days or until discharged).

6. Prioritisation of patients for placement in single rooms (SR)

Prioritize patients to single rooms in the following order:

1. Admitted from Residential/care home (green/amber pathway).
2. Patients who require end of life care (all pathways).

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 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	9
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Effective From	July 2020
		Review Date	TBC
		Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

7. Shielded Patients

Although people are not required to shield as of 01/08/2020 they remain a population at risk. As a matter of normal routine all patients should be risk assessed for the presence of infection or their vulnerability to infection and actions taken as appropriate. However, as a precaution, patients who have been previously assessed as requiring shielding should have the following put in place *if possible*:

1. Single room if available. If a patient has suspected infection you should contact your local IPCT for advice. Patients who do not require isolation for infection control reasons can be nursed in a bay area.
2. Patient should be encouraged to wear FRSM if tolerated.
3. In ward/bay areas consider closing screens to create a barrier if it is safe to do so.

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 NHS Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	10
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Effective From	July 2020
		Review Date	TBC
		Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

8. Management of contacts of a positive COVID-19 case

- If a patient tests positive for COVID-19 within a green or amber area they should be transferred to a red cohort. All patients in the same bay area are assumed to be contacts of the new positive case and should be cohorted together in an Amber cohort (single rooms or bay). They should be kept together as far as possible and observed for the development of symptoms for 14 days from the day the index patient was tested positive, or the day the index patient displayed COVID-19 symptoms.
- All contacts from the same exposure should be cohorted together if possible. Occasionally contacts from different exposures can be cohorted together but this may result in an extension to the time patients need to be monitored for COVID19, e.g. if a bay has three patients on day 7 post exposure and a new contact is admitted and tests positive then the clock ‘resets’ for the others i.e. they would need to be isolated for another 14 days. For this reason, it is preferred to have only contacts from one exposure cohorted together to minimise the risk of extended isolation.
- There is no requirement to test asymptomatic contacts routinely unless the patient is over 70 when they should be tested every four days but occasionally this will be requested by IPCT to assist with appropriate patient placement and incident management.
- Certain groups of patients will require a negative COVID-19 test before they can be discharged from isolation (please refer to Appendix 3 & 4 Discharge from hospital and stepdown from infection prevention and control precautions).
- When discharged from isolation, contacts can enter a Green pathway but each individual case should be assessed for risk factors e.g. immunosuppressed patients shedding virus for longer.
- If there is a clinically suspected case that has a negative test the clinical team should seek advice from Infectious Disease consultant if required.

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 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	11
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Effective From	July 2020
		Review Date	TBC
		Version	2

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www.nhsggc.org.uk/your-health/infection-prevention-and-control

9. Opening Wards closed due to COVID 19

There is currently no available guidance with regards to reopening wards closed due to unexpected clusters of COVID 19. Assessment is based on the following criteria but this list is not exhaustive:

- Number of patients still symptomatic
- Results of screening
- Number of isolation rooms/bays
- Clinical specialty

Reopening of wards is therefore based on local risk assessment by the site/sector IPCT and the local clinical and managerial teams.

10. Inter-hospital Transfer

At this time there is no national guidance in relation to inter-hospital transfer guidance. This may be considered by local teams in certain circumstances but the decision to implement should be reviewed by the appropriate clinical governance forum.

11. Evidence base

All information related to COVID 19 can be found at:

<https://www.hps.scot.nhs.uk/a-to-z-of-topics/wuhan-novel-coronavirus/>

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 NHS Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	12
		Effective From	July 2020
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Review Date	TBC
		Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

12. Appendixes

Appendix 1 - COVID 19 Cohort in General Ward Cohort Information V.1.6

Planning and communications	On each hospital site, wards and wards with suitable bed bays will be identified and a pathway agreed from ED to discharge. This will be communicated to the appropriate staff at huddles/briefs to support patient/bed management. Daily updates on bed spaces on cohort wards/bays should be available to support patient transfers from ED and acute receiving. Wards with cohort bays will not be closed to other admissions.
Definition of a cohort ward or bay	A cohort area is a bay/ward in which a group of patients (cohort) with the same infection are placed together. Patient cohorting may be appropriate when single rooms are not available and there is more than one patient with the same confirmed infection. If necessary it is possible to cohort a suspected COVID 19 cases where bed spacing is optimal e.g. 2.7 metres apart.
Decision to create a COVID-19 cohort	If a ward has bed bays and a number of confirmed COVID-19 patients, those patients should be nursed in a single bay as a cohort. If there are empty beds in that cohort, they can be used for COVID-19 patients from other areas. The decision to set up a cohort should be discussed with local IPCT. Out of hours - on call Microbiologist prior to being implemented.
Setting up the cohort	The cohort bay should have dedicated equipment as far as possible such as blood pressure, oxygen saturation and temperature recording devices within the cohort bay. A trolley with fresh linen, tissues, waste bags and commonly used disposable equipment such as oxygen tubing and masks will be useful for staff working in the cohort. Linen should be covered if out in the ward area. Use the IPC yellow sign at the entrance of the cohort.
Staffing (cohort nursing)	Cohort nursing (dedicated teams) should be implemented to minimise the risk of contamination between groups of symptomatic and non-symptomatic patients if staff resource allows. If not, contact the local IPCT who will help to undertake a risk assessment.
Bed spacing	Patients should be separated by at least 2.7 metres from each other in a cohort area, and bed curtains can be drawn as an additional physical barrier if possible.

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www.nhsggc.org.uk/your-health/infection-prevention-and-control

 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE	Page	13
	CONTROL OF INFECTION COMMITTEE	Effective From	July 2020
	STANDARD OPERATING PROCEDURE (SOP)	Review Date	TBC
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Version	2

The most up-to-date version of this policy can be viewed at the following website:
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Cohort patients	Patients who have confirmed COVID-19 can be nursed in a COVID-19 cohort until they have been deemed no longer infectious. However, It should be noted that patients being nursed together in a cohort should all have confirmed COVID-19. Patients who remain symptomatic but are well enough to be discharged can be sent home with advice on how to self-isolate. Patients who have COVID-19 and another infection e.g. diarrhoea or MRSA, should be nursed in a single room.
Testing	Laboratory testing will identify patients with COVID-19.
PPE	When entering a cohort area, don a FRSM, wear a disposable plastic apron, gloves and eye protection when in direct contact with the patient. Apron and gloves should be changed between patients and HH performed Mask should be worn at all times. You do not need to change your mask unless it becomes moist or you have finished working in the cohort. If patient requires AGP's this should not be done in a cohort. If this is not possible staff should wear full PPE – FFP3 mask, long sleeved fluid repellent gown, 1 pair disposable gloves and eye protection to carry out the procedure and for a maximum of 2 hours following the AGP procedure (please refer to local guidance on number of air changes in specific area).
Equipment	As far as possible, dedicated equipment should remain in the cohort bay for use on cohort patients only. For equipment that cannot be dedicated, items should be cleaned with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus and dried before removal from cohort. Casenotes should be left outside the room if at all possible.
Ward rounds	Ward rounds within a cohort will consist of 1 member of medical team entering the cohort in appropriate PPE to examine the patient only. Once exam completed, removal of PPE and hand hygiene should be performed. Any equipment used will either stay in the cohort or be decontaminated before removal.
Linen	Bed linen should be managed as infected linen Curtains should be changed if visibly contaminated or weekly.
Waste	Waste should be managed as healthcare waste

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 NHS Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	14
		Effective From	July 2020
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Review Date	TBC
		Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

Cleaning of Environment	Domestic services, wearing apron, gloves and a FRSM, should clean the cohort bed bay/ ward twice daily with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus. (Consideration should be given to a dedicated cleaning team on each site). Disposable cloths and reusable mop heads should be used. Bucket and mop pole will be cleaned after use with Actichlor Plus. If an AGP has been carried out, staff will restrict facility staff access to the cohort area for 2 hours following AGP.
Visitors	Please refer to GGC guidance on visitors.

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 NHS Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	15
		Effective From	July 2020
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Review Date	TBC
		Version	2

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Appendix 2 - COVID Aide Memoire Cohort

Planning and communications	On each hospital site, ICU/AGP hot spots will be identified and a respiratory pathway agreed from ED to discharge. This will be communicated to the appropriate staff at huddles/briefs to support patient/bed management. Daily updates on bed spaces on cohort wards/bays should be available to support patient transfers from ED and acute receiving. Wards with cohort bays will not be closed to other admissions.
Definition of a cohort ward or bay	A cohort area is a bay/ward in which a group of patients (cohort) with the same confirmed or on occasion's probable infection are placed together. Patient cohorting may be appropriate when single rooms are not available and there is more than one patient with the same confirmed infection. If necessary it is possible to cohort a suspected COVID cases where bed spacing is optimal e.g. 2.7 metres apart. It might be necessary to cohort patients with respiratory symptoms/illness without test results.
Decision to create a COVID-19 cohort	If a ward has bed bays and a number of confirmed COVID-19 patients, those patients should be nursed in a single bay as a cohort. If there are empty beds in that cohort, they can be used for COVID-19 patients from other areas. The decision to set up a cohort should be discussed with local IPCT on call Microbiologist prior to being implemented.
Setting up the cohort	The cohort bay should have dedicated equipment as far as possible such as blood pressure, oxygen saturation and temperature recording devices within the cohort bay. A trolley with fresh linen, tissues, waste bags and commonly used disposable equipment such as oxygen tubing and masks will be useful for staff working in the cohort.
Staffing (cohort nursing)	Cohort nursing (dedicated teams) should be implemented to minimise the risk of contamination between groups of symptomatic and non-symptomatic patients if staff resource allows. If not, contact the local IPCT who will help to undertake a risk assessment.
Bed spacing	Patients should be separated by at 2.7 metres from each other in a cohort area, and bed curtains can be drawn as an additional physical barrier if required.

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www.nhsggc.org.uk/your-health/infection-prevention-and-control

 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE	Page	16
	CONTROL OF INFECTION COMMITTEE	Effective From	July 2020
	STANDARD OPERATING PROCEDURE (SOP)	Review Date	TBC
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

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Testing	Laboratory testing will identify patients with COVID-19.
PPE	Before entering the cohort ward / bay, don respiratory PPE including 1 pairs of disposable gloves, long-sleeved gown, FFP3 mask and full face visor/goggles. For direct care, a plastic apron should be worn over the gown and changed along with gloves between patients. ABHR must be used between glove changes.
Equipment	As far as possible, dedicated equipment should remain in the cohort bay for use on cohort patients only. For equipment that cannot be dedicated, items should be cleaned with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus and dried before removal from cohort. For small items e.g. stethoscopes alcohol wipes can be used. Case notes should be left outside the room whenever possible.
Ward rounds	Ward rounds within a cohort will consist of 1 member of medical team entering the cohort in appropriate PPE to examine the patient only. Once exam completed, removal of PPE and hand hygiene should be performed. Any equipment used will either stay in the cohort or be decontaminated before removal.
Linen	Bed linen should be managed as infected linen. Curtains should be changed when visibly contaminated or weekly.
Waste	Waste should be managed as healthcare waste.
Cleaning of Environment	Domestic services, wearing respiratory PPE, should clean the cohort bed bay/ ward twice daily with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus. (Consideration should be given to a dedicated cleaning team on each site). Disposable cloth and mop heads should be used. Bucket and mop pole will be cleaned after use with Actichlor Plus.
Visitors	Follow the NHSGGC COVID Visiting Restrictions

The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

 <p>NHS Greater Glasgow and Clyde</p>	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	17
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Effective From	July 2020
		Review Date	TBC
		Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

Appendix 3 – Discharge from hospital and stepdown of IPC precautions

COVID-19 – Discharging from hospital and stepdown of infection prevention and control precautions

DISCHARGE TO HOME

When stable/improving respiratory function and ongoing care needs can be met at home

Patient factors:

- ICU/HDU during admission?
- Severe immunosuppression?
- Shielding?

No

Self-isolate **7 days^{1,2}** from discharge

Yes

Self-isolate **14 days^{1,2}** from discharge

Household members should complete **14** day stay at home period

- If vulnerable person(s) in household see 'Stay at home' guidance on NHS Inform
- If 'extremely vulnerable' (shielding) person(s) in household consider discharge to different home until completed self-isolation period

¹ if fever persists, continue self-isolation beyond 7/14 days until no fever for 48 hours

² If patient has already completed stepdown as outlined below, self isolation is not required

See full HPS guidance for:

1. Transport options for discharge
2. Definition of severe immunosuppression
3. Ongoing medical needs after discharge

STEPDOWN OF INFECTION CONTROL PRECAUTIONS IN HOSPITAL

Stepdown can be considered 14 days from symptom onset (or first positive test if symptoms are undetermined) with absence of fever for 48 hours (without the use of antipyretics) OR in severely immunocompromised patients following two -ve clearance PCR tests at least 24 hours apart.

If testing earlier than 14 days is needed to allow patient flow, two -ve PCR tests are required at least 24 hours apart

Clinical improvement and no fever for 48 hours

Yes

Severe immunosuppression

Stepdown IPC precautions

+ve PCR – Repeat after 7 days

No

Continue IPC precautions

No

Yes

PCR test*

-ve PCR – Stepdown IPC measures

*sputum/lower respiratory samples for PCR are preferable wherever possible

DISCHARGE TO CARE/RESIDENTIAL HOME

When stable/improving respiratory function and ongoing care needs can be met at care facility. Patient should be isolated for a minimum of 14 days from initial +ve PCR test or symptom onset and require two negative tests required prior to discharge.

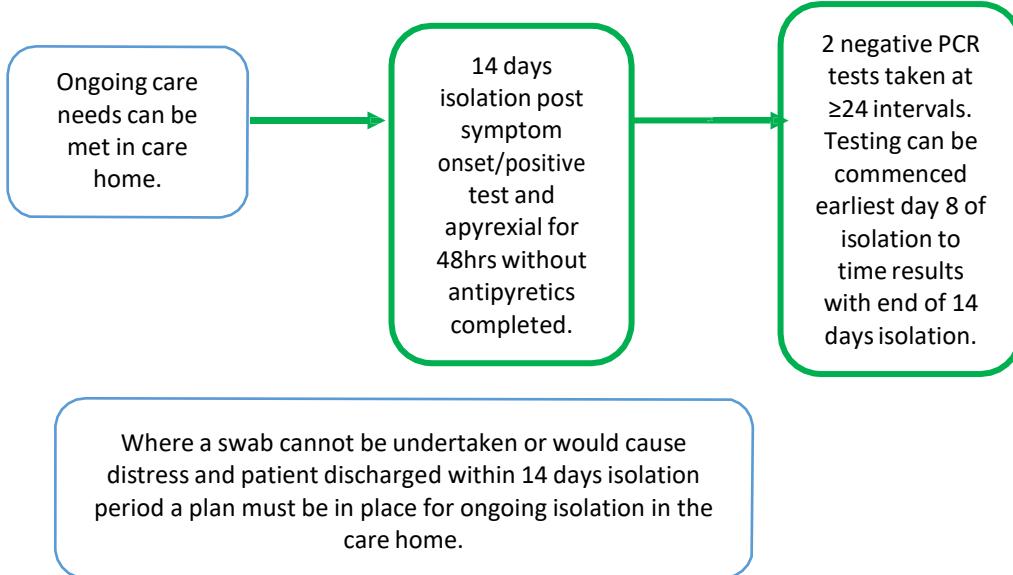
 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	18
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Effective From	July 2020
PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Review Date	TBC	
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The most up-to-date version of this policy can be viewed at the following website:
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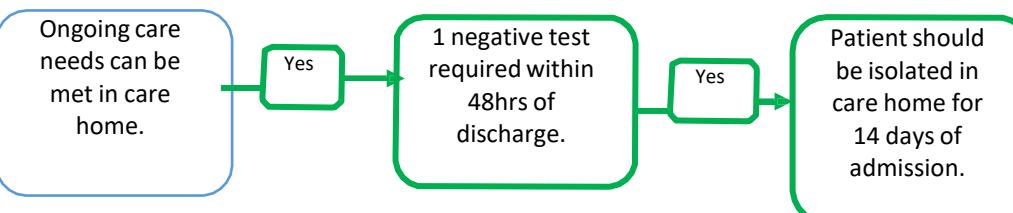
Appendix 4 – Discharge from Hospital to care home

Discharging from hospital to care home.

DISCHARGE FOLLOWING POSITIVE RESULT



DISCHARGE WHEN NEVER KNOWN POSITIVE



The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

 Greater Glasgow and Clyde	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	19
		Effective From	July 2020
	PATHWAYS AND COHORTING GUIDANCE FOR PATIENTS WITH CONFIRMED OR POSSIBLE COVID 19	Review Date	TBC
		Version	2

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

Appendix 5 – General Risk Assessment

 Greater Glasgow and Clyde	NHS Greater Glasgow & Clyde Infection Prevention and Control Team – General Risk Assessment Document
Purpose:	To describe the different risks associated with the current situation and recommend actions based on the assessment of relative risks.
Completed by:	
Date:	
Subject / Situation:	
Background	
Identification of Risk (S) Associated with this Situation	<p>1. Describe risk</p> <p>Assess the risk</p> <p>Risk =</p> <p>Likelihood =</p> <p>Impact/Consequences =</p> <p>Actions to mitigate this risk would be:</p>

		Impact / Consequences				
		Negligible	Minor	Moderate	Major	Extreme
Likelihood	Almost Certain	Medium	High	High	V High	V High
	Likely	Medium	Medium	High	High	V High
	Possible	Low	Medium	Medium	High	High
	Unlikely	Low	Medium	Medium	Medium	High
	Rare	Low	Low	Low	Medium	Medium
Recommendations						

The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control

Appendix 6: Infection Prevention and Control Risk Assessment
 (for patients with known or suspected infection that cannot be isolated)

Addressograph Label:
 Patient Name and DOB/CHI:



Daily Assessment / Review Required

	COMMENTS	DATE						
Daily Assessment Performed by <i>Initials</i>								
Known or suspected Infection - COVID-19 <i>Please state</i>								
Infection Control Risk, e.g. unable to isolate, lack of isolation rooms. Unable to use curtains to shield patients in neighbouring beds <i>Please state</i>								
Reason unable to isolate e.g. falls risk, observation required, due to cognitive impairment, clinical condition. <i>Please state</i>								
Additional Precautions put in place to reduce risk of transmission, e.g. trolley containing appropriate PPE at end of bed. Bed spacing 2.7 metres from centre of bed to centre of bed. Ensuring that patients sitting out of bed are not next to each other. Ask patient to wear a mask if tolerated <i>Please state</i>								
Infection Prevention and Control have been informed of patient's admission and are aware of inability to adhere to IPC Policy? <i>Yes / No</i>								
Summary Detail of Resolution								

Daily risk assessments are no longer required

Signed _____

Date _____