Public Health England

Guidance

Guidance for stepdown of infection control precautions and discharging COVID-19 patients

Published 9 April 2020

Contents

1. General scope

This guidance provides advice on appropriate infection prevention and control (IPC) precautions for COVID-19 patients recovering or recovered from COVID-19 and remaining in hospital, or being discharged to their own home or residential care. The NHS Hospital Service Discharge requirements issued in response to the COVID-19 emergency concerns all hospital discharges.

It is important to note that patients **can and should** be discharged before resolution of symptoms provided they are deemed clinically fit for discharge in a rapid, but safe, manner.

In general, persons with COVID-19 who are admitted to hospital will have more severe disease than those COVID-19 patients who can remain in the community, especially if they require critical care. In addition, they are more likely to have pre-existing conditions such as severe immunosuppression. In healthcare settings, there also are considerable numbers of immunocompromised and vulnerable patients.

Therefore, a precautionary approach with more stringent rules for ending isolation and infection control precautions is recommended for hospitalised patients, notably 14 days for those in critical care and/or immunosuppressed, compared to the 7-day since symptom onset rule applied to those managed in the community.

The main measures are detailed below.

2. Stopping of COVID-19 isolation and IPC measures if patient staying in hospital

After 14 days following a positive SARS-CoV-2 test, IPC measures for hospitalised COVID-19 patients can be stopped if there is:

- clinical improvement with at least some respiratory recovery
- absence of fever (> 37.8°C) for 48 hours
- no underlying severe immunosuppression

If testing for viral clearance is available, it should focus on:

- the severely immunocompromised patients to support the optimal use of side rooms, or where side rooms are not available
- any testing that optimises patient flow through the hospital, such as:
  - long-stay patients who are unable to otherwise be discharged
  - those being discharged to a household where an extremely vulnerable person is being shielded

3. Discharge of patients to own home

This can be done when the patient's clinical status is appropriate for discharge, for example, once assessed to have stable or recovering respiratory function, and any ongoing care needs can be met at home. They should be given clear safety-netting advice for what to do if their symptoms worsen.

Discharged patients should follow the Stay at Home guidance for households with COVID-19 patients:

- if they required critical care or they areseverely immunocompromised, they should complete their self-isolation until 14 days from their first positive test
- patients who did not require critical care and are not immunosuppressed should complete their self-isolation until 7 days from their first positive test

For all discharged patients, self-isolation at home should continue until their fever has resolved for 48 hours consecutively without medication to reduce their fever (unless otherwise instructed by their acute care provider – for example, another reason for persistent fever exists).

Cough may persist in some individuals, and persistent cough is not an indication of ongoing infection when other symptoms have resolved.

4. Discharge to a single occupancy room in care facility, including nursing homes and residential homes

Discharged patients should follow the care home guidance for settings with COVID-19 patients.

5. Specific instructions for ongoing medical needs for severely immunosuppressed patients and those who have received critical care

For those who received critical care, if there has been no virological evidence of clearance prior to discharge and ongoing medical attendances are required for their underlying condition (such as outpatient follow-up appointments), appropriate IPC measures should be used for all medical attendances for 14 days following the first positive test result.

For severely immunosuppressed patients, IPC measures should be continued unless either there has been virological evidence of clearance prior to discharge or there has been complete resolution of all symptoms – this is different to other advice sections but reflects the complex health needs of such patients and likelihood for prolonged shedding, with risk of spread in healthcare settings. Such patients may be retested at first follow-up appointment to help inform actions at any next medical appointment.

6. Additional background and measures

6.1 Inpatient stepdown of IPC in hospitalised patients

IPC measures should continue for COVID-19 patients until 14 days have elapsed since their first positive SARS-CoV-2 test (this differs from community settings, where symptom onset is used). This is due to uncertainties about the duration of infectiousness for patients with more severe illness or underlying immune problems that may delay them clearing the virus. If SARS-CoV-2 testing is not available or has not been done, then isolation periods for hospitalised patients with presumed COVID-19 should be measured from the day of admission.

Before control measures are stepped down for COVID-19, clinical teams must first consider the patient's ongoing need for transmission based precautions (TBPs) necessary for any other alert organisms (for example, MRSA carriage or C. difficile infection), or patients with ongoing diarrhoea.

One negative test is acceptable for stepdown. If repeat testing remains positive after 14 days, and only if local testing capacity allows, patient samples should be tested after a further 7 days if the patient remains in hospital, or at intervals of 2 weeks in the community (for example, at repeat hospital appointments).

If the patient is producing sputum or is intubated, a lower respiratory tract sample should be preferentially tested (rather than upper respiratory tract samples), as SARS-CoV-2 can be present in the lower respiratory tract despite being undetectable in the upper respiratory tract.

It may be operationally easier to cohort all COVID-19 patients in a ward area throughout their inpatient stay. In these areas, staff should maintain appropriate staff personal protective equipment (PPE) and recommended IPC measures.

6.2 Other household members in an individual's home setting

- if the discharged patient is returning to a shared household, other household members should complete their 14-day stay at home period (as described in Stay at Home guidance). If this did not start before the patient was admitted to hospital, then it should start from the day the patient returns to the household, unless the patient has already completed their appropriate period of isolation within hospital
- if there are any vulnerable individuals staying in the household who themselves are not currently infected, ensure that the discharged patient is advised on strict infection prevention and control measures as outlined in the Stay at Home guidance for vulnerable individuals
- if extremely vulnerable individuals live at their home, as outlined in the guidance on shielding, it is highly advisable for patients to be discharged to a different home until they have finished their self-isolation period or have laboratory confirmation of viral clearance

6.3 Ongoing medical needs for discharged patients within their isolation period

Should any patient deteriorate following discharge, either at home or in a care setting, they or their carer should seek advice from NHS 111 online or by telephone, or through pre-existing services such as specialist GP practice links with care homes. In an emergency, they or their carer should call 999 for assistance. In either case, they should inform the call attendant that they have been recently discharged from hospital with confirmed COVID-19.

If there are professional care needs at the patient's own home, visiting carers should follow the appropriate PPE precautions outlined in the home care guidance. Such care staff do not need to follow any other precautions apart from routine social distancing measures in their own personal life.

Once they have completed their 7 or 14 day isolation period, care workers in residential settings or patient homes should revert to their own routine guidance documents.

6.4 Specific instructions for ongoing medical needs for severely immunosuppressed patients and those who have received critical care

Isolation is longer for severely immunosuppressed individuals and those who have received critical care, as there are uncertainties about the duration of infectiousness for patients with more severe illness and, in particular, underlying immune problems that may delay them clearing the virus.

For those who received critical care, if there has been no virological evidence of clearance prior to discharge and ongoing medical attendances are required for their underlying condition (such as outpatient follow-up appointments), appropriate IPC measures should be used for all medical attendances for patients for 14 days since the first positive test result.

Where possible taking into account local laboratory capacity, testing for virological clearance is encouraged in severely immunosuppressed patients. For these patients, IPC measures should be continued unless either there has been virological evidence of clearance prior to discharge or there has been complete resolution of all symptoms. This is different to other advice sections but reflects the complex health needs of such patients and likelihood for prolonged shedding, with risk of spread in healthcare settings. Such patients may be retested at first follow-up appointment to help inform actions at any next medical appointment.

7. 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
- 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

8. How to transfer patients home

See Section 8.3 of the recent NHS Hospital Service Discharge requirements issued in response to the COVID-19 emergency that concerns all hospital discharges.

Transport home can be arranged via a variety of routes; if the patient has their own car at the hospital, and is well enough, they may drive home.

If they are taking shared transport, the need for further isolation of discharged patients with COVID-19 who have not completed their 7 or 14 day isolation period and who do not have virological evidence of clearance, should be communicated with transport staff (for example, ambulance crews and relatives). Those transporting them should not themselves be at greater risk of severe infection.

There is detailed NHSE patient transport guidance available for acute care settings to use. If isolation is to continue in a residential setting, the following guidelines apply to all methods of transport:

- the patient should be given clear instructions on what to do when they leave the ward to minimise risk of exposure to staff, patients and visitors on their way to their transport
- the patient should wear a surgical facemask for the duration of the journey, and advised that this should be left on for the entire time if tolerated (not pulled up and down)
- the patient should sit in the back of the vehicle with as much distance from the driver as possible (for example, the back row of a multiple passenger vehicle)
- where possible use vehicles that allow for optimal implementation of social distancing measures, such as those that have a partition between the driver and the passenger or larger vehicles that allow for a greater distance between the driver and the passenger
- vehicle windows should be (at least partially) open to facilitate a continuous flow of air
- vehicles should be cleaned appropriately at the end of the journey
- ensure the patient has a supply of tissues and a waste bag for disposal for the duration of the journey; the waste bag should then be taken into their house and held for a period of 72 hours before disposal with general household waste

Coronavirus (COVID-19)

Coronavirus (COVID-19): what you need to do

Transition period

Transition period: check how to get ready

Services and information

Benefits

Births, deaths, marriages and care

Business and self-employed

Childcare and parenting

Citizenship and living in the UK

Crime, justice and the law

Disabled people

Driving and transport

Education and learning

Employing people

Environment and countryside

Housing and local services

Money and tax

Passports, travel and living abroad

Visas and immigration

Working, jobs and pensions

Departments and policy

How government works

Departments

Worldwide

Services

Guidance and regulation

News and communications

Research and statistics

Policy papers and consultations

Transparency and freedom of information releases

Help Privacy Cookies Contact Accessibility statement Terms and conditions Rhestr o Wasanaethau Cymraeg
Built by the Government Digital Service