SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Cardiac and Respiratory Care
KEY TERMS	Aerosol-generating procedures
SUMMARY	To ensure a safe clinical environment for clinicians and patients. To minimise delay in initiating standard aerosol generating therapies/diagnostics in the treatment of respiratory or cardiac conditions.

Aerosol-generating interventions (AGI) for conditions during the COVID-19 pandemic period

SESLHDPR/754

1. POLICY STATEMENT

The procedure will be followed to minimise delay in initiating standard aerosol generating therapies/diagnostics in the treatment of respiratory or cardiac conditions.

2. BACKGROUND

Non invasive ventilation, high flow nasal oxygen (HFNO), spirometry, nebulisers and cough insufflator/exsufflator machines and some physiotherapy techniques may increase the risk of transmission of respiratory infections to staff members and other patients as they are AGPs. With ongoing community transmission of COVID-19 restrictions should be implemented to reduce the risk of transmission of COVID-19 within the hospital setting to ensure a safe clinical environment for clinicians and patients.

3. RESPONSIBILITIES

3.1 Line Managers will: oversee the correct use of the procedure.

3.2 Clinicians will: comply with the content of the procedure.

4. PROCEDURE

4.1 In scope therapies:

Aerosol-generating therapies:

- Non-invasive ventilation (NIV) including bilevel positive airway pressure therapy (Bi-PAP or VPAP)
- Continuous positive airway pressure therapy (CPAP)
- High flow nasal oxygen therapy (HFNO)
- Nebulisers
- Cough insufflator/exsufflator machine
- Other AGI/AGP therapies i.e. sputum induction, Positive Expiratory Pressure (PEP) device use, suctioning and manual assist cough.

Aerosol-generating diagnostics:

- Spirometry
- Peak flow monitoring

4.2 Application:

Includes: Adult inpatients in general ward areas, Coronary Care Unit, Emergency Departments (ED), Outpatients and patients enrolled in Respiratory coordinated Care Programs (RCCP) and other community patients utilising the above in scope therapies.

Excludes: Intensive Care, Recovery, Anaesthetics and Operating Theatres, Obstetrics, Paediatrics.

4.3 Risk Assessment

A risk assessment must be conducted prior to the initiation of any of the above aerosol-generating interventions. Alternative therapies and investigations that avoid AGPs must be considered. Non-urgent investigations should be deferred.

The risk assessment must be conducted by either a medical registrar, intensive care registrar, ED registrar, Advanced Trainee, consultant medical officer, respiratory CNC OR a senior physiotherapist.

The risk assessment should include a symptom screen for COVID-19. If the patient has no symptoms of COVID-19 and the patient is not a high risk contact of a case of COVID-19 then a COVID-19 Rapid Antigen Test (RAT) should be performed by a staff member wearing appropriate PPE. If the patient has symptoms or signs consistent with COVID-19 the patient should be tested with a RAT and a SARS-CoV-2 PCR test should be performed if a RAT is negative. For symptomatic patients the procedure must be performed in a negative pressure (or single room) with contact, droplet and airborne precautions The result of the risk assessment should be documented.

4.4 Ceiling of Care

For adults being admitted to hospital a discussion regarding ceiling of care should be held either at the time of admission or as soon as practicable. This includes appropriate documentation of ceiling of care and resuscitation orders in the event of initial treatment failure.

4.5 Transmission based precautions

As per Clinical Excellence Commission guidelines.
CEC COVID-19 Infection Prevention and Control Manual

4.6 Selection of PPE

Fluid resistant P2/N95 respirators are used when providing care to patients with suspected or confirmed COVID-19. Eye protection such as safety glasses, mask visor, goggles or a face shield are required for close contact within 1.5 metres of a suspected or confirmed COVID-19 patient.
See links below (page 126). As per Clinical Excellence Commission guidelines (page 119 Masks, 126 eye protection).
CEC COVID-19 Infection Prevention and Control Manual

4.7 Changes to Nurse / Allied Health initiated therapies

Ordinarily, in some clinical areas CPAP, bilevel NIV, prescription of nebulisers, spirometry and peak flow are nurse/allied health initiated.

To optimise safety AGPs will cease to be nurse/allied health initiated for the duration of the COVID-19 pandemic period.

Senior physiotherapists may approve spirometry, peak flow testing, cough assist machine and other physiotherapy techniques as listed in 4.1 after an appropriate risk assessment.

4.8 Changes to therapies

Nebulisers	• Nurse/allied health initiated normal saline nebuliser prescription has been removed as a nurse initiated option in eMR. • All standing orders for nebulised medications have also been temporarily rescinded and removed from eMR. • Spacers and metered dose inhalers or dry powdered devices are the recommended delivery system for inhaled medications. • The decision to use nebulisers can only be made by the Admitting Medical Consultant in conjunction with the NUM or Nursing Team Leader of the proposed location • With the exception of the ED Resus bays, all in scope clinical areas, should remove mask nebuliser set ups from stocked shelves for the duration of the COVID-19 pandemic period.
Tracheostomy or laryngectomy management	• Patients with a tracheostomy or laryngectomy requiring regular normal saline nebulisers /continuous humidification will require a risk assessment led by an Emergency, Respiratory or attending medical consultant on appropriate transmission based precautions. • Site specific management of in-line suction and closed circuits will be described in clinical business rules.
Domestic CPAP/Bi-level devices	• All inpatients usually on domestic CPAP/Bi-level devices should not use these therapies **until a risk assessment** is conducted by the attending medical consultant of the admitting team • For patients admitted under Respiratory Medicine or who are being consulted by Respiratory Medicine, domestic CPAP/ bilevel NIV devices can be used once a risk assessment is completed and documented by, or discussed with, the respiratory consultant.
Spirometry	• Ward spirometry will not routinely be performed. Spirometry will only be performed if justified by specific clinical need and after risk assessment. Choice of PPE and location will be determined during the risk assessment. Please refer to 4.5 above. • An in-line viral filter must be used.

5. DOCUMENTATION

Documenting the Risk Assessment: The risk assessment should be highlighted/flagged in the medical record by using a heading such as Risk Assessment for AGP.

The documented Risk Assessment for AGP in the medical record must state:

- actual clinical benefit of or specific indication for the AGP or alternative therapies
- the **patient's COVID-19 status**
- assess the clinical setting and the most appropriate **location** for the aerosol generating procedure (AGP) or investigation
- type of accommodation and type of precautions according to CEC guidelines.

6. AUDIT

As required.

7. REFERENCES

1.	ACI - Respiratory physiotherapy COVID-19 advice
2.	ACI - Lung function testing COVID-19 advice
3.	CEC COVID-19 Infection Prevention and Control Manual version 3, 28 February 2023

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
May 2023	4	Business rule SESLHDBR/094 converted to a district procedure. Minor review to include further information in Sections 1, 4.1, 4.3 and 4.7. Approved by Executive Sponsor.