SESLHD PROCEDURE COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
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FUNCTIONAL GROUP(S)	Infection Control
KEY TERMS	Respiratory Viruses, Airborne, Droplet Precautions and Contact Precautions, Surgical Mask Particulate Mask
SUMMARY	Prevention of transmission of respiratory viral infection between healthcare workers, patients and their visitors and enable appropriate accommodation and management.

Management of Acute Viral Respiratory Illness (including influenza and COVID-19)

SESLHDPR/581

1. POLICY STATEMENT

This procedure aims to prevent of transmission of respiratory viral infection between healthcare workers, patients and their visitors; and enable appropriate accommodation and management. These viruses can cause more severe illness including pneumonia. This more often occurs in patients who have clinical risk conditions (defined in the Immunisation Handbook). The diagnosis of respiratory viral illness in inpatients is pivotal as they can be highly transmissible. Caution needs to be exercised as respiratory virus infection can occur with more than one agent.

2. BACKGROUND

Respiratory viruses cause mild to moderate illness in most people; however, vulnerable patients can be at risk of severe disease. Healthcare workers should ensure that all efforts are made to minimise the risk of transmission of respiratory viruses within health care facilities (HCFs), with a focus on protecting patients, visitors and staff.

3. RESPONSIBILITIES

Directors of Medical Services and Directors of Nursing and Midwifery:

- Ensure that compliance is monitored and evaluated.

Patient Flow Managers:

- Ensure patients requiring admission with suspected acute respiratory viral infection are isolated correctly to reduce risk of transmission to others.

Nurse Unit Managers:

- Maintain a high index of suspicion for acute respiratory viral illness all year and manage according to this guideline.
- The clinical picture overrides diagnostic testing results for isolation and management purposes (i.e. COVID-19, influenza A/B, RSV may be negative however patients remain symptomatic and may have another transmissible infection which has not been excluded).
- Patients who are tested for Middle East Respiratory Syndrome (MERS) must be cleared by ID Consultant (or local protocol) and according to Communicable Diseases Network Australia (CDNA) guidelines. For MERS, a single negative test may not be sufficient to rule out disease.
- Visitors with respiratory viral symptoms must not be allowed entry unless on compassionate grounds approved by the executive.
- Manage healthcare workers with respiratory illness according to facility guidelines.
- Promote seasonal influenza vaccination and COVID-19 immunisation for staff and patients.

NSW Health Pathology Randwick Area Virology Laboratory, Serology and Virology Division (SAViD):

- Provide support for increased diagnostic testing seasonally and on the advice of the Public Health Unit, with feedback to clinicians via EMR and Infection Prevention and Control reporting.
- Reference testing for respiratory viruses and molecular diagnostics.

Medical staff or Nurse Practitioner:

- Ensure appropriate ordering of specimens as per Flowchart 1 and Table 1
- Ensure COVID-19 is ruled out for any patient with compatible symptoms. “Triplex” testing is available in SESLHD, and includes SARS-CoV-2, influenza A and/or B and or respiratory syncytial virus (RSV). Full respiratory virus panel testing should be requested only if “triplex” testing is negative and the patient is in HDU/ICU or immunocompromised.
- Ensure adequate handover to nursing staff when respiratory viral illness is suspected.
- Ensure follow-up of exposed people occurs as per Influenza Control guidelines and SESLHDPR/685 - Outbreak Management and Contact Tracing.

All Healthcare Workers (HCW):

- Participate in the seasonal influenza and COVID-19 vaccination program and comply with mandatory vaccination requirements as per the NSW Health Policy Directive PD2024_015 - Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases.
- Risk assess and manage all patients as per procedure.
- Adopt airborne, contact and droplet precautions and immediately isolate any patient who has suspected or confirmed COVID-19 or MERS.
- Adopt contact and droplet precautions for patients who are negative for COVID-19 (and cleared by local protocol), without epidemiological risk who still have viral respiratory illness, and attend to increased cleaning of frequently touched surfaces to manage patients with acute viral respiratory illness.
- Provide patient and consumer NSW Health fact sheets.
- Use spacers for respiratory tract medication delivery where possible (minimise the use of nebulisers).
- Staff to remain at home when unwell with a respiratory illness.

Infection Prevention and Control Staff:

- Support clinicians in the management of cases and contacts.
- Ensure rapid isolation of cases and monitoring of contacts to prevent and identify outbreaks.

Patient/Consumer:

- Be encouraged to be involved in education and consideration for treatment including receiving information in NSW Health fact sheets.

4. DEFINITIONS

Airborne Precautions: a type of transmission-based precautions, used to interrupt airborne transmission from patients known or suspected to be infected with agents transmitted person-to-person by the airborne route such as COVID-19.

Contacts: are patients, their carers or staff that were potentially exposed to respiratory droplets or aerosols from a case

e.g. same room or area or providing care for the case. Specific definitions are applied depending on the virus and may include high, moderate and low risk contacts which may be managed differently.

Contacts of high risk: high risk immunocompromised, >65 years, ATSI or pregnant patients or children contacts if there is a high suspicion of influenza (as per Ministry of Health).

Contact precautions: type of transmission-based precautions used to interrupt the transmission of infectious agents that are spread by direct or indirect contact with the patient or the patient's environment.

Droplet precautions: precautions applied to patients known or suspected to be infected with pathogens that can be transmitted by droplets to reduce the risk of transmission.

Influenza-like illness: flu signs and symptoms usually come on suddenly. People who are sick with flu often feel some or all of these symptoms:

- Fever* or feeling feverish/chills
- Cough
- Sore throat
- Runny or stuffy nose
- Muscle or body aches
- Headaches
- Fatigue (tiredness)
- Some people may have vomiting and diarrhea, though this is more common in children than adults

**It's important to note that not everyone with influenza will have a fever.*

Post exposure prophylaxis: provision of an antiviral or other therapy after exposure to prevent or ameliorate disease. Contact tracing should be undertaken when patients or staff working in high-risk settings (hospital wards specifically for people who are immunosuppressed or neonatal wards) have been exposed to a confirmed infectious case of influenza. Vulnerable patients who are close contacts should be advised of their risk and, if indicated, and in consultation with their health care provider, should be offered early treatment should symptoms develop.

Respiratory viruses: a group of viruses with predominant effects on the respiratory tract.

Surgical Mask: a fluid resistant single use loose fitting mask that covers the nose and mouth.

Particulate mask (P2, N95 or PFR95): a mask which provides a tight facial seal with a face-seal leakage of <10% and ability to filter particles one micron in size in the unloaded state with a filter efficiency of greater than/equal to 95% given flow rates of up to 50 litres

per minute.
Pooled swab: the collection of a single swab consisting of tonsillar beds, back of throat and both nostrils from patients with suspected viral respiratory illness. A pooled swab is collected by first swabbing the oropharynx, the same swab is then used to swab the inside of the nares.

5. PROCEDURE

5.1 Respiratory Virus Testing

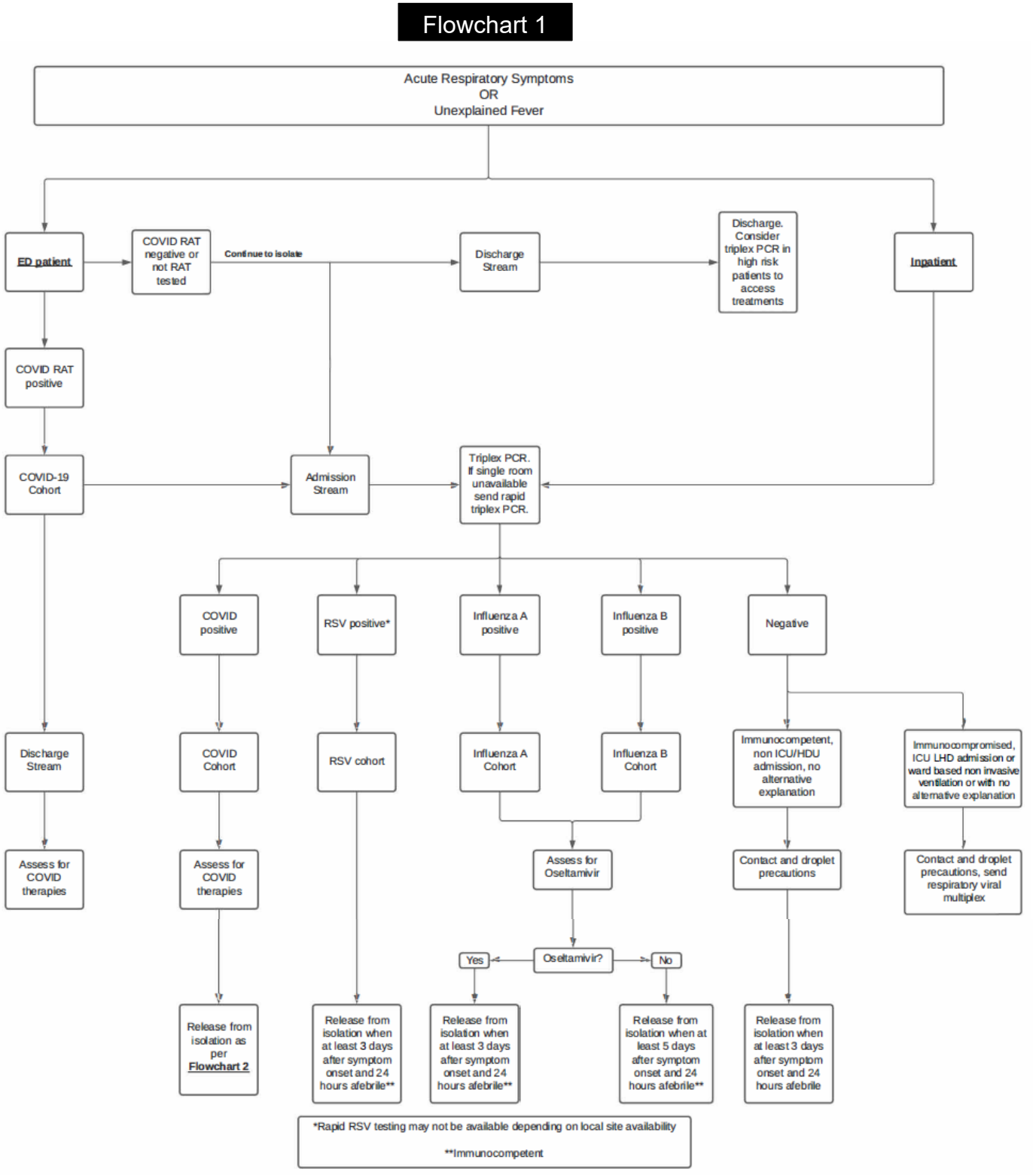
If symptoms consistent with acute respiratory viral illness isolate with airborne, droplet and contact precautions and manage until COVID-19 is ruled out. Obtain **throat and deep nasal pooled swab** from patients who may have respiratory viral illness.

Obtain one (1) pooled swab from tonsillar beds, and back of throat, the same swab is then inserted into both nares. See Section 6.2 for swab technique.

For patients with a negative “triplex” swab (and cleared by local protocol) isolate with droplet and contact precautions

- Patients who are identified as a high falls risk may need to be placed in an area where ability to visually observe patient can be achieved to ensure safety. Please contact site Infection Prevention and Control Consultant or contact Infectious Diseases Consultant on call to help with risk assessment.

Flowchart 1 - Respiratory virus testing and bed management in SESLHD facilities



Cohorting when isolation needs exceed available single rooms

Only same viruses can be cohorted together (i.e. influenza A with influenza A, rhinovirus with rhinovirus).

- Suspected COVID-19 cases must not be cohorted
- Patients with more than one respiratory virus must not be cohorted

5.2 Ordering Respiratory Virus Screening Panels on eMR

Clinicians to order "triplex" PCR (COVID-19/influenza/RSV) testing according to clinical assessment as per Flowchart 1 and Table 1. Additional respiratory virus testing is only recommended for patients being admitted to ICU/HDU or if immunocompromised.

Diagnosis of respiratory viruses other than COVID-19/Influenza/RSV are significant for the following groups:

- **Immunocompromised patients**
- **Paediatrics:** Immunocompromised patients (as above); moderate-severe viral exacerbations of chronic airways disease (e.g. asthma, CF).
- **Any:** patients with severe pneumonia requiring admission to ICU/HDU.

*All viruses can be ordered using one swab

In patients with severe illness PCR testing can also be undertaken on sputum as swabs may be falsely negative. If in doubt consult with Infectious Diseases.

Table 1 - Respiratory Virus Testing

Virus test set	**When to Order** NB. More than one test/ panel can be ordered on the one swab
SARS-CoV-2/Influenza/RSV 'triplex' test	For any patient who presents with the following symptoms: unexplained fever, cough, dyspnoea, malaise, fatigue, loss of taste and/or smell, and sputum/respiratory secretions. Other symptoms include headache, sore throat, fatigue, myalgia, rhinorrhoea, chills, and vomiting. Atypical symptoms may include chest pain, diarrhoea, conjunctivitis, and ILI.
RSV	As applicable if not included in triplex test and indicated as per local hospital policy.
Panel 2: Adenovirus, enterovirus, parainfluenzae 1-4, human metapneumovirus	**Adults:** Immunocompromised patients with acute respiratory illness e.g. haematology patients, solid organ transplants, immunology patients. **Paediatrics:** Immunocompromised patients (as above); suspected enterovirus infections; moderate-severe viral exacerbations of chronic airways disease (e.g. asthma, CF).
Panel 3: Rhinovirus, coronaviruses, bocavirus	**Adults:** Immunocompromised patients with acute respiratory illness e.g. haematology patients, solid organ transplants, immunology patients. **Paediatrics:** Immunocompromised patients (as above); moderate-severe viral exacerbations of chronic airways disease (e.g. asthma, CF).
Panel 4: Mycoplasma pneumoniae (MP), Chlamydophila pneumoniae (CP), Legionella pneumophila (LP), Haemophilus influenzae (HI), Streptococcus pneumoniae (SP), Bordetella pertussis (BP) and Bordetella parapertussis (BPP)	**Adults:** Severe (ICU/HDU admission) community-acquired pneumonia or immunocompromised patients with acute respiratory illness e.g. haematology patients, solid organ transplants, immunology patients. **Paediatrics:** Immunocompromised patients (as above); moderate-severe viral exacerbations of chronic airways disease (e.g. asthma, CF).

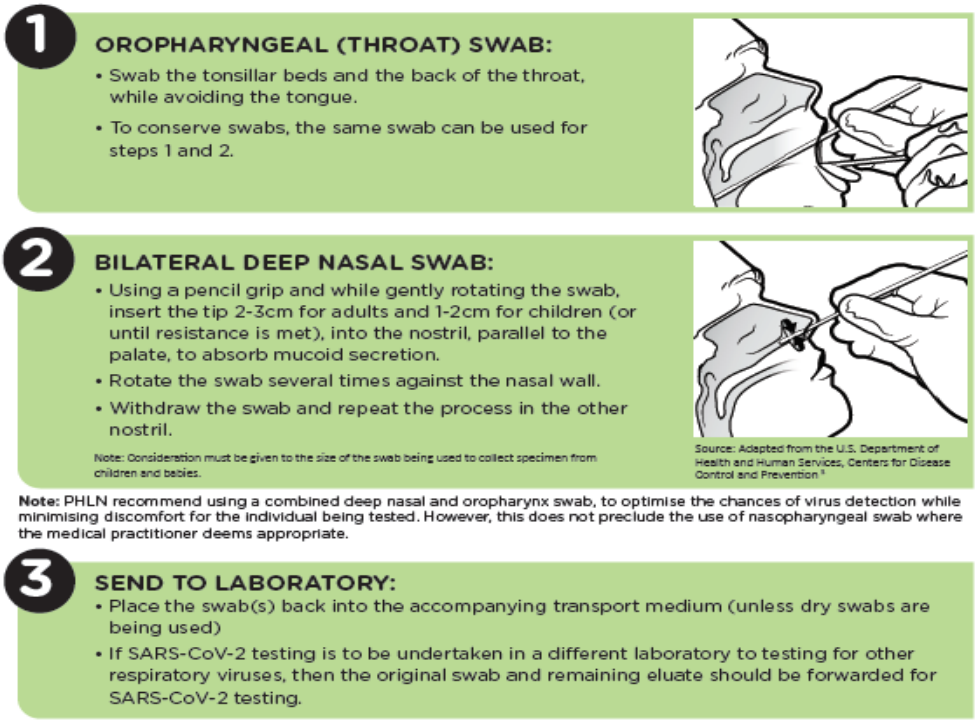
NB: Clinical picture overrides diagnostic testing results for isolation and management purposes. COVID-19, influenza A/B, RSV may be negative; however, patients remain symptomatic and may have other transmissible infections which have not been excluded.

6. COLLECTION OF VIRAL RESPIRATORY SWABS

6.1 UPPER RESPIRATORY TRACT SAMPLES

Deep nasal and oropharyngeal swab: may be dacron or rayon, although flocked is preferred. A pooled swab is undertaken to swab the tonsillar beds, back of throat and both nostrils in the following way:

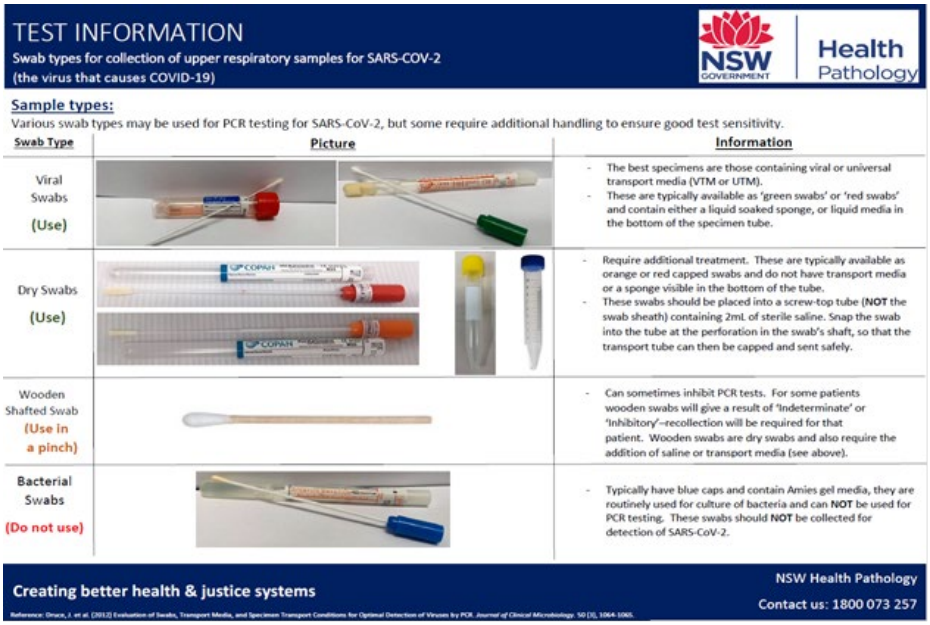
- Oropharyngeal (throat): swab the tonsillar beds and the back of the throat, avoiding the tongue, then using the same swab deep nasal swab
- Using a pencil grip and while gently rotating the swab, insert the tip 2–3 cm (or until resistance is met), into the nostril, parallel to the palate, to absorb mucoid secretion.
- Rotate the swab several times against the nasal wall.
- Withdraw the swab and repeat the process in the other nostril. To conserve swabs the same swab that has been used to sample the oropharynx should be utilised for nasal sampling.
- Place the swab back into the accompanying transport medium.
- Sampling both sites, deep nasal and oropharynx, is recommended to optimise the chances of virus detection. The swab should be placed in appropriate transport medium.



Source Public Health Laboratory Network 2020

6.2 SWAB TYPES

Viral respiratory swabs are often green in colour; however new types of swabs are able to be used as per below Test Information NSW Health Pathology. If in doubt, please contact your laboratory service.



TEST INFORMATION

Swab types for collection of upper respiratory samples for SARS-COV-2 (the virus that causes COVID-19)

NSW GOVERNMENT Health Pathology

Sample types:

Various swab types may be used for PCR testing for SARS-CoV-2, but some require additional handling to ensure good test sensitivity.

Swab Type	Picture	Information
Viral Swabs (Use)		- The best specimens are those containing viral or universal transport media (VTM or UTM). - These are typically available as 'green swabs' or 'red swabs' and contain either a liquid soaked sponge, or liquid media in the bottom of the specimen tube.
Dry Swabs (Use)		- Require additional treatment. These are typically available as orange or red capped swabs and do not have transport media or a sponge visible in the bottom of the tube. - These swabs should be placed into a screw-top tube (**NOT** the swab sheath) containing 2mL of sterile saline. Snap the swab into the tube at the perforation in the swab's shaft, so that the transport tube can then be capped and sent safely.
Wooden Shafted Swab (Use in a pinch)		- Can sometimes inhibit PCR tests. For some patients wooden swabs will give a result of 'Indeterminate' or 'Inhibitory'–recollection will be required for that patient. Wooden swabs are dry swabs and also require the addition of saline or transport media (see above).
Bacterial Swabs (Do not use)		- Typically have blue caps and contain Amies gel media, they are routinely used for culture of bacteria and can **NOT** be used for PCR testing. These swabs should **NOT** be collected for detection of SARS-CoV-2.

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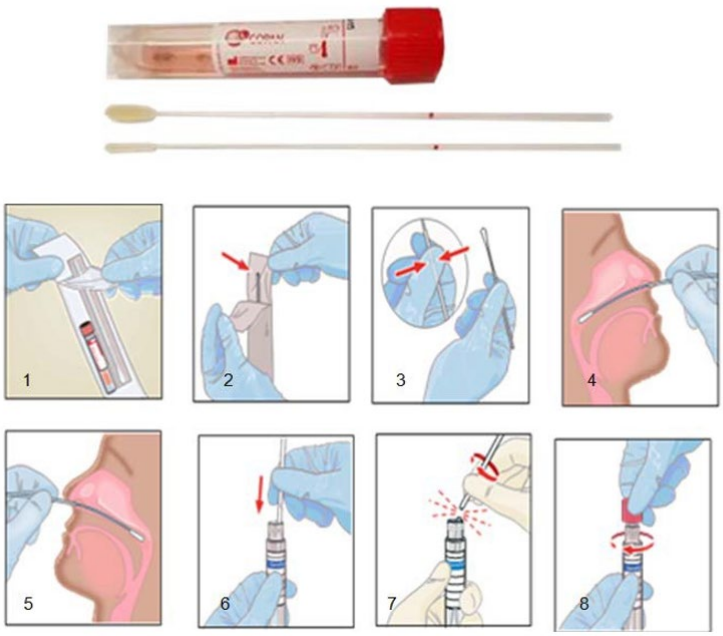
Contact us: 1800 073 257

Reference: Druce, J. et al. (2012) Evaluation of Swabs, Transport Media, and Specimen Transport Conditions for Optimal Detection of Viruses by PCR. *Journal of Clinical Microbiology*. 50 (3), 1064-1065.

6.3 COLLECTION OF RAPID VIRAL SWABS



1. Open the individual collection package that contains the swab and Xpert Viral Transport
2. Medium tube. Set the tube aside before beginning to collect the specimen.
3. Open the collection swab wrapper by peeling open the top of the wrapper. Remove the swab, taking care not to touch the tip of the swab or lay it down.
4. Hold the swab in your hand, placing your thumb and forefinger in the middle of the swab shaft across the score line.
5. Gently insert the swab into the nostril. Keep the swab near the septum floor of the nose while gently pushing the swab into the posterior nasopharynx.
6. As a visual reference, the swab should be inserted about half the distance from the opening of the patient's nostril and the ear. Rotate the swab several times.
7. While holding the swab in the same hand, aseptically remove the cap from the tube. Insert the swab into the tube with the transport medium.
8. Identifying the score line, break the swab shaft against the side of the tube. If needed, gently rotate the swab shaft to complete the breakage. Discard the top portion of the swab shaft. Avoid splashing contents on the skin. Wash with soap and water if exposed.
9. Replace the cap onto the tube and close tightly. Send immediately to pathology lab.

6.4 ORDERING OF RAPID VIRAL SWABS

- Clinician to Order Rapid SARS-CoV-2/Influenza/RSV PCR on eMR
- Rapid SARS-CoV-2/Influenza/RSV testing of nasopharyngeal swabs should only be requested if a single isolation room is not available or in an outbreak when approved by infectious diseases or infection control (see Flowchart 1) (result within one to four hours).

7. SURVEILLANCE TESTING FOR COVID-19 IN SESLHD FACILITIES

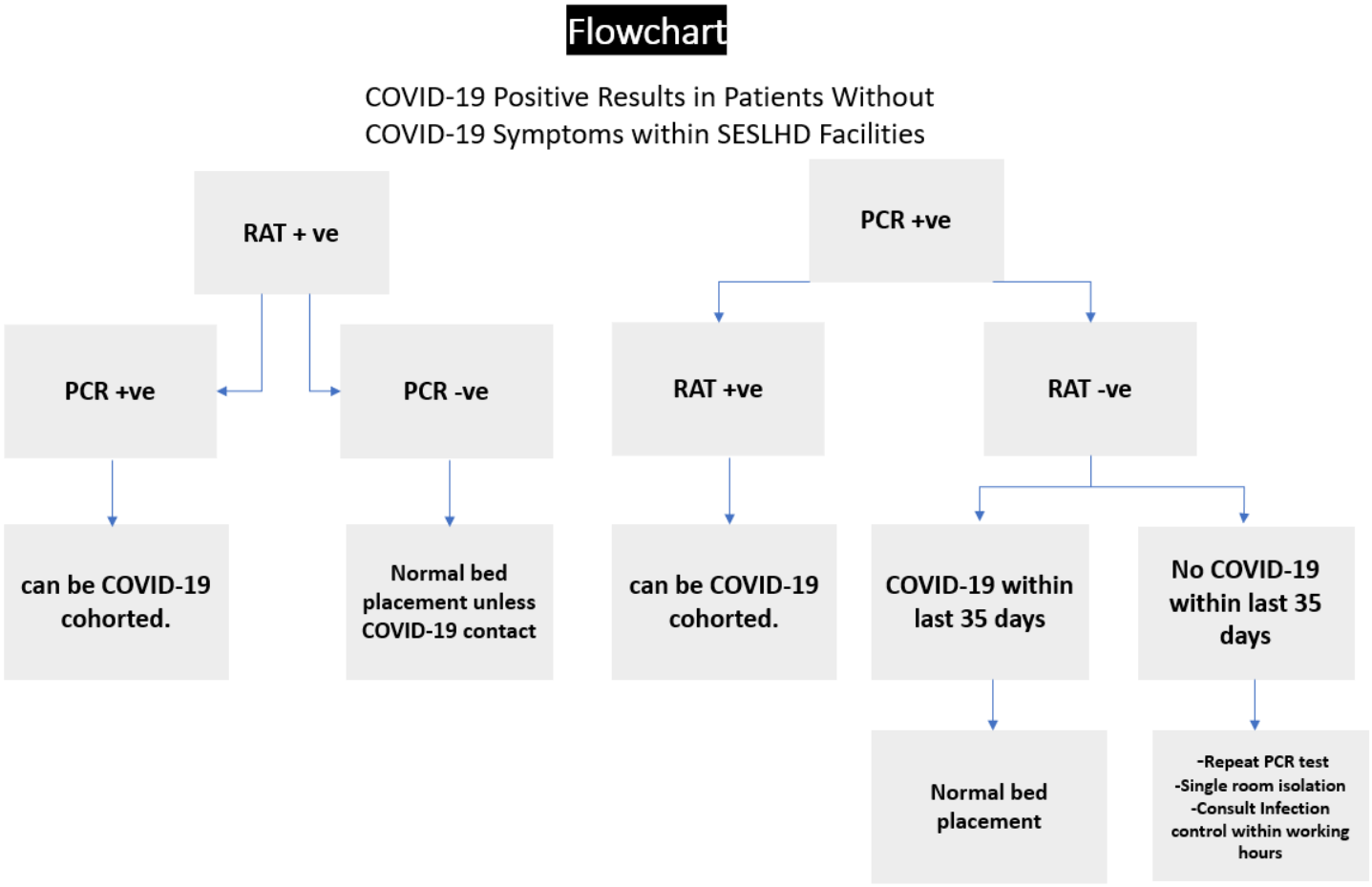
Surveillance testing for COVID-19 in asymptomatic patients in SESLHD facilities should be undertaken in accordance with SESLHD recommendations for surveillance testing.

This guidance provides locally tailored recommendations based on the latest Clinical Excellence Commission (CEC) guidance found here: CEC Infection and Prevention Manual and the CDNA COVID-19 National Guidelines.

People who have recovered from COVID-19 are EXEMPT from surveillance testing for 35 days from their onset of COVID-19 symptoms.

Asymptomatic patients with a positive test result should be managed according to Flowchart 2.

Flowchart 2 - COVID Positive results in patients without COVID symptoms in SESLHD facilities



8. COLLECTION OF SEROLOGY

- In general, serology is of limited value in the diagnosis of acute respiratory illness. Consult with Infectious Diseases.

9. CONTACTS OF A CASE

Manage as per Table 3.

Table 3 – Summary of contact screening requirements

Virus	Incubation (days)	Infectious period (days)	Contact tracing yes/no	Management
SARS-CoV-2	Usually 5-6 Range 1-14	Variable For clearance see flowchart 3	Yes Consult with infection control/ID team	High risk and moderate risk contacts must be isolated with contact, droplet and airborne precautions for a period and tested as advised according to current SESLHD advice.
Influenza A & B	Usually 2-3 Range 1- 7	Normal host 3-5 Immunocompromised >10	Yes Consult with infection control/ ID team	Monitor temperature 4/24 for 72 hours. Isolate if becomes symptomatic with droplet and contact precautions. Consider antivirals for influenza A and B contacts if necessary in particular for the at risk groups as per Influenza Control Guidelines or advice from Infectious Diseases team. Use airborne precautions if aerosol generating procedures are performed
Parainfluenza	2	Normal host 3-5 Immunocompromised >10		
Respiratory syncytial virus	2	Normal host 3-5 Immunocompromised >10		

Virus	Incubation (days)	Infectious period (days)	Contact tracing yes/no	Management
Rhinovirus	½-3	Normal host- variable Immunocompromised- variable	Yes, if likely outbreak of 2 or more cases Consult with infection control/ID team	In the event of an outbreak, monitor patient's temperature 4/24 for 72 hours. Isolate if become symptomatic with droplet precautions. Use airborne precautions if aerosol generating procedures are performed
Common coronaviruses (229E, NL63, OC43)	Variable	Normal host- variable Immunocompromised- variable		
Bocavirus	7-13	Normal host- variable Immunocompromised- variable		
Adenovirus	Variable	Normal host- variable Immunocompromised- variable		
Enterovirus	Variable	Normal host- variable Immunocompromised- variable		
Polyomaviruses Wu Ki	3-10	Normal host- variable Immunocompromised- variable		
Human metapneumovirus	3-5	Normal host- variable Immunocompromised- variable		

10. CLEARANCE OR DE-ISOLATION OF A CASE

For de- isolation purposes, the key factors to consider are:

- Day of symptom onset or positive test result
- Infectious period
- Infecting pathogen
- Any treatment given
- Current symptoms

For **immunocompetent** patients:

- De-isolate influenza and RSV according to Flowchart 1 or Table 5.
- De-isolate COVID-19 according to Table 4.
- For patients who are not diagnosed with COVID-19, influenza or RSV manage as per Flowchart 1 or Table 5

In general, immunocompetent hosts will NOT be tested for other respiratory viruses, but if they have been tested they can be de-isolated with reference to table 4 (generally >3d from symptom onset AND 24h afebrile).

For **immunocompromised** patients:

- De-isolate influenza and RSV according to Flowchart 1 or Table 5.
- De-isolate COVID-19 according to Table 4
- De-isolate other respiratory viruses according to Table 5

Table 4 - Release from isolation of COVID-19 cases in SESLHD facilities

- Patients who are not isolated or cohorted (with other COVID-19 patients) during their infectious period should be assessed and contact tracing undertaken.
- De-isolation requires **at least 24 hours** of symptom resolution (fever and ARI symptoms related to COVID-19 infection).
- Reinfection may occur. Retest any patients with new symptoms if more than 35 days has elapsed since their previous positive test.

De-isolation Decisions		
	Inpatient	Community
Patient Illness	NOT IMMUNOCOMPROMISED	
Mild-Moderate	On day 8 AND negative RAT OR On day 11 without testing.	Recommended isolate at home until day 5 AND at least 24 hours after resolution of symptoms. Avoid high risk settings until day 7.
Severe or Critical (requiring supplemental oxygen to maintain SpO2 92% and above)	On day 11 without testing.	Recommend isolate at home at least until day 5 AND at least 24 hours after resolution of symptoms. Avoid high risk settings until day 14.
	IMMUNOCOMPROMISED	
All categories of illness	On day 11 AND 2 negative RAT's on day 9 and 10 (24 hours apart).	Recommend isolate at home at least until day 7 since positive test. Avoid high risk settings until day 14.

1. Routine RAT is not required for patients being discharged to isolation at home. RAT may be required if entering a high-risk facility.
2. An immunocompromised patient refers to those patients who have a weakened immune system, due either to a medical condition or immunosuppressive medications/treatments. (2023, CDC). This includes patients who have one or more of the following: organ transplant and are on immune suppressive therapy, have had a haematopoietic stem cell transplant in the past 2 years, are on immune suppressive therapy for graft versus host disease, have had an active haematological malignancy, human immunodeficiency virus infection with CD4 T-lymphocyte count below 200 cells/ per mm3, other conditions specifically noted by the treating medical practitioner.

Table 5 – Infectious periods/de-isolation times for specific viruses

Virus	Incubation (days)	Infectious period (days)	De-isolation in days (if afebrile for 24 hours prior)	
			Antiviral	No antiviral
SARS-CoV-2 (COVID-19)	Usually 5-6 Range 1-14	Variable	n/a	See flowchart 3
Influenza A & B	1-4	Normal host 3-5	3	5
		Immunocompromised >10	7	10
Parainfluenza	1-7	Normal host 3	n/a	3
		Immunocompromised >10	n/a	7
Respiratory syncytial virus	2-8	Normal host 3	n/a	3
		Immunocompromised >10	7	7
Human metapneumovirus	3-5	Normal host- variable	n/a	3
		Immunocompromised - variable	n/a	7
Rhinovirus	½-3	Normal host - variable	n/a	3
		Immunocompromised - variable	n/a	5
Coronavirus	2-4	Normal host- variable	n/a	3
		Immunocompromised - variable	n/a	5
Bocavirus	Variable	Normal host – variable	n/a	3
		Immunocompromised - variable		Consult with ID/ Infection control
Adenovirus	2-14	Normal host- variable	n/a	3
		Immunocompromised - variable		Consult with ID/ Infection control
Enterovirus	3-10	Normal host – variable	n/a	3
		Immunocompromised - variable		Consult with ID/ Infection control
Polyomaviruses Wu Ki	Variable	Normal host –variable	n/a	3
		Immunocompromised - variable		Consult with ID/ Infection control

NB: If patient has been febrile, then must be afebrile 24 hours prior to de-isolation.

11. TREATMENT

Treatment options for COVID-19 and influenza A or B are available.

- Use of antiviral drugs for influenza contacts should occur as per Influenza Control Guidelines, or as per assessment by treating teams and infectious diseases clinicians.
- Influenza virus antivirals (neuraminidase inhibitors zanamavir – Relenza® or oseltamivir – Tamiflu®) are not effective against other viruses.
- Ribavirin may be used to treat RSV on a case-by-case basis.
- Antiviral therapy for COVID-19 is available.

12. OUTBREAK

- If two or more cases of respiratory viral disease occur within 72 hours in a ward, or bed unit this must be managed using outbreak management principles. The executive must be notified immediately of a possible outbreak.
- Refer to SESLHDPR/685 - Outbreak Management and Contact Tracing, for outbreak management principles.

13. DOCUMENTATION

- Health Care Records

14. AUDIT

- Annual influenza and COVID-19 vaccination rates of healthcare workers.
- Outbreak investigation reports, facility Infection Prevention and Control Committee.
- Personal protective equipment compliance audits from the facility audit program.

15. REFERENCES

- NSW Health Policy Directive PD2023_025 - Infection Prevention and Control in Healthcare Settings
- NSW Health Policy Directive PD2024_015 - Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases
- NSW Health Influenza Control Guidelines
- NSW Health COVID-19 Resources
- Clinical Excellence Commission Infection Prevention and Control Practice Handbook
- Clinical Excellence Commission COVID-19 Infection Prevention and Control Manual
- Australian Government, Department of Health, Communicable Diseases Network Australia National guidelines for public health units
- Australian Government, Department of Health. 2020 Coronavirus (COVID-19) resources

- SESLHDPR/277 - Influenza Clinics for Seasonal Influenza
- SESLHDPR/270 - Influenza - Critical Care Escalation and Management
- Centre for Disease Control and Prevention Influenza Case Definition

16. VERSION AND APPROVAL HISTORY

Date	Version	Version and approval notes
26 May 2017	Draft	Kim Brookes, Executive Sponsor, approved final draft for
02 June 2017	Draft	Processed by Executive Services prior to submission to CQC
June 2017	0	Approved by Clinical and Quality Council
June 2019	1	Minor review approved by Executive Sponsor. Updated and included cohort flowchart. Updated references to procedures and hyperlinks and definitions. Removed Appendix 2, Respiratory Viral Illness Risk Matrix. Updated treatment to include use of
July 2019	1	Tabled at July 2019 Quality Use of Medicines Committees (QUMC) for approval to publish.
July 2019	1	Approved by Quality Use of Medicines Committee. Procedure published.
June 2020	2	Inclusion of COVID-19 information.
July 2020	2	Approved by the Quality Use of Medicines Committee
July 2021	3	Minor review: Updated as per CEC COVID-19 and Department of Health Communicable Diseases
August 2021	3	Approved by the Quality Use of Medicines Committee
May 2022	4	Major review: Updated with introduction of SARS-CoV-2/influenza/RSV “triplex” testing and syndromal de-isolation in immunocompetent hosts. Approved by Executive Sponsor for interim publication. Draft for Comment period.
August 2022	5	Feedback incorporated. Approved by SESLHD Infection Prevention and Control Committee. Approved by Executive Sponsor.
October 2022	5	Approved at Quality Use of Medicines Committee meeting.
December 2022	5.1	Approved at November 2022 Clinical and Quality Council. Processed and published.
29 November 2023	5.2	Amendment to procedure: update to Flowchart 2; hyperlinks updated. Approved by Executive Sponsor.
2 October 2024	5.3	Minor Review: Change to COVID-19 deisolation criteria. Approved by the SESLHD Infection Prevention and Control Subcommittee.