OPERATIONAL MANAGEMENT OF COVID-19 WITHIN MCSA HOSPITALS

POLICY MCSA.C.1.1

1. Purpose

This COVID-19 Policy is an amalgamation of all policies relating to the operational management of COVID-19 in MCSA hospital as of 19th May 2021. It covers 3 broad Sections:

1. Management of Patients
2. Management of Healthcare Workers
3. Management of Visitors

Version 1 – UPDATES 28 May 2021

Updates include latest evidence and literature related to the impact of vaccination and diagnostic tests on the management of COVID-19 in patients, Healthcare Workers and visitors.

ACCESS CONTROL

- Number of access control points may be determined by the hospital, but must be limited during a surge.
- Hospitals should consider using trained security personnel at access control.
- A designated person to co-ordinate access control must be determined at hospital level.

TESTING AND DIAGNOSIS

- With our existing international knowledge on the impact of vaccination on patients, our current view on diagnostic testing for COVID-19 **remains in place** until further local or international guidance is available.
- **No change to pre-admission PCR testing requirements with vaccination**.
- Use of Rapid Antigen Testing, either laboratory or Point of Care test, may be used on symptomatic patients for rapid diagnosis and appropriate placement.
- Doctors' guideline: Ideal timing before elective surgery is 7 weeks post-acute COVID-19 infection. Doctor and patient to evaluate the risk and benefits of surgery when determining the urgency thereof.
- Doctors' guideline: Please indicate "Mediclinic pre-admission" on the laboratory request form: Location section. This is to be done for patients for surgery, as well as patients who are being seen as outpatients, during a surge. It will allow automated import of the results into the ICNet systems and then Notifiable Medical Conditions reporting to the NICD.
- COVID-19 Notifiable Medical Condition (NMC) reporting remains in place, no matter which testing method has been used. The reporting is now automated with the NICD for all patients who are loaded on ICNET, thereby removing duplicate reporting effort for IPC managers.

IPC PRACTICES PPE

- Current guidance from the WHO and the NICD on SARS-CoV-2 transmission routes has not changed. Therefore application of precautions, in addition to universal masking and eye protection,

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remains applicable based on the two known routes of transmission (via droplet and contact transmission routes). Aerosols may be generated when in close proximity to specific procedures and airborne precautions with the use of an N95, or equivalent respirator, is indicated.

- A disposable gown: Only indicated if a significant or expected exposure risk to fluids is anticipated which includes aerosol generating procedures and not routinely on an ongoing basis. Initially gowns were adopted when COVID-19 began. However, a gown is not required for ongoing care activities and healthcare workers are adequately protected by wearing a plastic apron.
- A plastic apron should be used when in close contact with COVID-19 patients.
- Gloves: Only when indicated for contact with non-intact skin, mucous membranes, blood and body fluid.
- Aprons (or gown) and gloves used must be removed before leaving the immediate patient area (patient zone).

HEALTHCARE WORKER SURVEILLANCE

- Access control for healthcare workers (HCWs), via the Health Professional Clearance App, continues and now includes symptoms and risk factors linked to their vaccination status,
- The following principles apply when interpreting symptoms or exposure in HCWs who are vaccinated:
    a. HCW with any symptoms immaterial of vaccination status, should be investigated and managed as per normal protocols
    b. HCW with high risk exposure immaterial of vaccination status, should quarantine and be tested on return on day 5. They should be monitored for symptoms by INCON (designated nurse where Incon is not present) and registered on the HCW monitoring app.
- With the roll out of the vaccination program for Healthcare workers, random staff testing is no longer required. Only targeted testing in outbreaks or for symptomatic HCWz is needed.

VISITING HOURS:

- Visiting hours are only stopped in situations of surge (of COVID-19 occupancy) to protect the HCWs, patients and visitors from spread.
- Where hospitals have lower COVID-19 occupancy, visitors to COVID-19 and non-COVID-19 patients should be allowed under specific circumstances as generously as possible.
- Normal provisions continue for terminal, long stay, vulnerable, maternity and paediatric patients.
- Virtual visitation is encouraged under all circumstances.
- Visitors who have been fully vaccinated (all required doses) and more than 30 days post-vaccination should be allowed to access the hospital if they are symptom free to visit COVID-19 positive patients.

This is a dynamic document which changes as the NICD case definition and guidance changes, the COVID-19 related regulations are promulgated and the pandemic waves evolves. It is effective at the time of issue and may be updated or changed at any time.

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2. Definitions

ABBREVIATION	DEFINITION	DESCRIPTION
AGP	Aerosol generating procedures	Aerosol generating procedures, where mechanical force during intubation, cardiopulmonary resuscitation, tracheotomy and bronchoscopy increase the risk of exposure and contamination.
COVID-19	Coronavirus disease 2019	Coronavirus disease is the infectious disease and illness caused by the novel SARS-CoV-2 virus.
EC	Emergency Centre	
HCW	Healthcare worker	HCW refers to Mediclinic employees, contract workers, agency staff, volunteers and ancillary healthcare workers, doctor and their staff.
MDRO	Multi Drug Resistant Organisms	Multi Drug Resistant Organisms are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents.
NICD	National Institute for Communicable Diseases	The National Public Health Institute of South Africa providing reference to microbiology, virology, epidemiology, surveillance and public health research, to support government's response to communicable disease threats.
PCR	Polymerase chain reaction	PCR is reverse transcriptase polymerase chain reaction (RT-PCR) molecular test for the identification of Sars CoV2 virus.
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2	The name given to the novel (newly identified) enveloped virus which is part of the Coronavirus group of viruses.
RTW	Return to work	

3. Responsibilities

Role	Responsibility
Hospital General Manager	• Ultimately accountable for the compliance with the minimum standards held within this policy. • Implementation of the requirements in this policy whilst adapting them to the specific situation and operational needs of the hospital. • Communicate the needs of this with doctors in the facility and ensure compliance.
Nursing Manager/Hospital Clinical Manager/ IPC and PSM	• Communicate and assist with the implementation of the policies and ensure compliance by all HCWs in the hospital.
All Health Care Workers including Medical Practitioners	• Ensure compliance with the requirements in this policy.

MANAGEMENT OF COVID-19 PATIENTS

The following key requirements must be implemented for all MCSA hospitals whilst the country has declared a Disaster and Disaster Management regulations are enacted.

1. Access control for all people accessing a facility

Access control must be implemented to limit risk of spread to patients and HCWs. The following needs to be in place whilst the Disaster Management Act is enforced:

a) Access control applies to every single person who visits or works in the hospital.

b) Access control at hospital entrances is to be implemented 24 hours a day, seven days a week.

c) Co-ordination of the access control function must be decided upon at hospital level and a dedicated person should be identified who can review and engage with Corporate Office on any update/improvements to this policy.

d) Hospital to determine the most suitable number of access control points in order to allow for the control of people entering the hospital. These may have to be limited when a surge occurs in order to control flow through the hospital.

e) A dedicated entrance for HCWs during shift change, over times, must be implemented. The goods access point is only for goods and not people.

f) The person/s manning the access points must be trained to understand the process and have access to a nurse well versed in the criteria for diagnosing COVID-19 where needed. Hospitals should consider utilising trained security personnel and use the electronic access applications wherever possible. Use of trained volunteers (within the parameters set out by HR) at access control points should also be considered.

g) For surgical, medical and obstetric admissions access is clinically based – these patients cannot be denied access as they need admission. However, in order to protect other patients and healthcare workers, they will need to be directed and managed in a dedicated area if they screen 'red'.

h) All patients and visitors to doctors rooms must have their temperature monitored, using either thermal or hand held temperature scanners. There is no need to record the temperature. Should their temperature be >38 degrees, they will need to assessed by a nursing professional and appropriately directed.

i) Placement of thermal cameras and hand held scanners needs to be reviewed in order to allow sufficient access points and reduce queues. Hospital to determine suitable placement of these, based on access control points.

j) All persons older than two years old entering the facility must wear a mask.

k) A parent with a child for admission, are seen as a single unit and are admitted together.

l) Signage: Way-finding signage needs to be in place, posters in the access control points must reflect the process that needs to be followed in this area and direct patients and visitors to the appropriate electronic application. These should include instructions to use the electronic access control app.

m) Physical distancing (indicate by markings on the floor) and hand hygiene have to be applied in the access control area. Ensure that alcohol hand rub is available and hand hygiene posters are displayed.

n) Paper based access control questionnaires should be kept for 3 months.

o) Access to the EC is only via the EC access control point which may be situated just inside/outside the EC pedestrian entrance. Ambulance access will still occur via the ambulance entrance.
The EC access control point may need to be moved outside the EC during a COVID-19 surge as the number of patients accessing the EC might limit the ability to safely social

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distance in the EC waiting room. The EC triage point can also be moved outside the EC during a COVID-19 surge in order to utilise the triage room as a clinical area.

Patients will have two modes of gaining access:
- At the main entrance on the day of admission – this can be by using the WhatsApp Bot or paper based, or
- Surgical patients will require a risk assessment online, 24 hours prior to admission via the Engage platform SMS system. If they do not complete this, they will follow the WhatsApp Bot or paper based version at the entrance on the day of admission.

2. Pre-admission symptom screening and access control for surgery patients

Pre-admission symptom screening and access control for all patients for elective surgery is a requirement utilising the Engage platform to streamline access on day of admission:

a) Doctor/practice rooms should be encouraged to guide all elective patients to complete the ENGAGE pre-admission risk screening process.
b) Risk assessment should occur 24 hours before their day of admission whereby the patient will complete their online risk assessment on the secure website (Engage).
c) Outcomes of the risk assessment are communicated to the patient and doctor.
d) The results of the risk assessment must be available as a "flag" on the theatre bookings list with each patient's risk assessment status. This should be available for relevant staff in the hospital to see.
e) Patients screening with symptoms or risk factors ("red status") must be reviewed by the surgeon or admitting doctor for COVID-19 test results and risk of proceeding with the procedure.
f) The doctor/practice rooms must contact the theatre scheduling clerk to confirm or cancel the patient with a "red status" and this information should be indicated on the theatre slate.
g) Patients who do not complete their preadmission screening via Engage will need to complete screening at access control on the day.
h) Ideally no "red" status patient or one with a positive COVID-19 test result should turn up on the day of surgery. However, if they do, the staff at access control should check if the patient is still on the theatre slate. If they are on the slate, they should continue to be admitted with the patient placed in the suitable ward in the hospital.

3. Daily symptom monitoring

A process must be followed to assess admitted non-COVID-19 patients on a daily basis to allow for early identification of the development of any signs or symptoms which may indicate COVID-19 infection. Upon identification, further action to review, test and isolate the patient, pending an outcome should occur. Daily symptom monitoring must be completed as per the COVID-19 Daily Symptom Screening document (N0800). This applies to:
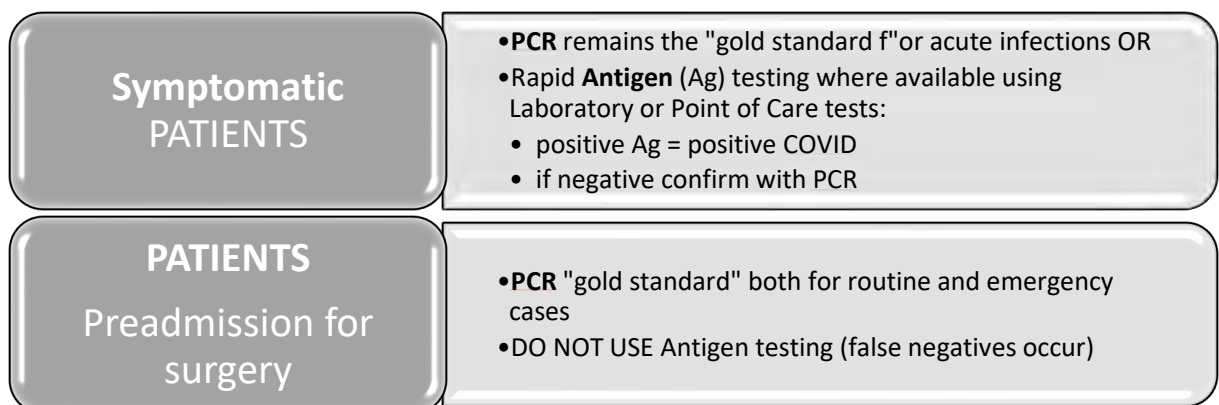
- All in patients identified as 'COVID-19 negative' from day 1 of admission until discharge.
- All maternity partners.
- All parents with children admitted.

4. COVID-19 diagnosis and testing

a) PCR remains the "gold standard" test for COVID-19 for patients prior to surgery.
b) All surgical patients must have a PCR testing 48-72 hours prior to surgery.
c) Symptomatic patients may have PCR or Rapid Antigen testing performed. In such patients a positive PCR or Antigen is considered diagnostic of COVID-19.

d) PCR may remain positive for up to 90 days and therefore repeat testing within this period is not needed. Alternative diagnoses should be considered and a respiratory PCR panel (either viral or bacterial) may assist with alternative diagnostics.

e) If after 90 days a PCR test is positive, then reinfection should be considered and reported to the NICD.

f) Patients with repeated short stay admissions should have an initial baseline PCR test performed and thereafter daily symptom monitoring. If they develop symptoms, rapid antigen testing may be utilised.

g) COVID-19 negative patients admitted for extended periods of stay should have a repeat COVID-19 test, if more than 5 days have passed since admission. If they develop symptoms at any point in time, an Antigen test or COVID-19 PCR should be performed.

h) Current knowledge on the impact of the COVID-19 vaccination on patients who require surgery is insufficient to change this policy so PCR testing prior to admission remains a requirement.

i) Additional international guidance on ideal timing for surgery indicates that where possible, elective surgery should be delayed for at least 7 weeks following SARS-CoV-2 infection. Patients with ongoing symptoms ≥ 7 weeks from diagnosis may benefit from further delay. It is for the doctor and patient to weigh up risks and benefits of surgery and determine the urgency, as the risk of mortality is as high at 23.8% whilst pulmonary complications occurred in 51% of patients.

j) Antibody serology testing is currently of limited value in diagnosing infection and documenting immunity post-vaccination or infection due to the challenges with interpretation of the results.

Figure 1 – Summary of testing methods

Symptomatic PATIENTS	• **PCR** remains the "gold standard f"or acute infections OR
	• Rapid **Antigen** (Ag) testing where available using Laboratory or Point of Care tests:
	  • positive Ag = positive COVID
	  • if negative confirm with PCR

PATIENTS Preadmission for surgery	• **PCR** "gold standard" both for routine and emergency cases • DO NOT USE Antigen testing (false negatives occur)

5. IPC practices

a) Current guidance from the WHO and the NICD on SARS-CoV-2 transmission routes has not changed therefore application of standard and transmission based precautions, in addition to universal masking and eye protection, remain applicable based on the two known routes of transmission of SARS-CoV-2 (via droplet and contact transmission routes). Aerosols may be generated when in close proximity to specific procedures and airborne precautions with the use of an N95 or equivalent respirator is indicated

b) Effective Hand Hygiene, ventilation, distancing and masks are the cornerstones to preventing its spread in the healthcare setting.

c) Standard precautions should be always adhered to. This always includes the use of a surgical mask. Eye protection should be worn in addition, when caring for suspected or confirmed COVID-19 patients.

d) Transmission based precautions are based on the route of transmission.

There are two known routes of transmission:

- Droplet route: Via respiratory droplets produced via sneezing, coughing or directly inhaled during close contact with the affected person.
- Contact route: Via respiratory droplets landing on environmental surfaces surrounding the infected person (also known as the patient zone and the health zone) which are then transferred through contact with contaminated hands to a person's face and mucous (eyes, nose and mouth).

e) It is possible during certain procedures, referred to as aerosol generating procedures (AGP), for example intubation, cardiopulmonary resuscitation, tracheotomy or bronchoscopy, where mechanical force disperses secretions that smaller, finer droplets, known as aerosols may disperse. For this reason, when in close proximity, airborne precautions (the use of an N95 respirator) will be required, in addition to eye protection.

f) Principles relating to standard precautions and utilisation of PPE and their applicability in the COVID-19 setting include:
- **Hand Hygiene**: This remains the cornerstone of preventing transmission in the healthcare setting and must be performed according to the 5 Moments of Hand Hygiene. Mediclinic Corporate Policy: Hand Hygiene: MCSA.C.IPC.1.6. http://intranet/sites/Policies/Records/Hand%20Hygiene.pdf.
- **Gloves** are used per patient during care as indicated by standard precautions and removed and discarded immediately after each use before leaving the patient zone. Contaminated gloves pose a risk and can transmit the virus and other multidrug resistant organisms to the other critical body sites on the same patient, to the environment and other patients.
- **Aprons** should be used during activities where there is a possibility of exposure to body fluids to provide a waterproof barrier and discarded after each patient intervention. They should be removed and discarded when leaving each individual patient zone.
- **Disposable gowns** are only indicated when a procedure is performed where there is a heightened risk for exposure to blood and body fluids, which includes aerosol generating procedures. Initially gowns were adopted when COVID-19 began. However, based on the route of transmission of SARS-CoV-2, a gown is not required for ongoing care activities and healthcare workers are adequately protected by wearing a plastic apron.

g) Environmental cleaning: SARS-CoV-2 can remain on certain surfaces (such as plastic and stainless steel) for up to 9 days. Therefore, cleaning of the environment is paramount. Increase the frequency of routine cleaning rounds to 3 times per day, with additional cleaning of frequently touched areas, especially in dedicated COVID-19 wards.

h) Equipment: Do not share equipment (as far as possible) amongst patients and ensure dedicated equipment for (isolated) patients, wherever possible. If equipment is shared, ensure that it is adequately cleaned and disinfected after use.

i) Social distancing: Maintain a distance from other people of 1.5 - 2 meters. SARS-Cov-2 droplets are heavy and do not normally travel more than 1 meter. Ensure that social distancing is maintained in tearooms and during hand over and ward rounds.

6. COVID-19 zones:

a) When COVID-19 patients volumes are low, hospitals can place patients within existing wards based on the risk-assessment and history done upon admission, i.e isolate COVID-19 positive or suspected patients, taking other multidrug-resistant organisms and infectious diseases into consideration. Dedicated zones are not required in such instances.

b) Dedicated COVID-19 and non-COVID-19 zones must be implemented during surge periods and patients placed based on their risk, into either a dedicated COVID -19 positive area, suspected patient area or negative areas. Staff need to wear the appropriate universal and additional PPE in these areas.

Zones in summary are:

- **COVID-19 positive ward (Red):** Patients with a confirmed positive result can be cohorted in one ward.
- **Suspected patient/high risk (Orange):** Patients with clinical signs and symptoms of COVID-19, or a history of contact with a confirmed or suspected case, are regarded as high risk of having COVID-19 and should be placed in an isolation room.
- If no isolation rooms are available, patients with respiratory symptoms can be cohorted.
- **Low risk/COVID-19 negative (Green):** The placement of patients in this group, should be based on risk stratification taking other IPC risks and history of MDROs into consideration:
  i. Patients without clinical signs and symptoms of COVID-19, and without a history of contact with a confirmed or suspected case, are regarded as low risk of having COVID-19 and can be cohorted with other patients if no single room is available.
  ii. Patients with prior positive tests, who have completed the required isolation period and are now symptom free, or fully vaccinated patients who are more than 30 days post-vaccination can also be placed in the green zone.

7. Personal protective equipment

a) Universal masking is required by all staff throughout MCSA hospitals. If the prevalence in the community is greater than 5%, visors must be added as universal PPE.
b) Mask and visors should be worn in COVID-19 red zones.
c) All PPE should be worn as appropriate according to IPC protocols. Table below provides an overview of the type of PPE that should be worn in each zone and based on the type of precautions needed.

Table 1: PPE use in zones

	PPE use for HCWs in each zone		
	Droplet precautions	**Contact Precautions**	**Airborne for AGPs**
COVID-19 Positive Patients	Mask Visor	Apron Gloves when indicated*	N95 or similar respirator Visor Disposable gown and/or plastic apron Gloves
Suspected or High Risk Patients	Mask Visor	Apron Gloves when indicated*	N95 or similar respirator Visor Disposable gown and/or plastic apron Gloves
Low risk and Negative Patients	Mask Visor when indicated	Only when indicated (e.g. risk of MDROs)	N95 or similar respirator for all AGPs Visor Gloves
	Universal Mask and visor		

* Contact with non-intact skin, mucous membranes, blood and body fluid

8. COVID-19 treatment

A separate guidelines details Mediclinic's preferred care process models and flow of patients between the Emergency Centre, wards/ICU and palliative care. This includes the admission and discharge criteria for each level of care and guides on best evidence available for medication and oxygenation treatment options and choices. It covers awake proning and links to the specific care and treatment of COVID-19 critical care, maternity and paediatric patients, as well as the management of COVID-19 patients in theatre.

9. Reporting and notification of COVID-19

The following are the COVID-19 reporting requirements for all hospitals with COVID-19 patients:

a) **COVID-19 Notifiable Medical Condition (NMC):** According to regulations, any healthcare provider (doctor or nurse) who makes a diagnosis of COVID-19 must immediately report the case to the district communicable disease co-ordinator, using one of the NMC platforms (either via the NMC App or by electronic submission of forms). This is currently being automated for all patients who are loaded on ICNET, removing duplicate reporting requirements from the IPC managers.

b) **Death certification and reporting of COVID-19 patients:** Based upon the NDOH Circular of the 21st of July 2020, by the Director General, the treating doctor must complete death certificates in a specific manner to allow for identification of COVID-19 related deaths. In addition, all patients with positive COVID-19 results who demise in a hospital are centrally and automatically reported, based on PAS discharge status codes (automated DATCOV reporting).

10. Surge management

When hospitals have become capacity and resources constrained, additional surge management principles may be implemented for the surge. The hospital should revert to normal operating principles as soon as safe to do so. Refer to COVID-19 Guidelines for the management of COVID-19 for details.:

a) **Care Areas**
   i. Plan for efficient patient flow through the hospital (all patient movement to be coordinated through the hospital command centre when activated).
   ii. Plan for escalation and de-escalation of all patients based on standardised assessment criteria (care process models).
   iii. Attempt to group patients with similar care needs and acuity together.
   iv. Movement of patients to different levels of care areas might take time, so consider the creation of a high-dependency area, a palliative care area and a discharge/lounge area.
   v. Critical care and high care units will both function as critical care units.
   vi. Plan to accommodate increasing and decreasing numbers of patients per care area. (need to have a Plan A, plan B and plan C based on volumes), e.g. the palliative area could be a room initially and eventually a whole ward.
   vii. Plan to manage growing volumes of patients with decreasing availability of staff: Think of how to re-purpose permanent and agency staff and to rationalise patient care.
   viii. Ensure that all staff are aware of the staff planning principles and rationalised documentation to be implemented during this scenario, as per guideline: 'Minimum staffing.'

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    ix.   Educate staff and plan appropriately regarding the rational use of PPE and conservation strategies that kicks in if the PPE supplies run low.

    x.   Plan for different scenarios of how the hospital is going to support healthcare workers in the hospital based on risk of exposure, including PPE usage, rest areas and meal serving.

b) **Patient flow**

The following guidelines support optimal patient flow through care areas:

    i.   All patients seeking emergency care enter the hospital through the Emergency Centre, where patients are assessed (COVID-19 or non-COVID-19). Except for elective admissions with negative tests, in which case normal admission channels can be used.

    ii.   Based on the patient's condition, a decision is made on the appropriate level of care the patient should be admitted to.

    iii.   All ward patients (COVID-19 and non-COVID-19) will be assessed daily by the medical team, using a standardised approach. All information will be sent through to the clinical management team. Patients needing up- or down escalation of care, will be managed accordingly.

    iv.   All ICU patients/patients needing critical care from the wards or Emergency Centre will be assessed by the Triage Team. This information will be sent through to the clinical management team.

    v.   The clinical management team will then decide which patients need to be moved to a different care area as they have an overview of bed availability in the hospital.

c) **Establish the structures**

    i.   Ensure a well-established triage team for consistent decision making around the allocation of critical care resources, using the latest guidelines from the Critical Care Society of Southern Africa.

    ii.   Ensure a well-established Triage Escalation Support Team (TEST) is in place to support the decisions of the triage teams and the clinical management team structures in equitable allocation of scarce resources.

d) **Staffing Levels**

The hospitals should plan for safe staffing to accommodate severe staff absenteeism and/or a surge of patients. The following assumptions underpin minimum staffing:

    i.   Oversight and doctors' involvement

- Healthcare staff will be redistributed and allocated as decided by the clinical management team.
- Both the physician teams and the nursing teams will report to the clinical commander who can resolve challenges that cannot be resolved at unit level.
- An emergency medical response team (crash/resuscitation team) should be available for assessment and/or intubation of deteriorating patients.
- Staff should be allocated to communicating with patients and next-of-kin as required, e.g. the doctor, patient experience manager and shift lead.
- Doctors' rounds will be re-designed, e.g. pre-planning of rounds including the UM/shift lead will be done before daily rounds (in person or virtually).

e) **Patient care**

    i.   Patients will not be moved out of the unit for procedures or investigations if possible.

    ii.   The donning/doffing of PPE creates additional workload and pre-planning of care (e.g. getting all items needed while with the patient in PPE; using a runner/scribe; using a buddy).

    iii.   Patient care record keeping to be minimised.

    iv.   Non-essential care activities to be omitted.

f) **Staff allocation**
  i. The care team model will be expanded, with task shifting or task sharing, and relevant changes in responsibility.
  ii. Staff will be authorised to act outside their scope of practice (depending on their ability to perform such acts with reasonable skills and safety, based on education, training and experience) and will be legally protected to do so, e.g.:
   • One Professional Nurse to handle Schedule 5/6 drugs.
   • Enrolled Nurse to administer IV/SC medication.
   • Enrolled Nursing Assistant (or person in the room) to give oral drugs (set out by Enrolled Nurse/Professional Nurse).
   • Enrolled Nursing Assistant handling/changing IV bags and reconnecting lines.

g) **Staff competencies**
  i. Re-purposed and upskilled staff (e.g. theatre and recovery staff, care workers) will be included in care teams, appropriately trained and information to be available to support clinical management of COVID-19-19 patients.
  ii. On-the-job training will be provided whilst working under the guidance of a more experienced nurse.

h) **Support staff**
  i. Appropriate unit administrative assistance will be provided (administration and stock control), additional to the patient care team.

i) **Team based doctor care models**

These should be considered to support the physicians involved in daily care. Alternative support for specialists can include GPs appointed for evenings or wards. Each hospital to determine their suitable team, based approach or doctor support, discuss and agree any financial and governance implications of these, with their Regional Operations Executive.

j) **Rationalised record keeping**

Measured against the disaster situation, disaster plan and general circumstances, the following legal principles pertaining to record keeping are applicable during a surge:
  i. The records should be sufficient to communicate relevant information amongst healthcare workers.
  ii. Looking back (e.g. a year later), all the information needed should be available.
  iii. This requires documents to be rationalised and shortened to ensure care is provided without additional administrative burden on staff.

k) **Charting of surgical stock in nursing units**
  i. There is an expectation that the charting of stock in the current manner might become challenging during a COVID-19 surge scenario.
  ii. The current stock replenishment system should not be changed, although the way in which the charge sheets are completed, could be adjusted, while not compromising the accuracy of stock charting and adherence to IPC principles.
  iii. A contingency plan needs to be in place should key staff be absent, with urgent training of staff for stock replenishment roles, before a surge of patients or increased staff absenteeism is experienced.
  iv. Re-allocated staff, allocated to stock replenishment in the nursing units, should preferably have knowledge of stock, e.g. theatre nursing staff, theatre/pharmacy stock controllers or other nurses.
  v. The suggestion is therefore that hospitals consider changing the way the daily charge sheet per patient is completed, at surge and in their specific context. Examples are provided in the guidelines.

MANAGEMENT OF HEALTHCARE WORKERS

The principles for the surveillance and monitoring of all HCWs[1] who are exposed to COVID-19 in the workplace is to ensure:

i. A team-based approach with the Human Resource Business Partners (HRBPs) as lead.

ii. Accurate implementation and management of the three healthcare worker surveillance and monitoring methods, namely (see figure 2 below):

- 'Access Control' to monitor all HCWs entering the hospital (low risk contacts, HCW who have completed their quarantine/isolation periods or unexposed) and govern access control to the facility by identifying respiratory symptoms/community and healthcare exposure.

- 'Workplace Exposure Monitoring' to identify and follow up on high risk contacts to ensure their wellbeing and actively manage their return to work process.

- 'COVID-19 Testing' for the SARS-CoV-2 virus which can be performed as part of clusters or outbreak management or when a HCW has symptoms.
    - Accurate and regular monitoring of the HCWs health.
    - Accurate and timeous data on the number of HCWs absent due to being in isolation or quarantine due to infection or high risk exposure to the SARS-CoV-2 virus.

Figure 2 – Healthcare Worker Surveillance and Monitoring

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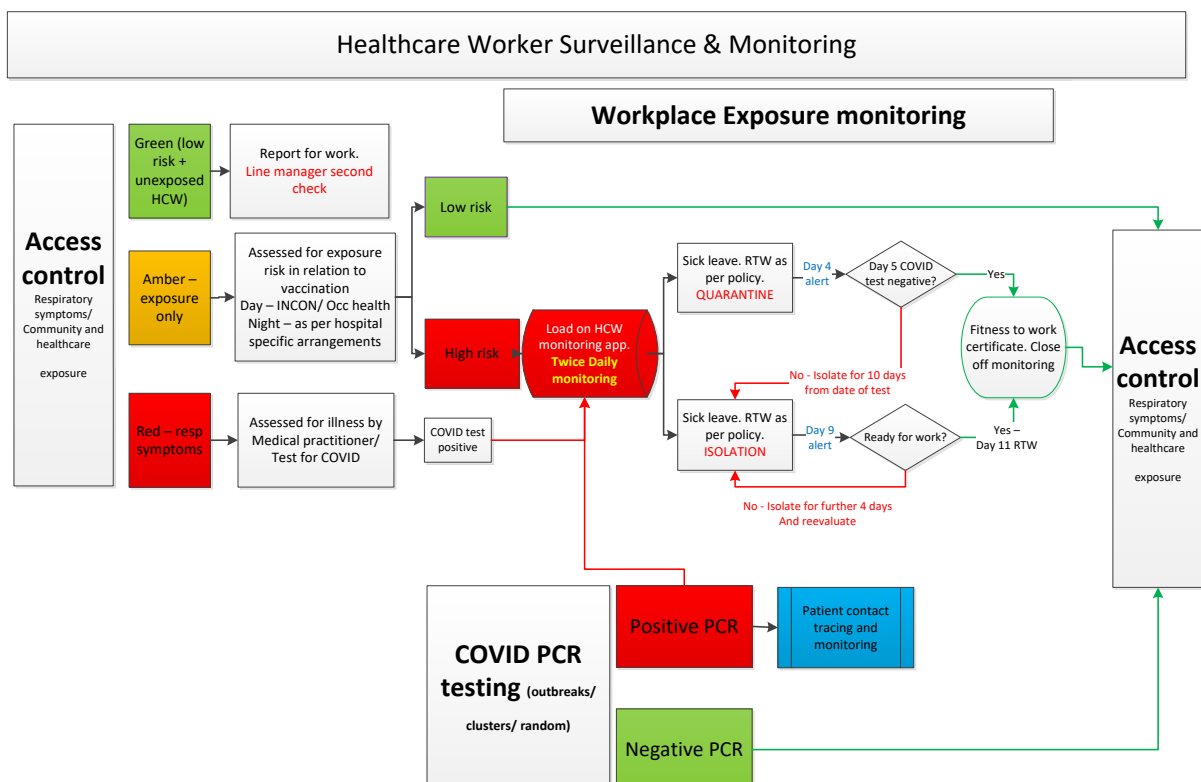
[1] Healthcare workers include Mediclinic employees, contract workers, agency staff, volunteers and ancillary healthcare workers, doctors and their staff.

1. Access control

Healthcare worker symptom reporting at access control must occur daily:

a. All HCWs who require access to the hospital premises, may do so online using the Health Professional Clearance App or using a paper based questionnaire system https://mediclinicforms.datafree.co/Clearance

b. Only those with a green outcome may be allowed to enter the hospital.

c. HCWs screening amber must be followed up by INCON/Occupational health services and those who screened red must be assessed for COVID-19 infections by a healthcare practitioner.

d. Hospital to determine the most suitable number of access control points to allow for the control of HCWs entering the hospital. These may have to be limited when a surge occurs to control flow through the hospital.

e. The entrance must be manned by designated staff members with access to a Nurse (e.g. L&DF, Patient Safety Manager, Clinical Facilitator, etc.) if the HCW is amber or red.

f. Hospitals should encourage the use of the electronic access applications wherever possible.

2. Workplace exposure monitoring

a. HCW with high risk contacts or exposure must be assessed and monitored.

b. Any person who has had close contact with a confirmed case, 2 days prior to a positive result or symptom onset until 14 days since onset of the symptoms of a case, should be carefully monitored for signs of respiratory symptoms (WHO contact tracing).

c. The names of all exposed healthcare workers must be recorded on the "contact line list" accessible on the Mediclinic intranet: http://intranet/communities/ClinicalServices/IPC/Guidelines/Forms/CoronaView.aspx.

d. High risk contacts must be monitored for 5 days after first exposure as required by the NICD and added to the Mediclinic Healthcare worker (HCW) monitoring application.

e. With our existing knowledge and current vaccination levels, any vaccinated HCW and has a high risk exposure should quarantine as per normal rules and test at day 5 on PCR.

f. If high risk HCWs are not responding on the HCW monitoring app, they should be followed up telephonically as per the "COVID-19 Procedure Monitoring of HCWs, 31st August 2020".

g. Low risk contacts do not need to be added on the HCW application but monitor themselves through the daily screening and do not have to be followed up actively by HRBPs.

A high risk contact (close contact) in a healthcare setting is defined as a person having had face-to-face contact (<1 meter) or has been in a closed space with a confirmed COVID-19 case for at least 15 minutes without wearing the appropriate PPE. This includes exposure within a household which is close contact for long durations of time.
Low risk contact (casual contact) - A healthcare worker or other person providing direct care for a confirmed COVID-19 case, while wearing recommended PPE.

h. All line managers should do a daily "check in" of staff on duty to ensure that no symptomatic people are at work.

i. Access control should be monitored daily and all staff who failed access control should be followed up immediately by their line manager and HRBP.

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The printed copies of this document shall be treated as uncontrolled. Please refer to the online version for the latest version.

3. COVID-19 Testing for HCWs

a. HCW will only be tested if they exhibit symptoms of COVID-19, immaterial of their vaccination status.

b. Each employee will provide consent at the time of testing which includes that their details[2] are provided to a laboratory service provider for them to conduct the COVID-19 test and submit the required regulatory information to the National Institute for Communicable Diseases (NICD).

c. PCR testing remains the "gold standard" for staff testing. However, antigen testing may be used for symptomatic staff only.

d. With the roll out of the Vaccination program for healthcare workers, random staff testing is no longer required. Only targeted testing in outbreaks or for symptomatic patients is needed.

4. Return to work following COVID-19 infection for HCWs.

a. This policy is based upon the existing regulations and guideline documents from South Africa and internationally [1] [2]. Duration of leave is based upon the type of infection or exposure the HCW had.

b. Currently the research doesn't indicate if symptomatic vaccinated individuals are able to transmit the virus onto unvaccinated staff. Therefore the following principles apply when interpreting symptoms or exposure in HCWs:

    i. HCW <u>with any symptoms</u> immaterial of vaccination status, should be investigated and managed as per normal protocols, knowing that symptoms in the first three days are possibly vaccine sick effect related;

    ii. HCW with high risk exposure immaterial of vaccination status, should quarantine and be tested on return on day 5. They should be monitored for symptoms by INCON (designated nurse where Incon is not present) and registered on the HCW monitoring app.

c. The return to work guidelines have therefore not been updated with the impact of vaccination. They remain in summary as follows:

    i. **HCW COVID-19 Positive with or without symptoms**: Isolate and RTW 10 days after onset of symptoms or positive test.

    ii. **HCW with High risk exposure – immaterial of vaccination status**: quarantine and RTW after 5 days and a medical evaluation and a negative COVID-19 PCR test.

    iii. **HCW Low Risk exposure**: Continue working whilst wearing appropriate PPE and daily access control symptom monitoring.

MANAGEMENT OF VISITORS

1. Access control screening

a. Every opportunity should be provided to allow visitors to see their loved ones in hospital, without compromising their safety, that of the HCWs and that of the patients.

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[2] Employee details include the employees name, surname, identification number, age, gender, race, contact details and address.
[1] NICD Clinical management of suspected or confirmed COVID-19 disease. Version 5 (19th August 2020)
[2] CDC Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (10th August 2020). https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html.
Strategies to mitigate healthcare worker shortages (19th July 2020). https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

b. Visitors of patient, visitors for doctors' rooms and partners of obstetric admissions, must have their clinical symptoms or contact risk evaluated as part of access control on a per entry basis. Anyone considered high risk will be denied access to the hospital, unless for seeking medical treatment.

c. Whilst the Disaster Management Act is still enforced in South Africa, all visitors will have two modes of gaining access to the hospital or doctors' rooms:

    iv. Using a WhatsApp Bot for online completion of symptoms and risk factors. They will receive a clearance notice on their phones. This allows access control to be completed prior to arriving at the hospital and is valid for the calendar day

    v. Paper based questionnaire at the entrance.

d. **Temperature screening**: All visitors to have their temperature checked prior to entry. There is no need to record the temperature.

e. **Visitor's with a temperature in excess of 38°C**: Visitor needs to be assessed by a clinical professional before access will be allowed. If they have a doctors' appointment, that doctor's practice/rooms should be contacted to inform them of the patient's temperature and seek further guidance on access.

f. **Visitors who have been fully vaccinated (all required doses) and more than 30 days post-vaccination should be allowed to access the hospital if they are symptom free to visit COVID-19 positive patients.**

2. COVID-19 Visitation Policy

Principles

a. Wherever possible, visitation should be facilitated for the wellbeing of patients and families and to make admission for elective surgery less daunting for patients.

b. Visitors will not be routinely permitted to visit COVID-19 patients. However, this should be considered where it will not pose heightened exposure risk to the visitor or other patients, or if the visitor has been fully vaccinated (all doses required and is more than 30 days post-vaccination). Adherence to prevention measures including wearing of masks and the appropriate PPE remains a requirement.

c. The policy must be maintained uniformly across all hospitals.

d. Every effort must be made to facilitate visitation of terminal and/or long stay patients, as well as vulnerable/special needs patients. This is irrespective of the COVID-19 status of the patient. This should be facilitated after an appropriate risk assessment and the necessary PPE should be worn.

e. At all levels of visitation, partners of obstetric patients must be allowed; as well as in the case of paediatric patients (the parent and child regarded as a unit). For Neonatal ICU, both parents may be allowed in at the same time if they are COVID-19 negative.

f. All visitation is subject to access control screening.

g. **Where visitation is not allowed**: Window visits must be facilitated where possible with patient rooms being accessible on the ground floor.

h. Where visits are not possible for COVID-19 or non-COVID-19 patients, a minimum of one virtual visit should be facilitated per day.

i. Should virtual visitation not be possible or by choice of the family, at least one daily update should be given to the family.

j. One person should be allowed to accompany a patient into the EC.

With the above in mind the visitation guidelines are as follows:

Option 1	**No visitation except for those mentioned above.** Recommended when the COVID-19 occupancy of the hospital is greater than 30% of occupied beds.
Option 2	**Visitation for non-COVID-19 patients in all "mixed" wards (where there are both COVID-19 and non-COVID-19 patients)** is restricted to 1 visitor per day (multiple entries) between 10h00 and 20h00. COVID-19 patients may be accommodated according to the principles above. Recommended for occupancies of less than 30% of occupied beds.
Option 3	**Visitation for non-COVID patients in all wards where there are no COVID-19 patients** - restricted to 1 visitor at a time between 10h00 and 20h00. Recommended for occupancies of less than 30% of occupied beds
Option 4	**Original Flexible Visiting Hours policy**. Recommended "back to normal".

In all cases, the above will be the official stance of the hospital. The appropriate documentation will be available from the Patient Experience Managers for speedy changeover and updating of the website information accordingly.

More generous visitation is encouraged if a hospital can safely facilitate same.

3. ASSOCIATED DOCUMENTS AND RECORDS

TITLE	LOCATION
COVID-19 Guidelines for the Management of COVID-19 in MCSA	Intranet
Guideline for the Clinical Management of COVID-19 patients	Intranet

4. HISTORY AND VERSION CONTROL

History

VERSION NO	EFFECTIVE DATE	AUTHOR	DETAILS OF UPDATE
1	28 May 2021	Dr Kim Faure	Consolidation of all prior COVID-19 operational and management policies
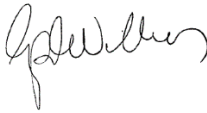
New version

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5. APPROVAL AND SIGN-OFF

Approved by

DEPARTMENT	REPRESENTATIVE NAME	SIGNATURE	DESIGNATION	DATE SIGNED
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