BUSINESS RULE COVER SHEET

Health
South Eastern Sydney
Local Health District

Prince of Wales Hospital and Community Health Services

Respiratory Viral Illness Management Including COVID-19 and Influenza-like Illness POWH CLIN167

Target Audience:

- Registered Nurses
- Nursing Unit Managers
- Medical Officers
- Patient Flow Team

Purpose & document Key Safety Points:

To ensure that individuals displaying symptoms of a respiratory viral infection are appropriately managed to prevent further spread.

- When ordering respiratory viral swabs for people with respiratory viral illness, all swabs that are required must be ordered at the same time.
- The decision to de-isolate people tested for COVID-19 rests with the patient's Medical Consultant (AMO). If there is doubt a medical officer can consult the Infectious Diseases Consultant on call. Infection Control staff can de-isolate all other infections.

This Business Rule should be used in conjunction with: SESLHD Procedure, SESLHDPR/581 Management of Acute Viral Respiratory Illness Procedure.[1]

Contact numbers:

Infection Control CNC: Pager 44219 (7 days 0800-1630 hours)
Geriatric/Infectious Diseases/Respiratory Medical Consultant: Via Switch
Patient Flow Nurse Unit Manager Mobile: 0412915322
After Hours Nurse Manager Mobile: 0411730844

Change Summary

Month & Year: July 2021, updated September 2021
Review type: New Document
Updated: Sections 4.1, 4.3, 4.8, 4.9, and 4.11

☐ Evidence/Procedural change
☐ Identified risk (RCA, Critical Incident, Safety Alert, Complaint, Audit data, Performance data)
☐ New/Updated MoH or SESLHD overarching document
☐ Scheduled Review according to Risk Rating
☐ Required as National Standards ☒ N/A new document

Feedback about this document can be sent to SESLHD-POWHPolicy@health.nsw.gov.au

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TYPE OF BUSINESS RULE	Clinical Business Rule
DATE OF RATIFICATION	14th July 2021
DATE THIS VERSION UPLOADED TO WEBPAGE	16th August 2021
REVIEW DATE	July 2024
RISK RATING	Medium Risk
NATIONAL STANDARD ALIGNMENT *Clinical policies to align with one or more of the National Standards 1-9 (Version 2)*	Standard 3: Preventing and Controlling Healthcare-Associated Infections
KPI / MONITORING COMPLIANCE METHOD	Transmission data. Reported to Patient Safety and Improvement Committee
FUNCTIONAL GROUP/SUBGROUP	Infection Control
FORMER REFERENCE(S)	Nil
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director of Clinical Services
AUTHOR/CUSTODIAN	Head of Infectious Diseases
KEY TERMS	Flu, COVID-19, Respiratory Viral Illness, Influenza-like Illness

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1. PURPOSE & SCOPE

Preventing the transmission of respiratory viral infections between healthcare workers, patients and their visitors is essential, as although respiratory viruses can cause mild to moderate illness in most people, vulnerable populations can be at risk of severe disease.[1]

To ensure that individuals displaying symptoms of a respiratory viral infection are appropriately managed to prevent further spread, all staff are required to follow the steps outlined in the Business Rule.

This Business Rule should accompany the processes outlined in SESLHD Procedure, SESLHDPR/581 Management of Acute Viral Respiratory Illness Procedure.[1]

Appropriate management includes but is not limited to:

- Timely testing
- Adherence to infection control measures
- Suitable bed allocation
- Prompt treatment
- Contact tracing for COVID-19 cases

2. KEY SAFETY POINTS

	Patients who have acute respiratory viral symptoms or Influenza-like Illness (ILI) should be swabbed for COVID-19 and other respiratory viruses with Respiratory Viral Panels 1, 2 and 3 at the same time.
	ALL patients being admitted should have the virology testing form marked “URGENT – INPATIENT” to ensure urgent testing by the lab (Unless a RAPID test is indicated)
	Infection control (in hours) or the After Hours Nurse Manager MUST be notified of all patients being tested for a respiratory viral infection to ensure appropriate bed placement and isolation
	If a SARS-CoV-2 test is requested on a patient the Infectious Disease (ID) consultant does not need to be called if the requesting doctor is comfortable that the test is indicated.
	The de-isolation decision rests with a medical consultant as the test does not have a 100% sensitivity and some people with COVID-19 will have a negative PCR test.
	If suspected COVID-19 or aerosol producing procedures use airborne,

	droplet and contact precautions.

3. ROLES AND RESPONSIBILITIES

Role	Responsibilities
Medical Officers or Nurse Practitioner	Ensure that swabs are ordered in a timely manner for those who meet relevant testing criteria. If it is determined that the patient will require additional respiratory viral testing, all tests should be ordered at the same time. Ensure handover is performed to nursing staff when respiratory a viral illness is suspected and swabs have been ordered.[1]
Infection Control and Prevention Team	Actively review patients who are isolated for a suspected viral respiratory illness. Escalate any delays in de-isolation to the appropriate consultant (see section 4.8) Assist Nursing Unit Managers in the management of cases and contacts.[1] Ensure rapid isolation and monitoring of cases to prevent outbreaks.[1]
Patient Flow Nursing Unit Manager	Ensure that patients requiring admission with a suspected acute respiratory viral infection are isolated appropriately.[1]
Nursing Unit Manager (NUM) or Nurse in-charge (after hours)	Escalate negative swab results to the appropriate person for potential de-isolation. If it is confirmed that the patient can be de-isolated, inform the bed manager. If the patient is located on an outlying ward for isolation purposes, and can return to their specialty ward, add the patient to inter-ward transfer on the Patient Flow Portal. Notify Infection Prevention and Control Team if a patient has developed symptoms and is swabbed as a result and the patient had previously not been isolated or managed with the appropriate precautions. After hours contact the After Hours Nurse Manager. Discuss any infection control issues with a member of the Infection Prevention and Control Team, and relay to the Patient Flow NUM if bed capacity is affected. Ensure that staff mandatory training requirements for infection control and prevention are completed and current.
All Healthcare Workers	COVID-19 immunisation is strongly recommended for ALL staff. Adhere to the standard of infection control appropriate to the clinical situation (contact/droplet/airborne). Participate in the seasonal influenza vaccination program. Category A high risk workers, volunteers and students placed in those areas

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	are required to be vaccinated against influenza.[2] Staff are to remain at home when unwell with respiratory symptoms and are to be tested for SARS-CoV-2 as required by NSW Ministry of Health COVID-19 guidelines.[3] Follow local protocols for sick leave notification. Undertake infection control mandatory training and N95/P2 mask fit testing. Staff who are close or casual COVID-19 contacts must inform their line manager and not return to work without approval.
Line managers	Ensure service compliant with all related policies and procedures. Complete staff risk assessment tool if staff have symptoms or are close or casual contacts of COVID-19.
Hospital Door Screening Staff	To direct people presenting to the hospital with respiratory viral symptoms to the POWH Business Rule, POWH CLIN142 COVID-19/Flu Assessment Clinic for swabbing in operating hours.
Pathology	Inform the Director of Clinical Services of any delays in processing respiratory swab results. Promptly notify the Infectious Diseases team of any positive COVID-19 test for patients tested in POWH or Sydney/Sydney Eye Hospital Emergency Department, wards or COVID-19/Flu Assessment Clinic or in the Royal Hospital for Women.

Training requirements

- All mandatory training requirements are current in HETI.
- Personal Protective Equipment for Combined Transmission-Based Precautions (course code: 294450660)
- Local induction to Personal Protective Equipment
- N95/P2 mask fit testing for staff who may require use

4. PROCESS / PROCEDURE

4.1 Non-Elective admissions – Testing requirements for all patients

Patients at higher risk of COVID-19:

Patients who have symptoms of COVID-19, are close or casual contacts of COVID-19, are homeless or marginally housed, are a person who uses drugs, have been released from custody should have an URGENT-INPATIENT test (unless a RAPID test is indicated) and be isolated in a single room with contact, droplet and airborne precautions pending the result.

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Patients at background risk of COVID-19:
All patients being admitted who do not meet any of the criteria above will have a COVID-19 PCR test regardless of risk of COVID-19 and be admitted without isolation. If their test comes back positive they will be immediately moved to single room isolation with contact, droplet and airborne precautions in Parkes1W until review by an Infectious Diseases Physician to determine if the test is a likely true or false positive result. If patients are being discharged from Emergency and need a clinic review within the next 3 days they should be tested before discharge from Emergency.

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Respiratory viral symptoms or influenza like illness or COVID-19 symptoms

Apply Personal Protective Equipment and Complete Clinical Assessment

Does the patient require admission?

Yes,
Admission Stream

- Administer COVID-19 + respiratory viral panel 1,2 + 3 test on one swab
- Mark request as 'URGENT-INPATIENT' unless RAPID test indicated. If rapid test mark "URGENT RAPID SARS-CoV- 2 test" and add indication for test and name of authorising doctor and phone number for result.
- Commence oseltamivir if influenza epidemiology and clinical features suggest influenza and not contraindicated

To ensure appropriate bed placement and infection you :MUST CONTACT

Infection Control on page 44219 from 0800-1630 7 days per week.

Outside of these hours contact the After Hours Nurse Manager on 0411730884

Isolate suspected COVID-19 cases with droplet, contact and airborne precautions. Patients who do not meet the CDNA definition of a suspect case can be managed with droplet and contact precautions.

Patients with respiratory viral symptoms should not be transferred into high risk wards.

High risk exclusion wards include:

Haematology – 10 West, Oncology – 4 East, Renal – 9 West & Spinal Injuries Unit

No,
Discharge Stream

Administer COVID-19 Test

- Give home self-isolation instructions and surgical mask
- If high risk case for influenza also commence on oseltamivir if influenza epidemiology and clinical features suggest influenza and not contraindicated

Influenza like Illness

Definition:

1. Fever (≥38^{0}C), chills, shivering, alternately feeling hot and cold or night sweats

2. Plus one of the following: Breathing difficulty/cough/sore throat/runny nose

Note: Elderly patients may not present with fever or only with fever.

Note: COVID-19 may present without a fever

***High risk patient groups for influenza include:**

- ≥65 years old
- Aboriginal or Torres Strait Islander
- Thalassaemia
- Cancer/immunosuppression
- Diabetes Mellitus
- HIV/AIDS
- Chronic lung, heart, liver or kidney disease
- Pregnancy
- Cohabitation with person with high risk condition as above

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4.2 Pathway for patients referred from ED with ILI or patients developing ILI on the ward/Inpatient Unit (Also see Appendix 2 for Printable version)

Excluding ED & ICU	Patient referred from ED with acute respiratory viral, ILI or COVID-19 symptoms	Patient develops acute respiratory viral, ILI or COVID-19 symptoms on the ward
TESTING	Check results from tests taken in ED. Clinical decision making re: other testing	Rapid COVID-19 test and panels 1-3 (if circulating influenza add rapid influenza test) with a single swab for throat and deep nasal swab. (mark "URGENT-INPATIENT" AND "URGENT-RAPID TEST" and add reasons for test and name of consultant approving test)
INFECTION CONTROL	Positive or results pending: • Single room • For complex issues discuss with Infection Prevention & Control / ID for advice • Contact, droplet and airborne precautions • Patient wears mask to bathroom if needs to walk outside room to bathroom • Spacer therapy instead of nebulizer COVID-19 de-isolation approved by AMO of team , otherwise by Infectious Diseases. Infection control can de-isolate other respiratory viral infections.	Notify Infection Prevention & Control between 0800-1630and After Hours Nurse Manager at other times • Put mask on patient if coughing and draw curtains if in shared room until moved • Move patient to isolation room with contact, droplet and airborne precautions • Patient wears mask to bathroom if needs to walk outside room to bathroom • Spacer therapy instead of nebuliser COVID-19 de-isolation approved by AMO of team , otherwise by Infectious Diseases. Infection control can de-isolate other respiratory viral infections.
TRANSFER	If patient requires positive pressure ventilation or high flow oxygen needs, case by case risk assessment with senior clinicians to decide appropriate bed placement.	If patient requires positive pressure ventilation or high flow oxygen needs case by case risk assessment with senior clinicians to decide appropriate bed placement.
TREATMENT	Check oseltamivir commenced in ED if indicated.	Commence oseltamivir if influenza epidemiologically and clinically suspected.

		Consider prophylaxis for exposed individuals and monitor closely for symptoms.

4.3 Planned admission, outpatient, ambulatory care or home visit – Testing requirements

All patients, regardless of LGA of residence should be tested for COVID-19 24-72 hours before their clinical encounter. If the result is not available and the care is not urgent or emergent then care should be rebooked. If the care is urgent or emergent and the result is not available then the patient should be seen in a single room/treatment space with contact, droplet and airborne precautions. All patients should be checked for COVID-19 symptoms and exposure risk (close or casual contact) and be managed with precautions if they have these present. Patients who have frequent planned attendances such as dialysis or daily treatment such as radiotherapy or chemotherapy should be tested every 72 hours.

4.4 Visitors – Testing requirements

Testing of authorised visitors should also be performed 24-72 hours before visiting, unless authorised by the Director of Clinical Services.

4.5 Respiratory Virus Testing

Patients who have acute respiratory viral symptoms or Influenza-like Illness (ILI) should be swabbed and tested for COVID-19 and other respiratory viruses with Respiratory Viral Panels 1, 2 and 3 at the same time. Patients who have a suspected respiratory viral illness but who do not have ILI should have the same testing performed. Patients who meet current NSW Health criteria for testing for COVID-19 should be tested for SARS-CoV-2. If they have any symptoms of another respiratory virus these should be tested at the same time.

ALL patients being admitted should have the virology testing form marked “URGENT – INPATIENT” to ensure urgent testing by the lab.

Other urgent indications for testing for SARS-CoV-2 include:
“URGENT- STAFF” or “URGENT- HEALTH CARE WORKER”
“URGENT – PREGNANT”
“URGENT- RESIDENTIAL CARE”
“URGENT - JUSTICE HEALTH” For patients in custody and staff
“URGENT – PUBLIC HEALTH” For testing requested by Public Health

A respiratory virus swab should be undertaken in accordance with the technique outlined in SESLHD Procedure, section 5.5, SESLHD Procedure, SESLHDPR/581 Management of Acute Viral Respiratory Illness Procedure.[1]

4.6 Ordering Respiratory Virus Screening Panels on eMR

Clinicians to order respiratory virus screening based on clinical assessment as per Section 5.3 and 5.4 in, SESLHD Procedure, SESLHDPR/581 Management of Acute Viral Respiratory Illness Procedure.[1]

4.7 Rapid Viral Swabs - Collection and Ordering of

Collection and ordering of rapid viral swabs should be performed as per section 5.6 and 5.7 in SESLHD Procedure, SESLHDPR/581 Management of Acute Viral Respiratory Illness Procedure.[1]

4.8 Ordering of a SARS-CoV-2 test

If a SARS-CoV-2 test is required on a patient the Infection Control Clinical Nurse Consultant must be notified by page on 44219 from 08:00-16:30 hours seven days per week (if the patient has been admitted through ED they should be called after the bed has been allocated). Outside of these times the After Hours Nurse Manager must be called on 0411 730 844. They will ensure immediate isolation, closure of beds if required and appropriate use of airborne/contact/droplet precautions. (Refer to Appendix 2). If suspected COVID-19 and aerosol producing procedure use airborne, contact and droplet precautions. Refer to Clinical Excellence Commission, COVID-19 – Infection Prevention and Control Manual (section 8.8)[4].

4.9 Rapid SARS-CoV-2 PCR and other viral testing

Rapid SARS-CoV-2 testing can be performed in specific circumstances.
However, there is a worldwide shortage of rapid testing cartridges so RAPID tests should only be requested where results would allow a life-saving intervention. Approval will no longer be required from Infectious Diseases, but the requesting clinician must write “RAPID TEST” and the reason for the test on the form. If this is not done the laboratory will not process the sample as a rapid test. Inpatient tests should continue be requested as “URGENT-INPATIENT”.

The following needs to be on the pathology request form:

- **Rapid Test SARS-CoV-2 test.**
- **The reason for the test**
- **The name of authorising the doctor**
- **The telephone number of the doctor for the result**

This will enable auditing to determine if the number of rapid tests exceed supply.

Rapid testing for Influenza A/B and RSV can be performed depending on the season and current epidemiology with the approval of Infectious Diseases, Public Health or the NSW Health Pathology Virologist.

4.10 Management of confirmed cases of COVID-19

Infectious Diseases and Infection Control and the Infectious Diseases consultant on call must be notified of all confirmed cases of COVID-19 in patients, visitors or staff to ensure appropriate management (including contact tracing) occurs. Management in a negative pressure room is preferred if available. If a patient is an outpatient at the time of diagnosis they should be referred to the COVID-19 POWH Telehealth Assessment Clinic.

4.11 De-isolation of patients who have had a SARS-CoV-2 PCR test that is negative

If a patient a negative COVID-19 test and has no symptoms of COVID-19 and is not a close or casual contact and has an alternate diagnosis they may be de-isolated by a Medical Officer. The decision should be made with the AMO for the patient and documented in the medical record.

If a patient has a negative COVID-19 test and has symptoms compatible with COVID-19 they can only be de-isolated by Respiratory Medicine, Geriatric or Infectious Diseases AMO. A second COVID-19 test may be required before de-isolation. A M9edical Officer should make a de-isolation call to the AMO. Do not call the AMO for de-isolation decision between 2300-0700 unless the After Hours Nurse Manager approves the need for the call due to a critical bed capacity shortage.

The decision to de-isolate a patient must be written in the eMR with a note as follows:

‘Dr X approves the de-isolation of this patient from contact, droplet and airborne precautions. The patient should have XXX precautions’. (The type of precautions will depend on whether the patient has a non-infectious alternate diagnosis, symptoms of another respiratory viral infection or colonisation with any MROs).
If you are calling a Consultant to request a de-isolation decision, the following information is required:

- What was the indication for the test? (What were the presenting symptoms?)
- Was the person exposed to a case of COVID-19 or had they been in an area with COVID-19 transmission (or a ‘location of concern’) within 14 days of symptom onset?
- Is there an alternate diagnosis?
- If there is not an alternate diagnosis are there any symptoms consistent with SARS-CoV-2 infection or another respiratory viral infection?

- Is the patient known to be colonised with any multiple resistant organisms (MRO) (Check eMR for this information).

4.12 Request for emergency accommodation for COVID-19 related isolation (SESLHD Staff and General Public)

Discuss any requests for emergency accommodation for COVID-19 related isolation with your line manager, who can escalate if required.

4.13 Process for notification and management of facility COVID-19 exposures

Refer to SESLHD Procedure, SESLHDPR/668 COVID-19 Patient, Staff and Visitor Management - Contact Tracing[7].

4.14 Outbreak

If two or more cases of respiratory viral disease occur in the same time period on a ward, or bed unit this must be managed using Outbreak Management Principles. The executive, Infection Prevention and Control, Head of Infectious Diseases and Infectious Diseases Consultant on call must be notified immediately of a possible COVID-19 outbreak. [1]

5. DEFINITIONS

Term	Definition
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 via the airborne route.[1]
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.[1]
SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus type 2)	Novel pandemic coronavirus, first identified in 2019 with pandemic spread. The clinical illness is called COVID-19 (Coronavirus diseases 2019). SARS-CoV-2 is closely related to a bat coronavirus. Can cause a full spectrum of disease from upper respiratory tract symptoms without fever to fatal pneumonia and multi-organ failure.[1]
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.[1]
Influenza-like Illness	Flu signs and symptoms usually come on suddenly. People who are sick with flu often feel some of or all of these symptoms:[1] • Fever* or feeling feverish/chills

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	• Cough • Sore throat • Runny or stuffy nose • Muscle or body aches • Headaches • Fatigue (tiredness) • Some people may have vomiting and diarrhoea, though this is more common in children than adults It is important to note that not everyone with influenza will have a fever
Pooled swab	The collection of a single throat and nose swab from patients with suspected viral respiratory illness. A pooled swab is collected by first swabbing the oropharynx, then same swab is then used to swab the inside of the nares.[1]

6. DOCUMENTATION

- eMR- Patient record
- Patient Flow Portal

7. COMPLIANCE

7.1 Compliance monitoring questions – N/A

7.2 Compliance Evaluation

Monitoring of Health Care Acquired Infections, reported to the Patient Safety Improvement Committee.

8. RELATED POLICIES/PROCEDURES/GUIDELINES/BUSINESS RULES

Number	Policy/Procedure/Guideline/Business Rule
1.	SESLHD. 2020. Management of Acute Viral Respiratory Illness Procedure (SESLHDPR/581)
2.	New South Wales Health. 2020. Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases (PD2020_17)
4.	POWH. 2021. COVID-19 Telehealth Assessment Clinic- POWH (POWH CLIN165)
5.	POWH Business Rule. 2021. COVID-19/Flu Assessment Clinic (POWH CLIN142)
7.	SESLHD Procedure, SESLHDPR/668 COVID-19 Patient, Staff and Visitor Management - Contact Tracing
8.	POWH Business Rule. 2021. COVID-19 Telehealth Assessment Clinic –

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	POWH (POWH CLIN165)

9. EXTERNAL REFERENCES

Number	Reference
3.	New South Wales Health. 2021. COVID-19 Clinic.
6.	Clinical Excellence Commission. 2021. COVID-19 Infection Prevention and Control Manual.

10. REVISION & APPROVAL HISTORY

Date	Revision No.	Summary of changes, Author and Approval
June 2021	0	New Clinical Business Rule. No previous existing document. Developed by Infectious Diseases and Infection Control
21.7.21	0	Released as an Interim document pending Committee approval.
July 2021	0	Approved by POWH/SSEH Policy and Procedure Review Committee for distribution
September 2021	1	Edited - 4.1, 4.3, 4.4, 4.8, 4.9 and 4.11 to align with altered POWH processes released 14.9.21 Memo TRIM: T21/66432

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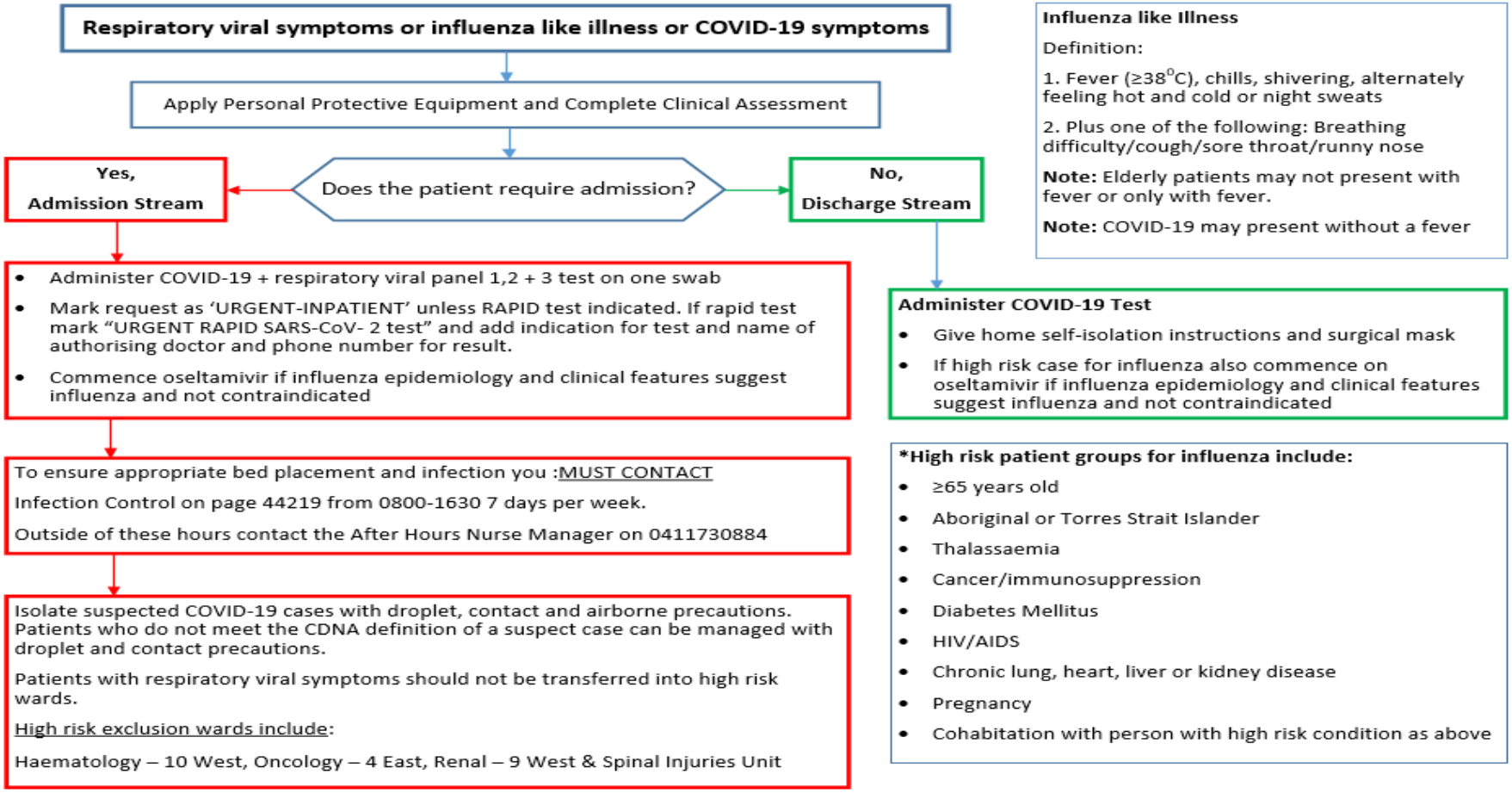
Appendix 1: Flowchart Emergency Department (ED) Respiratory Viral Illness (Also see Section 4.1)



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Appendix 2: Pathway for patients referred from ED with ILI or patients developing ILI on the ward/Inpatient Unit (Also see Appendix 2 for Printable version)

Excluding ED & ICU	Patient referred from ED with acute respiratory viral, ILI or COVID-19 symptoms	Patient develops acute respiratory viral, ILI or COVID-19 symptoms on the ward
TESTING	Check results from tests taken in ED. Clinical decision making re: other testing	Rapid COVID-19 test and panels 1-3 (if circulating influenza add rapid influenza test) with a single swab for throat and deep nasal swab. (mark "URGENT-INPATIENT" AND "URGENT-RAPID TEST" and add phone number of requesting doctor) Must discuss with ID consultant to approve rapid test.
INFECTION CONTROL	Positive or results pending: • Single room • For complex issues discuss with Infection Prevention & Control / ID for advice • Contact, droplet and airborne precautions • Patient wears mask to bathroom if needs to walk outside room to bathroom • Spacer therapy instead of nebulizer COVID-19 de-isolation by respiratory/geriatric consultant admitted under those services, otherwise by Infectious Diseases. Infection control can de-isolate other respiratory viral infections.	Notify Infection Prevention & Control between 0800-1630and After Hours Nurse Manager at other times • Put mask on patient if coughing and draw curtains if in shared room until moved • Move patient to isolation room with contact, droplet and airborne precautions • Patient wears mask to bathroom if needs to walk outside room to bathroom • Spacer therapy instead of nebuliser COVID-19 de-isolation by respiratory/geriatric consultant admitted under those services, otherwise by Infectious Diseases. Infection control can de-isolate other respiratory viral infections.
TRANSFER	If patient requires positive pressure ventilation or high flow oxygen needs, case by case risk assessment with senior clinicians to decide appropriate bed placement.	If patient requires positive pressure ventilation or high flow oxygen needs case by case risk assessment with senior clinicians to decide appropriate bed placement.

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TREATMENT	Check oseltamivir commenced in ED if indicated.	Commence oseltamivir if influenza epidemiologically and clinically suspected. Consider prophylaxis for exposed individuals and monitor closely for symptoms.

Influenza like Illness definition:
Fever (≥38^{0}C), chills, shivering, alternately feeling hot and cold or night sweats 2. Plus one of the following: Breathing difficulty/cough/sore throat/runny nose
Note: Elderly patients may not present with fever or only with fever, COVID-19 may present without a fever, check SESLHD Procedure, SESLHDPR/581 Management of Acute Viral Respiratory Illness Procedure.[1] for indications of COVID-19 testing.

Notes:
Patients with acute respiratory viral symptoms /ILI, COVID-19 symptoms or unexplained fever should not be transferred into high risk wards. The Infectious Diseases team can provide further advice when required.
High risk exclusion wards include Haematology, Oncology, Renal and Spinal Injuries Unit