Western Cape Government

Health and Wellness
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TO: ALL HEADS OF DIVISIONS / DIRECTORATES / CHIEF DIRECTORATES / HEADS OF INSTUTIONS / REGIONS / DISTRICTS AND SUB-STRUCTURES / CITY OF CAPE TOWN

CIRCULAR NO. H98/2022

COVID AND OTHER INFECTIOUS RESPIRATORY DISEASE PRECAUTIONS, POST THE COVID 5TH WAVE

Purpose

To provide updated guidelines after the 5th COVID wave period, which moves towards integrating COVID services with all other health services, including aligning COVID prevention activities with overall infection prevention control activities for all airborne and droplet infectious diseases. The reduction in COVID-19 infections and the comparatively much lower level of hospitalisations and deaths associated with COVID-19, which we are now experiencing, makes this possible. This circular replaces the previous circulars in this regard i.e. Circulars H35/2020, H43/2020, H50/2020, H51/2020, H52/2020, H77/2020 and H155/2020.

Background

The COVID-19 epidemic ushered in many mandatory social changes designed to prevent transmission of the coronavirus. Prominent amongst them were the need to avoid crowding, maintaining a safe physical distance between people and the wearing of masks in public settings. The severity of the COVID-19 pandemic has been attenuated by an increasing proportion of the population having acquired immunity to SARS-CoV-2 (the virus that causes COVID-19) via vaccination and prior infection. The decrease in COVID-19 severity, as evidenced by much lower hospitalisation and mortality rates, has provided an opportunity to modify our response to the COVID pandemic, such that the unintended negative consequences of economic deterioration and social isolation, can be eliminated. To this end the amendments to the National Health Act that regulated the size of gatherings and the compulsory wearing of masks in public spaces, have been repealed.

However, COVID has not gone away and while we are fortunately in a low prevalence period post the 5th wave, COVID is still a significant health risk, especially for those who are not vaccinated or have not had a prior infection. Additionally, TB and influenza remain as health risks, a risk of a measles outbreak is present due to low measles vaccination rates, and a SARS-CoV-2 variant that has higher transmission rates, immune escape capabilities, or results in severe disease, could arise. Hence the wearing of masks is still an important infection prevention measure in health care settings, when attending to people who have infectious respiratory diseases.

Similarly, crowding at health facilities still needs to be avoided, but this now needs to be achieved with a minimum of negative consequences. Fortunately, this can be done through prudent, individualised specific time scheduling of hospital OPD and PHC clinic patient visits, to avoid waiting room crowding at any point in time. Further decongestion of health facilities can be achieved by expanding the home delivery of chronic medication for stable patients and by increasing telehealth consultations.

Health services have for more than two years had to intensely focus on caring for people with COVID, especially during the waves. This COVID focus had diminished during the 4th wave and further diminished during the 5th wave, as fewer patients with COVID required hospitalisation, oxygen therapy and critical care, with a resultant lower mortality rate. The

substantial drop in need for urgent health care due to COVID, meant that health facilities had only to minimally modify the manner in which they provided services, to manage the infection transmission risks of coronavirus infected patients during the 5th wave.

The challenge now is to integrate services for COVID into general health care services, without any disruption to other services and, if possible, to maintain this during future waves.

Key interventions to enable this are:

Ventilation: Adequate ventilation is extremely important in preventing transmission of airborne infections such as COVID and tuberculosis. Hence health facilities should where possible, ensure ventilation in all areas of 6 to 12 air-changes per hour. Sufficient ventilation could be achieved via opening windows/door/vents or via mechanical ventilation systems. It might be difficult for all areas in a health facility to have adequate ventilation, and should this be the case at any health facility, then at the very least those patients with respiratory infectious diseases should be managed in areas of the facility that do have sufficient ventilation. Isolation units and areas where aerosol-generating procedures take place, require higher ventilation rates and extraction systems. Practicable and affordable mechanisms to monitor ventilation rates at health facilities, need to be identified and implemented.

Masks: Masks reduce the volume and spread of droplets and aerosols from people's mouths/noses and reduce and filter the droplets and aerosols breathed in by others. Hence masks remain a very important means of reducing airborne and droplet infectious diseases. Surgical masks should therefore be offered to and worn by patients with infectious respiratory symptoms, provided they can tolerate them. Staff caring for patients with suspected or confirmed airborne infectious diseases, such as COVID and TB, should wear properly fitted N95 respirators. Staff working in areas where there are no patients with suspected or confirmed infectious respiratory diseases, may optionally wear surgical masks. Staff at high risk of developing severe disease if infected with the coronavirus may optionally wear N95 respirators in environments where they feel unsafe. When performing aerosol-generating procedures on patients it is prudent for staff to wear properly fitted N95 respirators, and to perform these procedures in areas with adequate ventilation and extraction facilities.

Crowding: Prevention of crowding should be done by providing hospital outpatients and PHC clinic patients with specifically timed individualised appointments, by limiting escorts to those necessary for holistic care (including parents/carers, partners, those supporting disabled/enfeebled/cognitively challenged patients and those translating), by reducing visitor numbers, by expanding the home delivery of chronic medication and by implementing telehealth consultations. With the prevention of crowding, restrictions on physical distancing can be relaxed, so that strict physical distancing of keeping people 1,5 metres apart need not be enforced, although spreading patients out throughout the available waiting area is prudent.

COVID Vaccination: Vaccination against COVID remains the most effective way in which to reduce the severity of infection with the coronavirus and also assists in reducing transmission of the virus. Integration of COVID vaccination services into overall health services has already begun and this should be accelerated until all COVID vaccination is part of routine services. All patients and escorts who attend health facilities should routinely be offered vaccination/boosters against COVID, if they are not already vaccinated/boosted.

Hand Hygiene: Hand hygiene remains extremely important to prevent transmission of infectious diseases due to droplets, direct hand contact with infectious material and indirect hand contact with contaminated surfaces/equipment. Hands should be regularly washed with soap and/or disinfected with alcohol-based sanitiser between patients and procedures and washed when soiled. Alcohol sanitation bottles should be available at strategic locations throughout all health facilities to support hand sanitising. Washrooms should always be provisioned with water, liquid soap and paper towels.

Surface Cleaning: Surfaces/equipment that are visibly soiled should be cleaned and disinfected immediately and surfaces/equipment prone to contamination should regularly be cleaned and disinfected according to a pre-determined schedule. Terminal cleaning should be done when inpatients are discharged, at the end of the day or shift in areas where outpatients and emergency patients with respiratory infections are streamed to, and when someone with a respiratory infection has left an area where they are not usually attended to. See Circular on Cleaning and Disinfection for more details.

Risk Assessment of Staff: All staff who are at risk of severe respiratory infections (those who are immunosuppressed, those with chronic lung/liver/cardiac/renal disease, those on chemotherapy and immunosuppressants) should be strongly encouraged to be vaccinated and boosted against COVID and pnuemococcus, and to be annually vaccinated against Influenza. Where possible these staff should not work in areas where patients with infectious respiratory diseases are located, or should spend minimal time there, while wearing appropriate PPE.

Self-screening of Staff and Students: Staff and students should before commencing a shift, determine if they have any acute infectious disease respiratory symptoms, and those with symptoms should seek medical care and advice. Should isolation be necessary based on medical advice and/or testing (of staff member having COVID or influenza), then they should isolate for the required period.

Passive Screening of Patients/Visitors/Escorts: All patients, visitors and escorts should be advised, via broadcasts and via signage, to report to a clinical or administrative staff member, if they have respiratory symptoms. Those with respiratory symptoms, which are likely to have an infectious disease origin, should be offered a surgical mask and streamed away from other patients/visitors/escorts, to enable them to be assessed and provided with care in a well-ventilated separate area.

OPD and Emergency Centre Streaming of Patients: A special separation area with good ventilation and air extraction should be provided at all emergency centres, outpatient departments, CHCs, CDCs and clinics, for managing patients with respiratory symptoms suggestive of an infectious disease, as these patients might have COVID, TB, influenza, measles, chickenpox, or some other infection transmitted via the respiratory route. Patients who present at clinics, OPDs and emergency centres with respiratory symptoms suggestive of an infectious disease, should immediately be provided with a surgical mask (if they can tolerate it) and escorted to the special separate area where they can be safely attended to. Staff and students working in these separation areas should wear appropriate PPE.

Ambulances and Planned Patient Transport: Ambulances and patient transport vehicles should, where possible, transport patients with respiratory symptoms suggestive of an infectious disease such as TB and COVID, separately from other patients and those patients should wear a surgical mask (if they can tolerate it). Where it is not possible to transport these patients separately, then all the patients being transported should wear a surgical mask, if they can tolerate it. Staff should wear appropriate PPE.

Inpatient Isolation: Patients who are admitted with confirmed or suspected COVID and TB, should be placed in a separate COVID or TB isolation ward or side-room and managed as appropriate for their illness, and in accordance with standard isolation principles.

Personal Protective Equipment PPE: Staff and students attending to patients with confirmed or suspected COVID or TB, or entering respiratory isolation areas, or working in separation areas in OPD and emergency centres, or in ambulances and transport vehicles, should take full precautions and wear full PPE, which they should don and doff in the prescribed manner. Full PPE would require a properly fitted N95 respirator, gloves, gown/apron and face shield/goggles. Staff and students attending to patients with TB should wear N95 respirators.

Policy Position

Health facilities should endeavour to incorporate COVID services into overall health services, by aligning it with the processes that are followed for the existing provision of TB services. The following guidelines should be used when doing so.

1. Ventilation

Health facilities should, where possible, provide good ventilation in all areas of 6 to 12 air changes per hour and appropriate fit for purpose ventilation in isolation units and aerosol-generating procedure areas. Practicable low cost methods for measuring ventilation levels should be devised.

2. Masks

a) Staff and students managing, or transporting confirmed or suspected COVID, TB, measles or chickenpox patients, should wear properly fitted N95 respirators.

b) When performing aerosol-generating procedures staff/students should wear properly fitted N95 respirators.

c) Staff and students performing functions which clinically inherently require surgical masks, such as working in theatre, should continue to wear them as per usual.

d) Staff working in areas where there are no confirmed/suspected COVID or TB patients and performing functions for which surgical masks are not clinically required, do not have to wear a surgical mask, but may do so if they feel safer wearing a mask.

e) Patients/escorts/visitors do not routinely have to wear masks, but may do so if they prefer to.

f) Patients presenting with infectious respiratory symptoms, should be provided with a surgical mask to wear, provided they can tolerate it.

g) Patients/escorts who are by necessity in close proximity to other patients with confirmed or suspected COVID, TB, measles or chickenpox (e.g. due to space limitations in an emergency centre or transport vehicle), should be provided with surgical masks to wear.

h) Community health workers (CHWs) entering the homes of patients do not have to wear masks, but may do so if they wish. If anyone in the household has respiratory symptoms then the CHW should offer that person a surgical mask, put on a surgical mask as well, and, where possible, provide the service they visited for without entering the dwelling.

i) When visiting patients with confirmed COVID, TB, measles or chickenpox, then CHWs should wear a properly fitted N95 respirator.

3. Appointments at Hospital OPD and PHC Clinics

a) To prevent crowding and improve service efficiency, **patients attending hospital OPD and PHC clinics should be provided with individual specifically timed appointments.**

b) Providing the "same appointment time for many patients" and "block appointment slots" for hospital OPD and PHC clinics, should stop, and be replaced by individual specific appointments.

c) The "club model" of seeing chronic disease stable patients in a group, should cease, and be replaced by home delivery of chronic medication. Club groups for social solidarity of people having the same/similar disease, can be established outside of health facilities.

4. Physical Distancing Termination

Strict physical distancing of keeping people 1,5 metres apart and preventing them from sitting on adjacent chairs, can be stopped. However, spreading patients out throughout the available seating space in a waiting area, is a prudent precaution.

5. Home Delivery of Chronic Medication

Home delivery of chronic medication should be expanded, to allow all patients with stable chronic diseases to have their repeat script medication delivered to their home.

6. Hand Hygiene and Surface Cleaning

a) Regular hand washing and hand disinfection with alcohol sanitiser should be adhered to, using the 5 moments of hand hygiene.

b) Hands should be washed or disinfected before attending to a patient.

c) Surfaces and equipment should be regularly cleaned and disinfected.

d) Terminal cleaning should be done when inpatients are discharged, regularly in streamed areas for respiratory infections and when patients with infectious respiratory disease have left an area.

e) Misting, fogging and "deep cleaning" are **not** required.

7. Vaccination

a) COVID vaccination should progressively be incorporated into routine health services.

b) All patients and escorts who attend health facilities should routinely be offered vaccination/boosters against COVID, if they are not already vaccinated/boosted.

c) All staff and students are strongly encouraged to be vaccinated and boosted against COVID and pnuemococcus, and to be annually vaccinated against Influenza.

8. Risk Assessment of Facilities and Staff

a) All facilities should undergo a regular risk assessment at least every 24 months and when there is a change in the hazard status of the environment.

b) Staff who have a high risk of becoming severely ill due to COVID exposure, should be encouraged to receive vaccination and boosters, provided with optimal personal protection equipment, and accommodated in low exposure areas/activities where reasonably practicable without compromising overall effective service provision, and within the constraints of staffing levels. Where practically possible, and depending on the type of activities they need to perform and the impact on overall service provision of the unit/team/department, remote working arrangements could be arranged for staff at high risk of severe COVID.

9. Self-screening of Staff

Staff and students should self-screen for infectious respiratory symptoms suggestive of COVID infection, before coming on duty and should absent themselves from work, communicate with their direct line managers/supervisors and seek care, should they have symptoms. A record of self-screening is not required and similarly temperature checking is not required. Standard sick leave procedures should be followed.

10. Passive Screening of Patients/Escorts/Visitors

a) Active screening of patients/escorts/visitors by asking each person on arrival about symptoms, checking their temperature and recording the results, should stop.

b) All patients, escorts and visitors should be 'passively' advised via broadcasts and via signage, to report to a clinical or administrative staff member, if they have respiratory symptoms; and those that do should be provided with a surgical mask and streamed to a well-ventilated area to be attended to, separately from other patients. A record of passive screening is not required.

11. OPD and Emergency Centre Streaming of Patients

Patients presenting at OPD and emergency centres with respiratory symptoms suggestive of an infectious disease, should be streamed to a well-ventilated separate area and managed appropriately. Ideally this area should be the same as the current TB areas.

12. Ambulances and Planned Patient Transport

a) Ambulances and patient transport vehicles should provide patients with confirmed or suspected COVID or TB, with surgical masks, if they can tolerate them, and should where possible transport them separately from other patients.

b) In isolated instances when they cannot transport these patients separately, then the other patients in the vehicle should be provided with surgical masks.

13. Inpatient Isolation

Patients who are admitted with confirmed or suspected COVID should be placed in a separate COVID isolation ward or side room if they are deemed infectious.

14. Personal Protective Equipment PPE

Staff and students attending to or transporting patients with confirmed or suspected COVID, should wear full PPE, including a properly fitted N95 respirator, gloves, gown/apron and face shield/goggles.

It should be noted that some of the above activities might have to be modified, should a SARS-CoV-2 variant that has higher transmission rates, immune escape capabilities, or results in severe disease, arise.

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