ICU inpatient clearance of COVID-19 infection
Clinical Guidelines

For an adult or paediatric inpatient of a Queensland Public intensive care unit (ICU) to be considered cleared (no longer infectious) of COVID-19, a medical practitioner or multidisciplinary team review, working within a COVID-19 healthcare framework approved by Queensland Health, must:

1. determine the patient meets the clearance criteria for release from COVID isolation; and
2. authorise the patient's release from a COVID-19 treatment area.

Clearance criteria

An inpatient of a Queensland public ICU may be considered cleared of COVID-19 subject to the following recommended requirements:

1. ICU inpatient being treated primarily for symptoms of COVID

If the patient is primarily admitted for treatment of severe symptoms related to COVID-19, or develops severe symptoms while admitted for another reason, they may be considered cleared subject to the conditions outlined below.

Days since positive test	Absence of fever	Negative test results
Day 10 or more after receiving an initial positive test (RAT or PCR) for COVID-19 (for immunocompromised or immunosuppressed patients – see below).	24 hours after the resolution of fever attributed to COVID-19 without the use of fever-reducing medications dispensed primarily for this purpose.	Negative results from at least 2 consecutive COVID-19 tests (RAT preferred) collected ≥ 24 hours apart, commencing no earlier than Day 9 since their initial positive test with a maximum of 10 days of testing (20 days total since initial positive test) – see Notes.

2. Immunocompromised ICU patients with primary or incidental COVID infection

If the patient is admitted to ICU for any reason, and has tested positive for COVID-19 with symptoms of any severity, and is considered a severely immunocompromised person (see Notes), the patient may be considered cleared subject to the conditions outlined below.

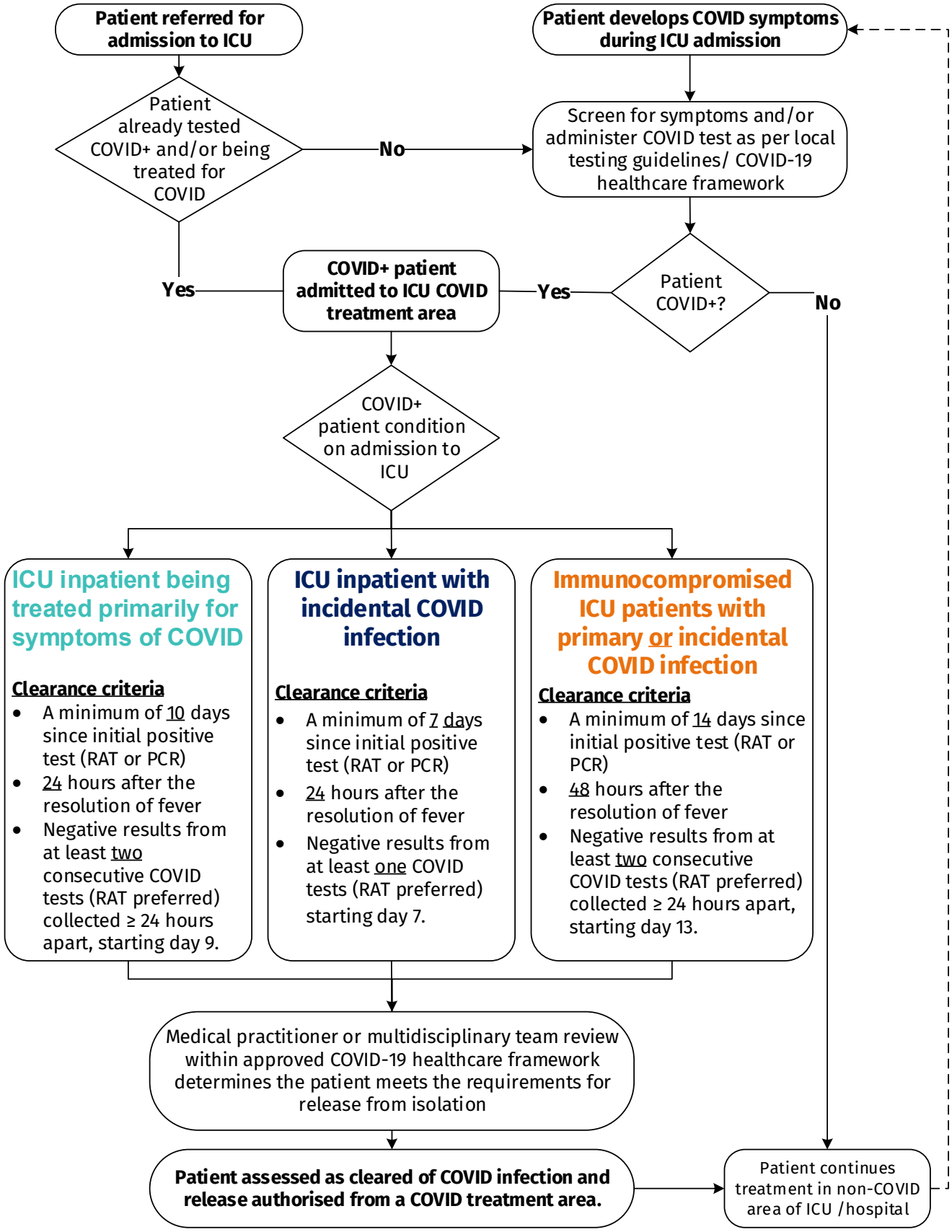
Days since positive test	Absence of fever	Negative test results
Day 14 or more after receiving an initial positive test (RAT or PCR) for COVID-19.	48 hours after the resolution of fever attributed to COVID-19 without the use of fever-reducing medications dispensed primarily for this purpose.	Negative results from at least 2 consecutive COVID-19 tests (RAT preferred) collected ≥ 24 hours apart, commencing no earlier than Day 13 since their initial positive test with a maximum of 10 days of testing (24 days total since initial positive test) – see Notes.

3. ICU inpatient with incidental COVID-19 infection

If the patient is admitted to ICU for another condition but has also tested positive to COVID-19 and is asymptomatic or only has no/mild/moderate symptoms, the patient may be considered cleared subject to the conditions outlined below.

Days since positive test	Absence of fever	Negative test results
Day 7 or more after receiving an initial positive test (RAT or PCR) for COVID-19.	24 hours after the resolution of fever attributed to COVID-19 without the use of fever-reducing medications dispensed primarily for this purpose.	Negative results from at least one COVID-19 test (RAT preferred), collected no earlier than Day 7 since their initial positive test with a maximum of 10 days of testing (17 days total since initial positive test) – see Notes.

ICU inpatient clearance of COVID-19 infection - flowchart



Notes

a. In all cases clinical judgment and discretion should be utilised, and these clinical guidelines considered in conjunction with local policies and procedures.

b. The COVID-19 Testing Framework Implementation Plan Version 2.2.4 requires symptomatic patients with risk factors for severe disease, patients in high risk environments, and susceptible asymptomatic patients be considered for screening testing.

   ICUs should follow their local COVID-19 healthcare framework and testing guidelines for consideration of symptom screening and testing prior to admission.

c. All patients should continue to be screened for COVID-19 symptoms as part of their admission and tested as required.

d. An ICU inpatient considered cleared of infection may still exhibit ongoing symptoms of COVID-19 relating to their prior infection, and be released from a COVID-19 treatment area to receive ongoing treatment (including ventilation, ECMO, and/or dialysis) in a non-COVID-19 pod/ward/HDU at the discretion of the treating team.

e. Patients may continue to shed viral fragments for many weeks following infection detectable by PCR tests for COVID-19, but have a substantially reduced chance of passing on their infection. As such, PCR testing for patient clearance is not recommended, with RAT the preferred option.

   Discretion on testing following infection – especially if using PCR tests for clearance - may be used in seeking consecutive negative results, with a suggested upper limit of an additional 10 days from when testing commences (ie: 20 days from initial test results for patients with severe symptoms, 24 days for immunocompromised patients, 17 days for incidental infections). Once this upper limit is reached, discuss with an infectious disease specialist if the patient should continue to be considered infectious. See CDC Guidelines - https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

f. Generally, patients are unlikely to get COVID-19 again within 28 days of completing isolation from an earlier COVID-19 infection. Immunocompromised patients have a greater chance of COVID-19 reinfection following initial infection, including within this 28-day period. Clinical discretion should be exercised in COVID-19 testing within this period for asymptomatic patients.

g. Severely immunocompromised patients - for the purposes of this guidance, the Communicable Diseases Network of Australia (CDNA) Guidelines for Public Health Units definition of a severely immunocompromised person may include, but are not limited to, patients that:
   - have had an organ transplant and are on immune suppressive therapy
   - have had a haematopoietic stem cell transplant in the past 2 years
   - are on immune suppressive therapy for graft versus host disease
   - have had an active haematological malignancy
   - are being treated with biological therapies and most disease modifying anti rheumatic drugs (DMARDs), including 6 Mercaptopurine > 1.5 mg/kg/day; Methotrexate 10 mg/day; any dose of Tacrolimus, Cyclosporine, Cyclophosphamide, Mycophenolate or any dose combination of multiple DMARD
   - have human immunodeficiency virus infection with CD4 T-lymphocyte count below 200 cells/per mm
   - are receiving dialysis
   - have other immunosuppressing conditions specifically noted by the treating medical practitioner.

References:

This positions statement meets the requirements of the COVID-19 Infection Prevention and Control Manual for acute and non-acute healthcare settings (Version 1.0 as at 31 October 2022) is informed by the best practice standards of:

- Infection prevention and control guidelines for the management of COVID-19 in healthcare settings Version 4.0 22 June 2022
- The Communicable Diseases Network of Australia (CDNA) Guidelines for Public Health Units
- US Centre for Disease Control Ending Isolation and Precautions for People with COVID-19: Interim Guidance
- UK Health Security Agency Stepdown of infection control precautions and discharging COVID-19 patients and asymptomatic SARS-CoV-2 infected patients
- The Alfred Hospital (Vic) - Cessation of precautions for COVID positive patients in ICU as at 8/11/2021
- NSW Clinical Excellence Commission COVID-19 Infection Prevention and Control Manual for acute and non-acute healthcare settings –– as at 22 February 2022
- Queensland Health COVID-19 Testing Framework Implementation Plan Version 2.2.4 – as at July 2022

Version History

Version 2.0			
Clinical Guidelines - ICU inpatient clearance of COVID-19 infection Queensland Intensive Care Clinical Network Clinical Excellence Queensland			
Published:	9 March 2022		
First Review	31 October 2022	**Next Review**	12 months
Endorsed by the Statewide Intensive Care Clinical Network on 17 February 2022			
Endorsed by the Statewide Infectious Disease Clinical Network on 24 February 2022			
Endorsed by the COVID System Response Group on 8 March 2022			
Review endorsed by the Queensland Infectious Disease Clinical Network and Queensland Intensive Care Clinical Network on 27 October 2022			

Contact: qldintensivecarenetwork@health.qld.gov.au