

Appendix 2 – Patient placement (cohorting) advice

Confirmed cases

Cohorting of confirmed cases of COVID-19 must only be undertaken following consultation with local experts, such as infectious disease physicians, the local infection prevention and control service and public health unit as relevant. **Where practicable, managing patients with mild illness in their own home is the preferred approach rather than cohorting patients in hospital.**

Cohorting patients who are infected with COVID-19 confines their care to one area and prevents contact with other patients.

The following principles apply when making decisions about patient placement:

- Prioritise patients who have severe pneumonia symptoms for placement in single rooms with negative pressure air handling.
- Consider the patient's ability to perform hand hygiene and follow appropriate cough and personal hygiene etiquette.
- **Care should be taken to ensure that probable and suspect cases are not cohorted with confirmed cases.**
- Care should be taken to ensure that confirmed COVID-19 cases co-infected with influenza or other respiratory viruses are not cohorted.

A suitable ward should be identified for the exclusive use of cohorting confirmed COVID-19 patients. When determining the location of the cohort ward, the following should be considered:

- the ability to isolate the ward air handling system (if aerosol-generating procedures are to be performed anywhere on the ward)
- the ventilation of the ward area:
 - in heating, ventilation and air conditions (HVAC) systems with modulating outside air systems, or where manual adjustment is possible, increasing outside air rates to provide increased dilution should be considered. It is recommended that ventilation or air conditioning systems that normally run with a recirculation mode should be set up to run on full outside air where this is possible. This will also require increasing the system's exhaust air rate and will help dilute any contaminants in the circulating air.
 - It should be noted that increasing outside air rates and or ventilation rates will generally result in increased energy usage and in some circumstances may result in difficulties in the system maintaining the desired internal temperature and humidity conditions.
 - Early engagement with local engineering experts (BEMS) is advised. These local experts understand the way the systems have been designed, operated and perhaps modified over the years and can

help to ensure the understanding of the movement of particular airflows and that sharing of return air is allocated across the facility.

- the ability to limit entry/access to the ward
- the ward contains the necessary equipment
- spatial separation of greater than 1.5 metres between bed spaces
- patient populations of adjacent areas. The cohort ward should be separated from patients who are potentially at greater risk of complications from COVID-19, for example, haematology, oncology and transplant services
- wherever possible, curtains, privacy screens or barriers should be used to physically separate patients to help reduce the transmission of infection.

Management of cohort areas should incorporate the following:

- When cohorting cases, consideration must be given to the need to escalate use of PPE in line with the advice to use standard, contact and airborne precautions in:
 - settings where there is a high density of COVID-infected patients, particularly in wards or cohorted areas without optimal ventilation and where prolonged episodes of care are required, and
 - where there are high numbers of COVID-19 patients AND a risk of challenging behaviours and/or unplanned aerosol-generating procedures. Refer to the section on [Transmission-based precautions](#).
- Standard and transmission-based precautions must be maintained. The following options can be used:
 - Gowns and gloves must be changed and hand hygiene performed between contact with each patient in the cohort area.
 - A plastic apron is worn over the long sleeve gown when providing care with minimal patient contact. The plastic apron and gloves must be changed, and hand hygiene performed between contact with each patient.
- When using one of the above options, surgical mask and eye protection can stay in place between patients. Once a mask is removed it must be discarded. Once eye protection is removed it must be either discarded or cleaned and disinfected appropriately (according to whether it is a single use or reusable item).
- Where there is extensive patient contact, in addition to the apron and gloves, the gown must also be changed at the end of the procedure and hand hygiene performed. Examples of extensive contact are providing care such as dressing large or complex wounds; hygiene cares for incontinent clients; hygiene cares or pressure area care when a client is fully dependent; urinary catheter cares.
- Whenever possible, healthcare workers assigned to cohorted patient care units should be experienced healthcare workers and should not float or be assigned to other patient care areas. Separate staffing arrangements for COVID-19 and non-COVID-19 patients may also assist in protecting patients, as well as staff members, at particular risk of COVID-19 complications.
- The number of persons entering the cohorted area should be limited to the minimum number necessary for patient care and support.

- Records of persons entering the cohort area are to be maintained.
- Patient transport should be limited by having necessary equipment, e.g. portable X-ray, available in cohort areas.
- The frequency of environmental cleaning and disinfection should be increased in cohort areas.
- The need for frequent emptying of waste bins used for the disposal of PPE in clinical areas should be considered. Anecdotal evidence suggests that when such bins become full, healthcare workers may start to tamp down the waste when discarding used PPE, potentially leading to self-contamination.
- During aerosol-generating procedures, contact and airborne precautions should be followed for at least the duration of the procedure. Where available the procedure should be undertaken in a negative pressure room. Where this is not available, the procedure should be undertaken in a treatment room with the door closed, away from other patients. In all cases, leave the room vacant with the door closed for 30 minutes after the procedure and the patient has vacated the room. The room may be cleaned by a worker wearing the correct PPE during this period.

Suspect cases

The decision to cohort suspect cases needs to be taken following consultation with local experts, such as infectious diseases physicians and infection control practitioners.

Cohorting suspect cases is not recommended if it can be avoided.

Where suspect cases must be cohorted, epidemiological and clinical suspicion should be considered when deciding which suspect case are placed together. Physical distancing measures must be adhered to with a minimum of 1.5 metres distance maintained between patients at all times.

In addition to the requirements outlined above for cohorting suspect cases, curtains, privacy screens or barriers should be used at all times to physically separate patients. This will help to reduce the potential for transmission of infection. The curtains or barriers between patients must remain in place whenever a patient is present.

Probable and suspect cases should not be cohorted with confirmed cases.

Version control – Appendix 2

Version	Date	Comments
V1.2	1 September 2020	Inclusion of requirement to maintain records of all persons entering cohort areas. Inclusion of further advice to consider ventilation of cohort areas, PPE escalation, increasing frequency of environmental cleaning and emptying of waste bins.
V1.1	23 April 2020	Inclusion of advice for probable cases. Revised: confirmed cases.
V1.0	6 March 2020	New appendix