From the Chief Medical Officer
Prof Sir Michael McBride

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSS(MD) 22/2022

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: 028 9052 0563
Email: Michael.McBride@health-ni.gov.uk

Our Ref: HSS(MD) 22/2022
Date: 13 May 2022

FOR ACTION
Chief Executives, Public Health Agency/SPPG /HSC Trusts/NIAS
GP Medical Advisers, All General Practitioners and GP Locums *(for onward distribution to practice staff)*
OOHs Medical Managers *(for onward distribution to staff)*
RQIA *(for onward circulation to independent sector health and social care providers)*

PLEASE SEE ATTACHED FULL CIRCULATION LIST

Dear Colleague

UPDATED COVID-19 TESTING GUIDANCE TO SUPPORT CLINICAL PATHWAYS

Introduction

1. In line with the Department's Test and Trace Transition Plan, advice to the general population in relation to COVID-19 Test, Trace and Isolation has changed from 22 April 2022. The Plan can be found here: https://www.health-ni.gov.uk/sites/default/files/publications/health/Test-Trace-Transition-Plan.pdf.

2. HSS(MD) 17/2022 issued on 4 May 2022 set out updated COVID-9 testing and isolation guidance for Health and Social Care Workers and guidance on visitor testing in line with the transition plan. https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hss-md-17-2022_0.pdf

3. The purpose of this letter is to set out the updated guidance on COVID testing to support clinical pathways in hospital settings. The guidance in this letter replaces that in version 9 of the COVID-19 Interim Testing Protocol issued in October 2021 which should now be withdrawn from use.

4. The letter sets out the testing advised to support a wide range of clinical pathways. For ease of reference the letter is set out in sections covering the guidance on testing recommended for:

    a) Diagnosis and clinical decision making in hospital settings;
    b) Unscheduled admissions to hospital;
    c) Planned admission to hospital;
    d) During inpatient stays;
    e) Patients who are COVID-19 cases or contacts;
    f) Long stay patients;

g) Patients being discharged to care homes;
h) Admission to labour ward;
i) Mental health and learning disability inpatient units; and
j) Testing of patients with cancer.

(a) Diagnosis and clinical decision making in hospitals

5. All patients in a hospital setting requiring a test to support diagnosis and clinical decision making during their care should be offered a polymerase chain reaction (PCR) test. **There is no change to the testing pathway for this group of patients.**

(b) Unscheduled admission to hospital

6. All patients including those without COVID-19 symptoms who require emergency/unplanned admission via Emergency Departments (ED) or any other route (e.g. medical/surgical assessment units, GP direct admission) should be tested for COVID-19 using PCR, NAAT or LumiraDx. **There is no change to the testing pathway for this group of patients.**

7. LumiraDx testing should be used on patients on arrival in the ED setting. A further LumiraDx test can be undertaken every 24 hours a patient remains in the ED.

(c) Planned admission to hospital

8. Patients with planned admissions should be tested using Lateral Flow Device tests (LFDs) in advance of admission. Patients should take a first LFD test 48 hours before admission, a second 24 hours prior to admission and a third on the morning of admission. Patients should **immediately** inform their treating HSC Trust if any of these LFD tests are positive, as Trusts may be able to schedule other patients to avail of the cancellation. Patients should be advised to obtain LFD test kits at their local pharmacy (if they have no symptoms) or via Order coronavirus (COVID-19) rapid lateral flow tests - GOV.UK (www.gov.uk), where they will be asked to confirm that they are eligible to order rapid lateral flow tests. This applies to those requiring post-operative inpatient stays as well as those with planned day case procedures. **This is a change to the testing pathway for this group of patients.**

9. Patients should also be asked to upload their LFD test result (whether positive or negative) on the GOV.UK website, and use the notification provided through this reporting to demonstrate proof of their negative results on admission (SMS or email confirming the LFD test result).

10. Trusts should put in place alternative arrangements for patients who have difficulties undertaking with home testing or who fail to test in advance of their planned admission, including where a patient may need to attend for elective surgery at short notice, for example due to a cancellation or reschedule. In most cases, procedures for patients without symptoms of COVID-19 who are not able to provide evidence of a negative test result or who did not test 48 and 24 hours in advance as set out above, should go ahead provided the patient has a negative result from an LFD (or other rapid test) carried out on the morning of admission. Admissions areas should hold a stock of LFD tests

to allow patients to self-test prior to admission if they are not able to provide proof of a negative test.

(d) Testing for hospital inpatients

11. Patients who do not have COVID-19 symptoms who test negative on admission to hospital should be tested **using an LFD test** every 5 days during the first two weeks of their stay. HSC Trusts can order supplies of LFD tests for this purpose via the Trust's usual ordering route. **This is a change to the testing technology for this group of patients.**

12. The use of LFD tests, rather than PCR, for this purpose is new. LFD tests have been used widely in the population since Summer 2021. Their use in the context of the management of hospital outbreaks in Northern Ireland has been recommended since January 2022. However, to ensure Trusts can put robust arrangements in place for carrying out and recording all LFD test results for this group of patients, a short period of implementation may be applied where this is deemed necessary by a Trust. While the implementation of this guidance should be applied from the date of this letter, Trusts should fully implement the advised switch from PCR to LFD for the testing of hospital inpatients before the end of June 2022.

13. Severely immunocompromised patients should be tested using PCR tests rather than LFD tests.

14. There is no requirement for asymptomatic inpatients (those with no COVID-19 symptoms) to continue to be routinely tested after **Day 14** of their hospital stay. However, subject to an appropriate risk assessment by the relevant HSC Trust Infection Prevention Control (IPC) Team, asymptomatic inpatients in a high risk setting may continue to be tested with LFD every 5 days if deemed necessary. **This is a change to the testing pathway for this group of patients.**

15. If an inpatient develops COVID-19 symptoms during their hospital stay, they should be tested by PCR. **There is no change to the testing pathway for this group of patients.**

(e) Patients who are COVID-19 cases or contacts

16. Cases: For inpatients with COVID-19, isolation should continue up to 10 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms). The isolation period can be reduced provided the following clinical criteria have been met:

    - clinical improvement with at least some respiratory recovery;
    - absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication;
    - no underlying severe immunosuppression; and
    - two negative LFD or other rapid antigen test, taken 24 hours apart on day 6 and day 7. Isolation can end after the second negative test.

17. The residual risk of infection after a two negative tests taken on day 6 and 7 is similar to stepping down isolation precautions without testing at day 10. Starting testing on day 5 with release from isolation on day 6 if both tests are negative (as is currently advised for the general population) slightly increases this risk, however organizations

may wish to balance the slightly elevated risk against other potential harms to patients across the system.

18. The advice above does not apply to severely immunocompromised patients. It is possible for severely immunocompromised patients to remain infectious for prolonged periods, even if they do not display any symptoms of COVID-19. The isolation period for these patients whilst in hospital should be at least 14 days. In severely immunocompromised inpatients, resolution of symptoms should not be used as a marker of decreased infectiousness and these patients should be isolated until they return a negative PCR test. Staff should strictly adhere to recommended IPC measures throughout the inpatient stay. Severely immunocompromised patients can end their isolation after a single negative PCR test result taken no earlier than 14 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms).

19. Contacts: As a precaution in the hospital setting, inpatients without COVID-19 symptoms who are identified as either household contacts of COVID-19 or who have been identified as a close contact following exposure in the hospital setting should be tested using LFD tests. Patients should be tested at the time they are identified as a contact, 48 hours later and again 3-4 days after the second LFD, giving a total of three LFD tests in the 7 days following identification as a contact.

20. If symptoms occur, the patient should be tested with PCR and isolated or cohorted with other symptomatic contacts of COVID-19 cases.

(f) Long stay patients

21. Long stay patients (over 3 months) e.g. patients in units for care of the elderly, dementia and learning disability should only be tested if symptomatic. Routine regular asymptomatic testing should not be used in this group.

(g) Patients being discharged from hospital to a care home or hospice

22. Patients to be discharged to a care home should be tested with PCR for COVID-19 within the 48 hours prior to discharge. Every patient going to a care home or hospice must receive the COVID-19 PCR result before discharge from hospital. The only exception is for those who are known to have previously tested positive for COVID-19 who are within 90 days of their symptom onset or positive test date (if asymptomatic) and who have developed no new COVID-19 symptoms. If available, a LumiraDx test should also be performed on the day of discharge as an additional mitigation. Unlike PCR, LumiraDx can be used within 90 days of a previous positive PCR. **There is no change to the testing pathway for this group of patients.**

(h) *Admission of women to a labour ward*

23. Women admitted to a labour ward or equivalent setting should be tested as soon as is practical at the hospital using a rapid automated test e.g. point of care PCR test or LumiraDx. Birth partners are to be treated in the same way as hospital visitors and should be encouraged to LFD test.

24. Babies born to women who test positive for COVID-19 should be tested at day 0 using PCR testing. If the baby tests negative and they remain in hospital,

they should be tested again by PCR at day 3 and 5 of their hospital stay. **There is no change to this pathway.**

(i) Mental health and learning disability inpatient units

25. Patients without COVID-19 symptoms who require emergency admission to a learning disability or mental health inpatient unit, and patients returning from a period of planned leave to these settings should be tested using LFDs at the time of admission. **This is a change to the testing technology for this group of patients.**

(j) Patients with cancer

26. Cancer patients undergoing systemic anti-cancer therapy (SACT) who have COVID-19 symptoms should be PCR tested. **There is no change to the testing pathway for this group of patients.**

27. Chemotherapy patients and their households are no longer advised to test regularly using LFD tests if they have no symptoms. **This is a change to the testing pathway for these patients and their households.**

28. Patients with cancer being admitted for planned surgery should follow the same pre-admission testing as other planned admissions (paragraph 8) and take an LFD test 48 and 24 hours before admission and on the morning of admission. **This is a change in testing pathway for this group of patients.**

29. Paediatric haematology admissions should continue to be tested by PCR. Parents of acute paediatric haematology patients should be tested using LFDs. This testing can be offered more frequently than the testing recommended for other hospital visitors. **This is a change in testing pathway recommended for the parents.**

Conclusion

30. In conclusion, I appreciate these continue to be challenging times for our hospital services and we recognise the continuing pressures on our health and social care system and on staff. All elements of test and trace policy continue to be kept under review. Further correspondence will issue accordingly as needed.

31. I would like to take this opportunity to once again thank you all for your commitment and dedication to serving the needs of patients across our health and care services in Northern Ireland.

Yours sincerely

PROF SIR MICHAEL McBRIDE
Chief Medical Officer

Circulation List

Director of Public Health/Medical Director, Public Health Agency (*for onward distribution to all relevant health protection staff*)
Assistant Director Public Health (Health Protection), Public Health Agency
Director of Nursing, Public Health Agency
Assistant Director of Pharmacy and Medicines Management, SPPG *(for onward distribution to Community Pharmacies)*
Directors of Pharmacy HSC Trusts
Director of Social Care and Children, SPPG
Family Practitioner Service Leads, SPPG *(for cascade to GP Out of Hours services)*
Medical Directors, HSC Trusts *(for onward distribution to all Consultants, Occupational Health Physicians and School Medical Leads)*
Nursing Directors, HSC Trusts *(for onward distribution to all Community Nurses, and Midwives)*
Directors of Children's Services, HSC Trusts
RQIA (*for onward transmission to all independent providers including independent hospitals*)
Joe Brogan, Assistant Director, Head of Pharmacy and Medicines Management, Strategic Planning and Performance Group (SPPG) (*for onward distribution to SPPG Pharmacy and Medicines Management Team and community pharmacists*)
Regional Medicines Information Service, Belfast HSC Trust
Regional Pharmaceutical Procurement Service, Northern HSC Trust
Professor Donna Fitzsimons, Head of School of Nursing and Midwifery QUB
Professor Sonja McIlfatrick, Head of School of Nursing, University of Ulster
Heather Finlay, CEC
Donna Gallagher, Open University
Professor Paul McCarron, Head of School of Pharmacy and Pharmaceutical Sciences, UU
Professor Colin McCoy, Head of School, School of Pharmacy, QUB
Professor Colin Adair, Postgraduate Pharmacy Dean, NI Centre for Pharmacy, Learning and Development, QUB
Michael Donaldson, Head of Dental Services, SPPG *(for distribution to all General Dental Practitioners)*
Raymond Curran, Head of Ophthalmic Services, SPPG *(for distribution to Community Optometrists)*
Trade Union Side
Clinical Advisory Team
Louise McMahon, Director of Integrated Care, SPPG

This letter is available on the Department of Health website at https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/hssmd-letters-and-urgent-communications