महत्वपूर्ण / कोविड–19
संख्या– 470 / 71–3–2020

प्रेषक,

डॉ0 रजनीश दुबे,
प्रमुख सचिव,
उ0प्र0 शासन।

सेवा में,

1– कुलपति / कुलसचिव, किंग जार्ज चिकित्सा विश्वविद्यायलय,लखनऊ / यू0पी0यू0एम0एस0, सैफई, इटावा / निदेशक, डा0 राम मनोहर लोहिया, आयुर्विज्ञान संस्थान, लखनऊ / एस0जी0पी0जी0आई0, लखनऊ / सी0बी0 एम0आर0, लखनऊ / लखनऊ कैंसर संस्थान, चक गजरिया, लखनऊ / जी0आई0एम0 एस0,ग्रेटर नोएडा / एस0एस0पी0एच0 एण्ड पी0जी0टी0आई0 नोएडा।

2– प्रधानाचार्य, राजकीय मेडिकल कालेज, आगरा / मेरठ / प्रयागराज / कानपुर / झांसी / गोरखपुर / अम्बेडकरनगर / आजमगढ़ / सहारनपुर / कन्नौज / जालौन / बॉदा / बदायूँ।

3– प्रधानाचार्य, स्वशासी राज्य चिकित्सा महाविद्यालय, अयोध्या / बस्ती / बहराइच / फिरोजाबाद / शाहजहॉपुर।

4– प्रधानाचार्य / निदेशक, समस्त निजी मेडिकल कालेज (कुल 28)

चिकित्सा शिक्षा अनुभाग–3 लखनऊः दिनांक 22 अप्रैल, 2020

विषय– Micro Management of Emergency/ Trauma cases of Medical Colleges with special reference to COVID-19 Pandemic के प्रोटोकाल के सम्बन्ध में।

महोदय,

उपर्युक्त विषयक शासनादेश संख्या–443 / 71–3–2020, दिनांक 13.04.2020 का संदर्भ ग्रहण करने का कष्ट करें, जिसके द्वारा इमरजेन्सी एवं ट्रामा में आने वाले मरीजों के कोविड–19 के संक्रमण की दृष्टि से उपचार एवं प्रबन्धन हेतु प्रोटोकाल निर्गत किया गया है। तदक्रम में महानिदेशक, चिकित्सा शिक्षा एवं प्रशिक्षण, उ0प्र0 लखनऊ द्वारा इमरजेंसी तथा ट्रामा में आने वाले मरीजो के उपचार एवं प्रबन्धन व मरीजों की स्कीनिंग तथा सेग्रीगेशन किये जाने हेतु टास्क फोर्स की संस्तुति के अनुसार Micro Management of Emergency/ Trauma cases of Medical Colleges with special reference to COVID-19 Pandemic (छायाप्रति संलग्न) का विस्तृत प्रोटोकाल उपलब्ध कराया गया है।

2– इस सम्बन्ध में यह भी उल्लेखनीय है कि कोविड–19 के संदिग्ध एवं कन्फर्म मरीजों के चिन्हांकन हेतु स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार द्वारा Guidelines to be follwed on detection of suspect/confirmed COVID-19 case in a non-COVID Health Facility निर्गत की गयी है।

3– अतः इस संबंध में मुझे यह कहने का निदेश हुआ है कि कृपया इमरजेंसी तथा ट्रामा में आने वाले मरीजो के उपचार एवं प्रबन्धन व मरीजों की स्कीनिंग तथा सेग्रीगेशन किये जाने हेतु संलग्न माइक्रो मैनेजमेन्ट प्रोटोकाल एवं भारत सरकार की गाइडलाइन्स के अनुसार आवश्यक कार्यवाही सुनिश्चित कराने का कष्ट करें।

संलग्नक–यथोक्त

1. टास्क फोर्स की संस्तुति के अनुसार माइक्रो मैनेजमेन्ट प्रोटोकाल।
2. भारत सरकार की गाइडलाइन्स।

भवदीय,

(डॉ0 रजनीश दुबे)
प्रमुख सचिव।

संख्या–470 (1)/71–3–2020, तद्दिनांक।

प्रतिलिपिः निम्नलिखित को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित।

1. निजी सचिव, प्रमुख सचिव, मा0 मुख्य मंत्री, उ0प्र0 शासन।
2. निजी सचिव, मा0 मंत्री जी चिकित्सा शिक्षा विभाग उ0प्र शासन।
3. मुख्य स्टाफ आफिसर, मुख्य सचिव, उ0प्र0 शासन।
4. महानिदेशक, चिकित्सा शिक्षा एवं प्रशिक्षण, उ0प्र0 शासन को इस अनुरोध के साथ प्रेषित कि कृपया उपरोक्त सभी को अपने स्तर से सूचित करने का कष्ट करें।
5. चिकित्सा शिक्षा अनुभाग–2

आज्ञा से,

(अनिल कुमार)
संयुक्त सचिव।

Annexure-1

MICROPLAN for Management of Patients in Emergency Department (ED) of Medical Colleges with special reference to COVID-19 pandemic

(These guidelines are subject to modifications based on epidemiology, transmission and treatment)

During the COVID-19 Pandemic the thrust has been on its management, hence routine OPD & IPD functioning has been severely curtailed. As per government regulations, Trauma & Emergencies and Emergencies of Cardiology, Ante-Natal and Peri-Natal services, Radiotherapy and Dialysis will continue to run in hospitals. Therefore Emergency Department (ED) services have been kept functional to deal with the Emergency Medical & Surgical health related issues.

Every hospital therefore should have two different care areas for the management of patients:

A. **COVID Care Facility** for management of COVID-19 patients.

B. **EMERGENCY Department** for the management of Medical & Surgical Emergencies for Non-COVID patients(two categories- COVID suspect in HOLDING area to be investigated and Non-COVID clean patient- for admission if required)

These two areas A and B should be separate to avoid cross infection and accidental admission of suspect or confirmed COVID-19 patient in Non-COVID area.

The following MICROPLAN is proposed for the management of patients presenting to ED of a Non-COVID Hospital.

1. The Incharge for the ED would be SIC/CMS/MS providing round the clock administrative service.
2. For Nursing care administrative work Nursing Superintendant / Deputy Nursing Superintendant / Matron should be made incharge.
3. Ensure single point entry into the Non-COVID Hospital as far as possible
4. Proper signages should be put at all entries in the Non-COVID Hospital premises and within the campus to guide a person towards either the COVID Care Facility &/or the Non-COVID Hospital ED both in English and Hindi.
5. Before entry into the ED, the patient first enters the reception which is the **First Screening Area** at the Non-COVID Hospital entrance.
   a. It should preferably be in an open well ventilated area.
   b. It must have a separate entry and exit for staff away from the patients

c. The Team at this First Screening Area may include

- JR / Intern/ PRO
- Junior Staff nurse
- Ward boy
- Ward Aaya
- Safai worker
- Volunteer to guide the patient
    - Prior training of all medical and paramedical staff is mandatory in their specific roles
    - Proper social distancing should be maintained by staff, patients and their relatives at all times.
    - All staff and the patients/ attendants attending the ED should be wearing appropriate masks as advised by the Ministry of Health and Family Welfare (MOHFW); (If not Triple layer masks should be provided at this area mandatorily)
    - Standard Infection Control Practices as recommended by WHO should be ensured.
    - The medical team should be stationed in an adequately ventilated glass cabin with bi-way communication via microphone for communication with patients or their relatives.
    - Proper IEC material related to COVID-19 should be displayed at this area.
    - Current updated list of hotspot areas should be available at this screening area.
    - Proper social distancing shall be maintained at all times by staff, patients and their relatives.
    - Deployment of adequate security should be ensured.
    - Surveillance via CCTV cameras should be ensured.
    - All patients should be screened based on pre-designed questionnaire annexed as Annexure-1. This questionnaire may change depending on the stage of the epidemic.
    - Temperature monitoring via infrared thermometers or Thermal scanning should be performed for all patients.

- Any COVID – suspect patient will be immediately tagged as RED and others as GREEN
- Based on the above categorization:
  - RED tagged patient would be referred to the **COVID-19 triage in the dedicated COVID facility/ Hospital.**
  - GREEN tagged patient not suspected to be COVID-19 would be referred to the **Second Screening Area in the Non-COVID facility/Hospital.**
- Ensure availability of wheel chairs and stretchers close by if needed

B. In the **Second Screening Area:**

a. It should preferably be in an open well ventilated area.

b. It must have a separate entry and exit for staff away from the patients.

c. The Teamat second Screening Area may include

- SR / JR/ Emergency Medical officer
- Senior Staff nurse
- Ward boy
- Ward Aaya
- Safai worker
- Volunteer to guide the patient

d. Prior training of all medical and paramedical staff is mandatory

e. The medical team should be stationed in an adequately ventilated glass cabin with bi-way communication via microphone for communication with patients or their relatives.

f. Standard Infection Control Practices as recommended by WHO should be ensured

g. All staff stationed in this area should be wearing appropriate PPE-kits and masks as advised by the Ministry of Health and Family Welfare (MOHFW)

h. All patients and their attendants shall compulsorily wear masks (That have been provided at the First Screening Area and if not then triple layer masks must be provided)

i. Proper social distancing shall be maintained at all times by staff, patients and their relatives.

j. Deployment of adequate security should be ensured.
k. Surveillance via CCTV cameras should be ensured.
l. Separate Toilets for staff and patients that are regularly sanitized be ensured.
m. All patients should be screened based on pre-designed questionnaire annexed as Annexure-1. This questionnaire may change depending on the stage of the epidemic.
n. Current updated list of hotspot areas should be available at this screening area as well
o. Based on the above observations:
    i. In case a suspect COVID-19 patient is identified then immediately change the tag from GREEN to RED and refer the patient to the **COVID-19 triage** in the dedicated COVID-19 facility/Hospital.
    ii. Patients not suspected to be COVID-19 would continue to wear the GREEN tag and be subjected to investigation for confirmation of COVID-19 status
        1. RT-PCR is the Gold Standard investigation.
        2. However, Rapid Diagnostic Test (R.D.T.) kits as and when approved by ICMR would also be used with their known limitations.
    iii. All GREEN tagged suspect cases shall be admitted to the **HOLDING Area** ward till their report comes.

After screening the clean patients may be admitted to the respective DESTINATION ward if admission still needed. And only suspect patients with COVID 19 will be kept in holding area.

C. **HOLDING Area Ward:** Asymptomatic patients coming due to apprehension and any COVID-19 suspect shall be admitted in the **HOLDING Area** till their test results are available. Patients admitted in this area must be categorized as STABLE or UNSTABLE depending on their ABCD approach of the internationally accepted Emergency Severity Index (ESI) (Annexure-3).
    a. If the test results are Negative and the patient does not require admission he/she would be sent home with instructions for **Home Quarantine** for 14 days. However, if the patient needs admission he/she can be admitted in the respective DESTINATION ward.

b. If the test results are Positive, immediately change the tag from GREEN to RED the patient would be referred to Isolation in the dedicated **COVID Care Facility/Hospital.**

i. The Sick patients shall be categorized as 'STABLE' and 'UNSTABLE' based on the ABCD approach of the ESI triage (Annexure-3). Patients in ESI-1 &2, need immediate life supportive interventions, while those in ESI-4 & 5 need minimal to nil support. Patients in ESI-3 are the ones who can fluctuate and hence need more vigilant monitoring

1. STABLE (ESI- 4 & 5) patients shall receive symptomatic treatment and shall stay in the **HOLDINGArea** till their test results are received –

   a. If the test results are Negative, the patient should be removed from this area to a DESTINATION ward to reduce his risk of further exposure. He/she shall receive symptomatic treatment there and be discharged only after complete recovery.

   b. If the test results are Positive, immediately change the tag from GREEN to RED and the patient would be referred to Isolation in **COVID Care Facility/Hospital.**

2. For UNSTABLE (ESI- 1 & 2) patients, immediate life saving interventions may be required. All such patients would be treated as per the standard Infection Prevention & Control (IPC) practices for COVID-19 patients. The medical team for these patients would either be a Medical Emergency Team and or Surgical Emergency Team with/ without super-specialties as needed. Treatment shall be as per the Standard Operating Protocols (SOP) laid down for each disease and intervention as required like Dialysis, Labor Room, O.T., Surgery, etc.

c. Proper signage and facilities for Dialysis, OT, ICU, etc will be made available in the Emergency Department.

d. The medical team shall be on daily 8-12 hourly shift for a continuous period of 14 days. After their daily work shifts staff will go for active quarantine within the

Hospital premise if possible. After their 14 days of duty the staff will go 14 days of passive quarantine preferably outside the Hospital premises.

e. Infection control practices, cleaning & disinfection and biomedical waste disposal would all be at par with any COVID-19 facility/Hospital.
f. All health care workers should wear appropriate PPE and N95 as per standards laid down by MOHFW.
g. Though isolation beds with separate room would be preferred, in case where such facilities are not available due to logistic reasons, isolation wards can be used and distance between beds of 2 meter maintained.
h. The beds, ventilators, dialysis machine, OT, etc would be earmarked for each patient and properly sanitized after each use.
i. All patients and their attendants shall compulsorily wear masks.
j. Proper social distancing shall be maintained.
k. Proper security should be deployed.

Surveillance CCTV cameras should be available. Separate Toilets for staff and patients should be regularly sanitized. The turn around time for using the OT, Dialysis should be worked out and displayed.

A flow chart of the above MICROPLAN is annexed as Annexure-4.

Annexure-1

Screening Format

- Such format should be tagged to the case sheet of the patient
- Suspected: Fulfilling any one (or more) of the points forscreening - Red Tag
  (Red tag patients will be kept in these wards till the nasal/throat swab report for COVID-19 comes out to be positive or negative. It will take 12-24 hours) .
- Not fulfilling any one of the points forscreening -Green Tag
- These wards should have preferably separate chambers/rooms with separate toilets. If separate rooms are not available, patients should be kept at least 2m apart from each other.

Name: Sex: Address:	Age: ID: Mobile No.:

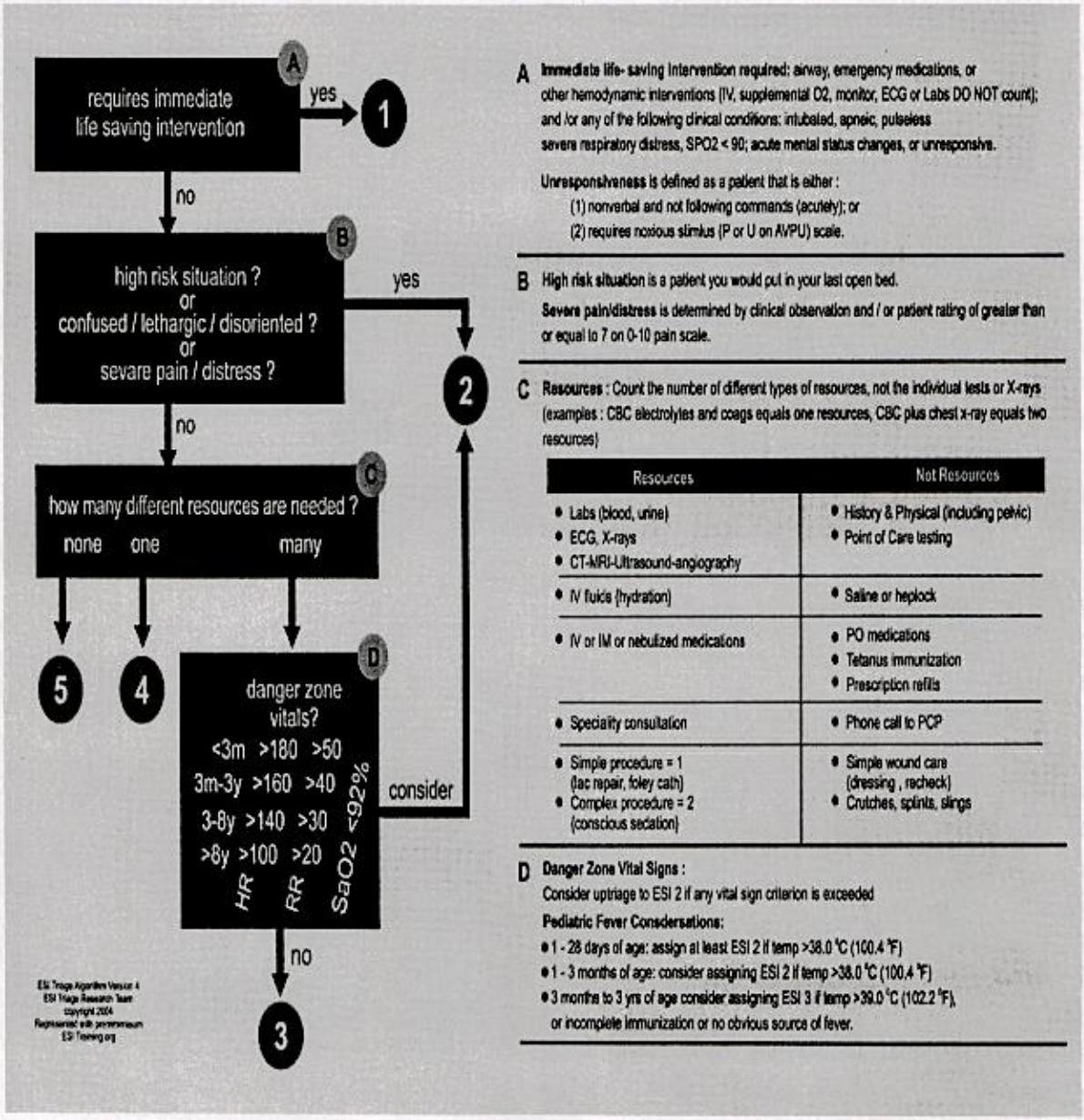
Tag Green: Red:	(Yes/No)
Fever?Sore throat, cough, breathlessness	
International travel within 28 days?	
Contact with COVID-19 positive person/from hotspot area/ large migration gathering/evacuee centre?	
Participation and/or contact with TabliqiJamaat within a month?	
All suspected health care workers.	
Screen for SARI?	
Antibody testing for COVID-19?	

Annexure 2:

General Guidelines

1. Training of all medical and paramedical staff is mandatory.
2. Strict protocol of safety for medical and paramedical staff.
3. Protocol for sanitation and disinfection is applicable to all places according to guidelines.
4. Infection prevention control is a critical and integral part of managing such patients starts from point of entry and standard precautions including hand hygiene, use of PPE & N-95 masks and avoiding direct contact with the patients and patients body fluids and secretion should be practiced.
5. Droplet precautions should also be taken care of.
6. Dedicated equipment like stethoscopes, Infrared/handgun thermometers and BP instrument should be used.
7. Standard precautions must also include prevention of injury, safe waste management, cleaning and disinfection of equipment.
8. Environmental cleaning is a part of precaution and ensure disinfection procedure consistently and correctly.
9. Bio-medical Waste Management: All PPEs, face masks and gloves worn during sampling to be incinerated (yellow bin). Rest of all plastics should be autoclaved (red bin)
10. Separate Laundry facility should be available.
11. Wherever possible disposable sheet should be used.
12. Laundry of active quarantined to be soaked in 0.5% hypochlorite for 30 minutes followed by wash by hot water.(70 degree C)
13. Departments like cardiology, Gynaecology & Obstetrics, radiotherapy, and dialysis units should follow the standard protocol for staff, sanitation, disinfection and protection. - Should have dedicated and fully equipped ward with separate entry/exit, Dedicated COVID positive OT and labour room to be earmarked.
14. Radiotherapy: Should have dedicated and fully equipped ward with separate entry/exit.
15. Dialysis Unit: Should have dedicated and fully equipped ward with separate entry/exit. Dedicated dialysis machine for the patients.
16. All COVID positive precautions must be strictly followed and all staff members should be monitored for COVID-19infection.
17. Doctors, technicians, nursing staff, inserting lines in such patients should wear PPE. Rest of all staff can maintain a safe distance with standard precautions
18. All departments should have round the clock services with trained paramedical and medical staff.
19. All dedicated OTs/ Cath Labs/wards/labour rooms should have separate donning and doffing rooms.

Annexure-3



A **Immediate life- saving intervention required:** airway, emergency medications, or other hemodynamic interventions (IV, supplemental O2, monitor, ECG or Labs DO NOT count); and /or any of the following clinical conditions: intubated, apneic, pulseless severe respiratory distress, SPO2 < 90; acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient that is either :

(1) nonverbal and not following commands (acutely); or

(2) requires noxious stimlus (P or U on AVPU) scale.

B **High risk situation** is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and / or patient rating of greater than or equal to 7 on 0-10 pain scale.

C **Resources :** Count the number of different types of resources, not the individual tests or X-rays (examples : CBC electrolytes and coags equals one resources, CBC plus chest x-ray equals two resources)

Resources	Not Resources
• Labs (blood, urine) • ECG, X-rays • CT-MRI-Ultrasound-angiography	• History & Physical (including pelvic) • Point of Care testing
• IV fluids (hydration)	• Saline or heplock
• IV or IM or nebulized medications	• PO medications • Tetanus immunization • Prescription refills
• Speciality consultation	• Phone call to PCP
• Simple procedure = 1 (lac repair, foley cath) • Complex procedure = 2 (conscious sedation)	• Simple wound care (dressing , recheck) • Crutches, splints, slings

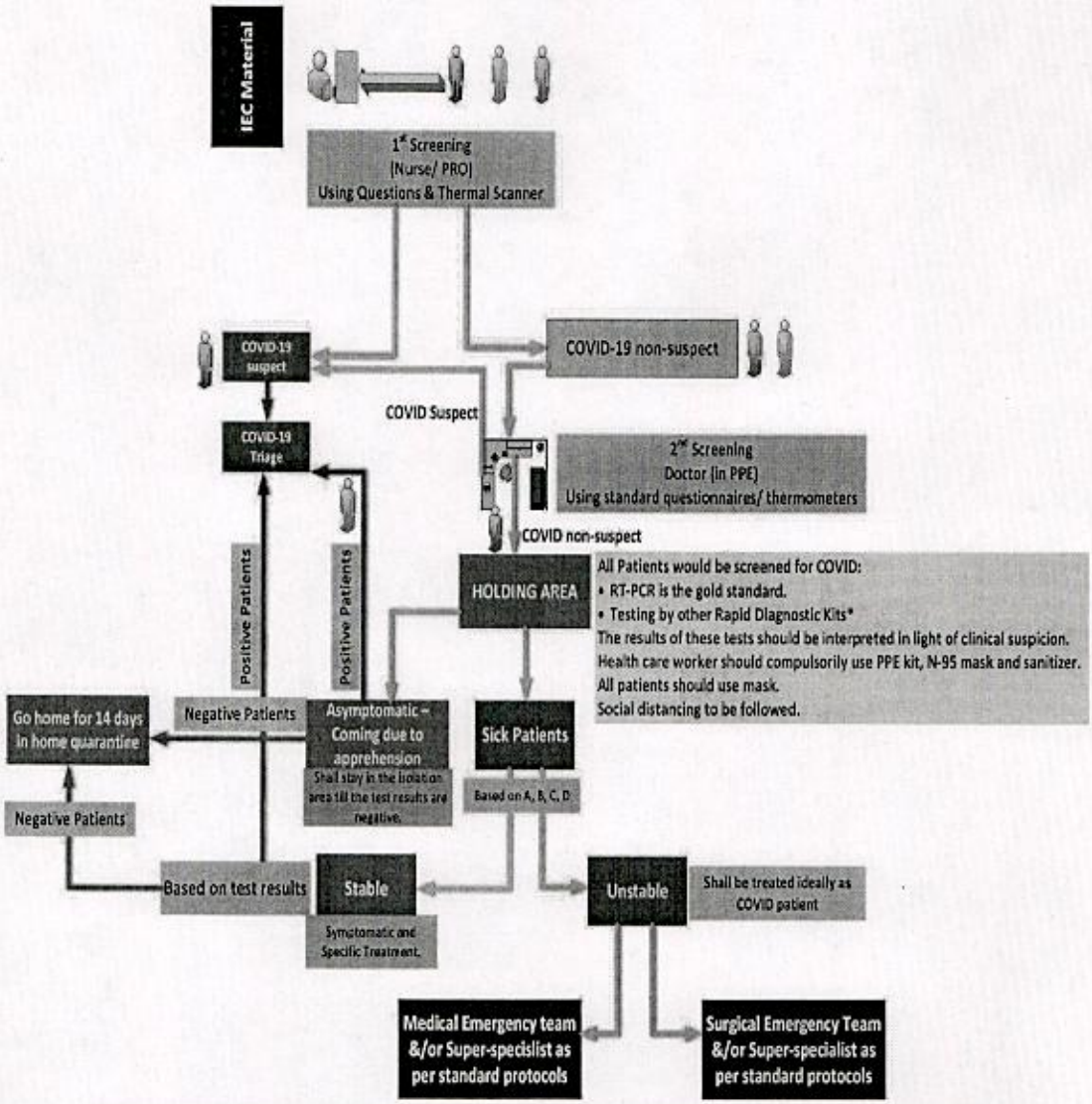
D **Danger Zone Vital Signs :**

Consider uptriage to ESI 2 if any vital sign criterion is exceeded

Pediatric Fever Considerations:

- 1 - 28 days of age: assign at least ESI 2 if temp >38.0 °C (100.4 °F)
- 1 - 3 months of age: consider assigning ESI 2 if temp >38.0 °C (100.4 °F)
- 3 months to 3 yrs of age consider assigning ESI 3 if temp >39.0 °C (102.2 °F), or incomplete immunization or no obvious source of fever.

Annexure-4



- 8-12 hourly duties for 14 days is recommended with 14 days quarantine.
- The beds/ dialysis machine/ OT/ etc. should be earmarked for suspect cases.
- All health care workers to use full protective measures; all patients to use masks and sanitizers.
- Toilets to be sanitized regularly.

Annexure-2

Ministry of Health & Family Welfare
Directorate General of Health Services
EMR Division

Guidelines to be followed on detection of suspect/confirmed COVID-19 case in a non-COVID Health Facility

1. Background

There have been some instances of hospitals having closed down as few health care workers (HCW) working there turned out to be positive for COVID -19. Also some non-COVID health facilities have reported confirmation of COVID-19, in patients admitted for unrelated/non-respiratory illness, causing undue apprehension among healthcare workers, sometimes leading to impaired functionality of such hospitals.

Although Ministry of Health & Family Welfare has issued comprehensive guidance to prevent occurrence of Hospital Acquired Infection(HAI) in health facilities, the practice of universal precautions might still be lacking in many of our hospitals.A COVID-19 case with mild/asymptomatic/atypical presentation may go undetected and inadvertently transmit the infection to other patients and healthcare workers, putting these individuals at risk of contracting disease and compromise the functionality of the healthcare facility.

2. Purpose of document

This document aims to provide guidance on action to be taken on detection of suspect/confirmed COVID-19 case in a healthcare facility.

3. Scope

This document in intended for both (i) COVID-19 healthcare facilities (public and private) which are already receiving or preparing to receive suspected or confirmed COVID-19 patients as well as (ii) Non-COVID healthcare facilities.

4. Institutional arrangement

The Hospital Infection Control Committee (HICC) has well-defined composition, roles and responsibilities. This committee is responsible for establishing a mechanism for reporting of development of symptoms suggestive of COVID-19 in HCW. These include surveillance for fever/cough/breathing difficulty through either self-reporting or active and passive screening at the beginning of their shift. The Committee will also monitor patients (who have been admitted for non-COVID illness) for development of unexplained fever/cough/breathing difficulty during their stay.

HICC will ensure that existing IPC guidelines against such high risk situations must be audited, updated and reiterated to all HCW. Further, all IPC guidelines will be strictly

adhered to and followed at all times. As a matter of abundant precautions for hospitals located in proximity/catering to COVID-19 containment zone/s it might be desirable to treat all patients as suspect COVID-19 case until proven otherwise and exercise standard care.

Whenever a non-COVID patient or any healthcare workers is suspected to have COVID like symptoms/tests positive for COVID-19, the HICC will come into action, investigate the matter and suggest further course of action as described below.

4.1 Action to be taken on detection of COVID -19 case in non-COVID health facility

When a positive COVID-19 patient is identified in a health care facility, not designated as COVID-19 isolation facility:

- Inform the local health authorities about the case
- Assess the clinical status of the patient prior to referral to a designated COVID facility
- The patient should be immediately isolated to another room (if currently being managed in a shared ward/room). If the clinical condition permits, such patients should be masked and only a dedicated healthcare worker should attend this case, following due precautions.
- If the clinical status of the case permits, transfer such case to a COVID-19 isolation facility (Dedicated COVID Health Centre or dedicated COVID Hospital), informing the facility beforehand about the transfer, as per his/her clinical status, test results (if available), with information to local health authority. Complete case records of such patients must be made available to the receiving hospital.
- Follow appropriate standard precautions while transporting the patient
- This should be followed by disinfection procedures at the facility and the ambulance
- All contacts of this patient (other patients being managed in the same room or ward, healthcare workers who have attended to him/her, support staff who may have come in close contact, caretaker/visitors etc.) should be quarantined and followed up for 14 days. Their details must also be shared with the local health authorities.
- All close contacts (other HCWs and supportive staff) of the confirmed case should be put on Hydroxychloroquine chemoprophylaxis for a period of 7 weeks, keeping in mind the contraindications of HCQ.
- If a healthcare worker is suspected to have contacted the disease, the following additional action needs to be performed.

4.2 When a suspect/confirmed COVID-19 HCW is identified

- HCWs developing respiratory symptoms (e.g. fever, cough, shortness of breath) should be considered suspected case of COVID-19.
- He/she should immediately put on a facemask, inform his supervisor and HICC. He/she should be isolated and arrangement must be made to immediately to refer such a HCW

to COVID-19 designated hospital (if not already working in such a facility) for isolation and further management.

- He/she should be immediately taken off the roster
- Rapidly risk stratify other HCWs and other patients that might have been exposed to the suspect HCW and put them under quarantine and follow up for 14 days (or earlier if the test result of a suspect case turns out negative). Their details must also be shared with the local health authorities.
- All close contacts (other HCW and supportive staff) of the confirmed case should be put on Hydroxychloroquine chemoprophylaxis for a period of 7 weeks, keeping in mind the contraindications of the HCQ.
- **All health facilities (HCF) must have a staffing plan in place including a contingency plan for such an event to maintain continuity of operations. E.g. staff in HCF can be divided into groups to work on rotation basis every 14 days and a group of back up staff which is pooled in case some high risk exposure/HCW with suspected COVID-19 Infection is detected.**
- Ensure that the disinfection procedures are strictly followed.

Once a suspect/confirmed case is detected in a healthcare facility, standard procedure of rapid isolation, contact listing and tracking disinfection will follow with no need to shut down the whole facility.

5. Decision on further /continued use of non-COVID facilities where a single/multiple COVID-19 case has been reported

The likely scenarios could be:

- **Socio-demographic reasons:**
  a) Hospital's catchment area is a large cluster of COVID-19.
  b) Catchment area is having a population which has a large number of vulnerable individuals having multiple co-morbid condition, poor nutritional status and/or having individuals not able to practice social distancing e.g. slum clusters.

- **Internal Administrative Reasons:**
  a) The health facility is not up to the mark in IPC practices.
  b) Non-fulfilment of guidelines regarding triaging of patients in the outpatient department and emergency.

Based on the scope of the cluster and degree to which the hospital has been affected (HCW patients, and HCW contacts), degree of the risk to the patients visiting the hospital such as those with chronic diseases etc. the decision can be made based on a risk assessment to:

- If the hospital authorities are reasonably satisfied that the source case/s have been identified and isolated, all contacts have been traced and quarantined and adequate disinfectionhas been achieved, the hospital will continue to function.
- In addition to steps taken above, if the health facility still continues to report new hospital acquired COVID-19 cases in the following days, it would be advisable to temporarily close the defined section of the health facility where the maximum number of HAI is being reported. After thorough cleaning and disinfection it can be put to use again.
- Despite taking the above measures, if the primary source of infection could not be established and /or the hospital is still reporting large number of cases among patients and HCWs a decision needs to be taken to convert the non-COVID health facility into a COVID healthfacilityunder intimation to the local health department.In such a scenario, the entire healthcare workers of the facility should be oriented in Infection Prevention and Control practices for which guidance is available at www.mohfw.gov.in.

6. Follow up actions

When a non-COVID health facility reports a COVID-19 case, the HICC will ensure the following in order to minimize the possibility of an undetected contact/case amongst other patients/HCWs:

- Ensure that active screening of all staff at the hospitals is done daily (by means of thermal screening especially at the start of shift)
- All healthcare and supportive staff is encouraged to monitor their own health at all the time for appearance of COVID-19 symptoms and report them at the earliest.
- Be on the lookout for atypical presentation (or clinical course) of admitted patients
- Standard precautions to be followed diligently by all
- Follow all guidelines regarding triaging of patients in hospital emergency and outpatient departments.