

## **Belgian COVID-19 testing strategy in the context of viral respiratory infections prevention in all circumstances (pandemic, epidemic, endemic) for healthcare activities, nursing homes and long term care facilities**

*Open Urgent consultation validated by mail on 12/05/2023*

At the urgent request of the Interministerial Conference (IMC) on Public Health and the Risk Management Group (RMG) of the Federal Public Service (FPS) Health, the Superior Health Council (SHC) proposes an urgent Open Consultation on the Belgian COVID-19 testing strategy to prevent viral respiratory infections in all circumstances (pandemic, epidemic, endemic) in healthcare activities, nursing homes and long term care facilities (LTCF).

This urgent Open Consultation is not a classic SHC advisory report and only engages the responsibility of the signatories of the document who have approved it by consensus and by email. It is not intended to be made public in its current state without following all the quality procedures of the SHC. A broader advisory report (SHC 9749: Comprehensive management of COVID-19 patients in health care institutions and common standard procedures for the prevention of severe acute respiratory infections - SARI) is underway and will include the main recommendations of this urgent document.

In order to ensure an optimal coordination of the Belgian recommendations to the Authorities and the professionals in the field, a consultation is set up between the SHC, experts from Sciensano, experts from the Risk Assessment Group (RAG) and experts from the Strategic Scientific Committee (SSC).

These recommendations could be adapted to the **particularities of the hospital, nursing homes and long term care facilities**, regarding the specificities of the clinical services and **type of care**, some people from **the population at risk** of severe COVID-19 infections (SHC-9622 pregnancy, 2020; SHC-9618 risk groups under 65 years of age, 2021; SHC-9691 immunocompromised patients - IC, 2022), the **local hygiene procedures** and the **health personnel and health facilities equipment available**.

Some SARI are seasonal but other less. The late autumn-winter is more critical for the health care system with the onset of some SARI approximatively during the same period. These recommendations should be re-evaluated according to the **epidemic situation**, the **level of transmission** and **in the event of a new variant with different characteristics** (higher proportion hospitalizations/ICU). Then, the testing strategy might be reviewed again, within the frame of the preparedness strategy as described in March 2022<sup>1</sup>.

Actually, the epidemiological situation is evaluated by the RAG (see reports [NL](#) and [FR](#)). The RAG proposed to decrease the management **from level 2 to level 1 on April 13 2023**, which was approved by the RMG and effective as of April 20 2023.

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<sup>1</sup> [https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth\\_theme\\_file/note\\_rmg\\_-\\_depistage\\_isolement\\_et\\_quarantaine\\_strategie\\_moyen\\_terme\\_20220307.pdf](https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/note_rmg_-_depistage_isolement_et_quarantaine_strategie_moyen_terme_20220307.pdf)

## 1. List of abbreviations

BMT	Bone Marrow Transplantation
CDC	Centers for Disease Control and Prevention - US
CFS	Clinical Frailty Scale
COVID-19	Coronavirus disease 2019
Ct	Cycle threshold - estimation of the viral load
FFP2	Filtering facepiece 2 masks
FPS	Federal Public Service - BE
GVHD	Graft-versus-host disease
HCW	Health Care Workers
HHC	Hospital Hygiene Committee
OST	Outbreak Support Team
IC	Immunocompromised
ILI	Influenza-like Illness
IMC	Interministerial Conference on Public Health - BE
IPC	Infection Prevention and Control
KRINKO	<i>Kommission für Krankenhaushygiene und Infektionsprävention - DE</i>
LTCF	Long Term Care Facilities
PBSCT	Peripheral Blood Stem Cell Transplantation
PCR	Polymerase Chain Reaction
PPE	Personal Protective Equipment
PPV	Positive Predictive Value
RAG	Risk Assessment Group - BE
RAT	Rapid Antigenic Testing
RMG	Risk Management Group – BE
RSV	Respiratory Syncytial Virus
SARI	Severe Acute Respiratory Infection
SARS-CoV2	Severe Acute Respiratory Syndrome Coronavirus 2
SF2H	<i>Société Française d'Hygiène Hospitalière - FR</i>
SHEA	Society for Healthcare Epidemiology of America - US
SPAR	<i>Société Française d'Anesthésie et de Réanimation - FR</i>
SHC	Superior Health Council - BE
SSC	Strategic Scientific Committee – BE
VE	Vaccine Effectiveness
WHO	World Health Organization - INT

## 2. Epidemiological and scientific background

The expert group uses the following epidemiological evidence to make its recommendations:

- Epidemiologic indicators reflecting low circulation of SARS-CoV-2 (low incidence in the population; low number of nosocomial COVID-19 cases and low number of patients hospitalized with a diagnosis of COVID-19 in conventional and critical care);
- Highly immunized population (post-vaccination/post-infection);
- Easy access to vaccines and early curative treatment;
- Overall less severe clinical prognosis with Omicron variants (and different sublineages) especially for immunocompetent populations.

The urgent document also draws heavily on the following international publications:

- *SF2H - Société Française d'Hygiène Hospitalière. Recommandations relatives aux indications du diagnostic de la COVID-19 par biologie moléculaire en milieu hospitalier - Version 1 \_ 28/02/2023 – France*  
<https://www.sf2h.net/publications/recommandations-relatives-aux-indications-du-diagnostic-de-la-covid-19>
- *SF2H - Société Française d'Hygiène Hospitalière. Note relative à la protection des patients et des professionnels en contexte COVID-19 - Version du 08/05/2023*  
<https://www.sf2h.net/note-relative-a-la-protection-des-patients-et-des-professionnels-en-contexte-covid-19>
- ECDC - European Centre for Disease Prevention and Control. Considerations for infection prevention and control in relation to respiratory viral infections in healthcare settings. 6 February 2023. ECDC: Stockholm; 2023.  
<https://www.ecdc.europa.eu/sites/default/files/documents/Considerations%20for%20IPC%20respiratory%20viral%20infections%20in%20HC%20settings.pdf>
- CDC - Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic – 08/05/2023  
[Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\) | CDC](https://www.cdc.gov/infection-control/control-recommendations-for-healthcare-personnel-during-the-coronavirus-disease-2019-pandemic)

### 3. Introduction

With the actual COVID-19 pandemic slowing down after 3 years and the removal, by the World Health Organization (WHO), this Friday May 5, of the maximum global alert level for Covid-19, requests have been made by (health) care workers, patients, residents, visitors and Belgian authorities for further adaptation of the Belgian COVID-19 testing strategy. These recommendations are part of a general context of "normalization" of the COVID-19 risk in the same way as other viral respiratory infectious diseases, including influenza and respiratory syncytial virus (RSV) infections.

The urgency of the decision to be made in this regard is also guided by a need to harmonize scientific procedures and recommendations at the national level and by the significant financial impact of the current strategy on the health care budget.

An adapted synthesis of the COVID-19 tests performed in Belgium is available in the recent RAG report: COVID-19 Testing strategy - Update May 2023 - RAG meeting 08/05/2023. According to the work of Sciansano, the main conclusions concerning COVID-19 tests are:

- The majority of tests currently performed **remain PCR**, on average 87% of the tests performed during the period 22-28/04/2023 were PCR.
- Among tests for which the prescription reason is known, tests **for possible cases of COVID-19** and tests **for screening in hospital setting** remain the most important indications for which a PCR test is done (although the proportion of tests for screening in hospital setting has decreased in comparison with the end of 2022 – 4.877 PCR tests in April 2023 vs 14.141 tests in November 2022).
- Tests for screening in hospital setting remain almost exclusively (97%) PCR tests.
- Regarding tests for possible cases of COVID-19, 61,6% of those tests performed are PCR and 38,2% are RAT.
- For the majority of PCR tests (54.000/86.000), **there is no linked prescription**, and therefore no prescription reason available. The proportion of PCR tests without linked prescription has increased steadily for private labs. In hospital labs this proportion has only increased slightly.
- The majority of PCR tests are performed in hospital labs.

The objectives of these recommendations are therefore to position the COVID-19 screening or PCR diagnostic test in order to:

- **Make a clinical diagnosis** and thus be able to adapt the medical management of the patient according to the test result (benefit for the patient);
- **Prevent nosocomial transmission between patients/residents and (HCW) health care workers** (benefit for patients and caregivers within a department and/or institution);
- **Monitor the evolution and severity of clusters** within a department and/or institution (benefit for patients, caregivers and institutions).

Literature data that emphasize the value of universal screening for COVID-19 (including screening of asymptomatic individuals) prior to hospitalization (Talbot et al., 2023; Klompas et al., 2021; Brody et al., 2021; Moreno-Pérez et al. 2021) or preoperatively (COVIDSurg Collaborative, 2020; Deng et al., 2022; Haffner et al., 2021; Prasad et al., 2022; Le et al., 2022) come **from studies conducted during the early waves of the COVID-19 pandemic** (prior to vaccination and/or prior to circulation of the

Omicron variant and its sublineages). Furthermore, the results of an SFAR (*Société Française d'Anesthésie et de Réanimation*) study on the impact of preoperative Omicron variant COVID-19 on postoperative respiratory morbidity in a predominantly vaccinated population, concluding that **there was no additional risk in a majority of surgical patients**, allowing for a reduction in the preoperative screening strategy for certain asymptomatic patients (Garnier et al., 2023).

The Society for Healthcare Epidemiology of America (SHEA) recommends **against routine universal use of asymptomatic screening for SARS-CoV-2 in healthcare facilities**. Specifically, preprocedure asymptomatic screening is unlikely to provide incremental benefit in preventing SARS-CoV-2 transmission in the procedural and perioperative environment when other infection prevention strategies are in place, and it should not be considered a requirement for all patients. **Admission screening may be beneficial during times of increased virus transmission in some settings where other layers of controls are limited** (eg, behavioral health, congregate care, or shared patient rooms), but widespread routine use of admission asymptomatic screening is not recommended over strengthening other infection prevention controls (Talbot et al., 2023; ECDC, 2023).

A non-balanced COVID-19 testing strategy could also have deleterious effects in a low viral circulation setting including (Lippi et al., 2021; Talbot et al., 2023):

- **Delayed management** (prolonged length of stay, delayed medical care, emergency room congestion – Kelen et al., 2021) in some hospitals depending on site organization and availability of molecular tests in emergency;
- **Disorganization of activity**: disruption of care pathways and deprogramming of scheduled surgeries in the context of suffering organizations;
- Difficulties in interpreting molecular tests with **false positives**, e.g., wrongly isolating non-contagious patients with low levels of viral RNA several weeks after infection, inappropriate antiviral treatment (Alsuhaibani et al., 2022 ; Uchida et al., 2021 ; Esserman et al. 2014) or **false negatives**: a patient incubating 48-72 hours before surgery may be incubating and positive the day of surgery, false security impression;
- **Costs** (Alsuhaibani et al., 2022; Abbas et al., 2022);
- **Laboratory constraints-stains** for specimen collection and testing (personnel and equipment).
- **Risk of creating social inequalities** if the cost of testing is de-reimbursed and paid for directly by the patient. Only patients with better financial means would have to pay for the test.
- **Risk of overuse and interpretation** for example in case of no respect of international and national laboratory guidelines (Dufour et al., 2022).

The performance of molecular tests for SARS-CoV-2 **has been validated in symptomatic patients and not in asymptomatic patients** (Cevik et al., 2023).

The performance of diagnostic tests **depends on prevalence**: the positive predictive value (PPV) decreases when prevalence decreases (Srinivasan et al., 2022).

**Sickness presenteeism (working while sick) among HCW** risks nosocomial infection, but its prevalence among HCW with COVID-19 is unknown. Contemporaneous interviews revealed a **sickness presenteeism prevalence of 49.8%** among 255 HCW with symptomatic COVID-19. Sickness presenteeism in HCWs likely contributes to nosocomial transmission of respiratory viruses (Linsenmeyer et al. 2023).

More recently, Cuypers and collaborators (2023) conclude that **a multi-layered strategy, including environmental sampling, immunomonitoring and early antiviral therapy**, should be considered to prevent post-vaccination COVID-19 mortality in nursing homes.

#### 4. In which health care settings and clinical situations should this guideline apply?

- **Hospitals:** acute, rehabilitation, psychiatric, pediatric, etc.
- **Other (health) care collectivities:** LTCF, home for disabled persons, nursing homes, handicapped homes, etc.
- **Ambulatory health care:** private clinic or consultation with a general practitioner, specialist, dentist, pharmacy, home nursing, physiotherapist, psychologist, etc.
- **Medical transport and emergency intervention.**

These guidelines can be adjusted to the specific situation in the field and are left to the discretion of the care institutions and the hospital's hygiene committee depending on the type of patients and especially on the risk analysis specific to the hospital or care communities.

Given the particular challenges of 'finding the equilibrium between protection and quality of life', the implementation of these recommendations in the diverse LTCF may need to be discussed with the local responsible (eg. resident's physician, coordinating physician of the LTCF) and locally relevant stakeholders (e.g. Outbreak Support Teams - OST-teams). An equilibrium needs to be sought between protection of the vulnerable, prevention of transmission and outbreaks and well-being or respectful quality of life.

For ambulatory care, medical transport and emergency intervention or in the absence of a risk analysis, these general guidelines should be applied everywhere in Belgium and in a uniform way to facilitate the understanding and the adherence of patients and caregivers to them.

As is already the case for hand hygiene, respiratory hygiene and cough etiquette<sup>2</sup>, use of antibiotics, vaccination, mask\* wearing, etc., a coordinated information and awareness campaign will be necessary for staff in care institutions, communities, outpatients, patients and the general population. The latter should be particularly focused at times of transition from one level to another.

\* In this document, when 'masks' are mentioned, surgical masks are meant. Filtering facepiece 2 (FFP2) masks are kept for the care of patients with suspected or proven airborne transmission (COVID-19, tuberculosis, measles, etc.) and during aerosol-generating procedures. Moreover as the debate on the FFP2 superiority for protection in Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV2)-transmission is still ongoing (Li et al., 2021 ; Jefferson et al., 2023).

<sup>2</sup> <https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>

## 5. To whom should this guideline apply?

- **Patients in hospitals**
  - With no additional risk of severe COVID-19
  - With additional risk of severe COVID-19 defined for COVID-19 testing strategy as:
    - **Severe geriatric patients and CFS - Clinical Frailty Scale** (Church et al., 2020; Wernly et al., 2023; Pranata et al., 2020; Rottler et al., 2022; Kastora et al., 2021; Tam et al., 2022; Hussien et al., 2021; Dumitrascu et al., 2021)

**Older residents of care homes** (where frailty is common) were particularly suffering enormously from this pandemic with high rates of admission to hospital and associated high inpatient mortality and morbidity. It soon became clear that the whole epidemiology of COVID-19 incidence, severity of illness and mortality seem to be shifted towards older people particularly those with **multiple comorbidities** such as diabetes, hypertension, and cardiovascular disease. Nevola and collaborators (2023) show that predictors factors associated with higher mortality were older age (P <0.0001), presence of active hematologic malignancies (P <0.0001), renal failure (P <0.041), and need for O2 therapy (P <0.001).

Frailty was also an independent predictor of viral pneumonia {relative risk (RR) 3.06, P = 0.01} which also highlights the role of frailty in institutionalised populations for the increased risk of viral illness. Vaccine Effectiveness (VE) against symptomatic infection is lower in patients with frailty compared to the robust and prefrail groups, and that the peak effectiveness of the vaccine is also delayed. The waning of vaccine effectiveness was also more pronounced in patients with frailty compared with the robust and prefrail groups (Sinclair, 2023).

**Frail patients presented atypical symptoms** (less dry cough, myalgia-arthralgia, and anosmia-dysgeusia, and more confusion). Frailty was an independent predictor for death, regardless of severity, and mild-moderate frailty was associated with hospitalization and readmission (Marti-Pastor et al., 2023 ; Zhu et al., 2022 ; Azevedo et al., 2022). Although frailty has been endorsed as a tool to inform estimates of COVID-19 risk, it may have a broader role in primary care and public health by identifying people who may benefit from interventions to reduce health and social impacts of COVID-19 and future pandemics (Griffith et al., 2022 ; Zhang et al., 2021). Moreover, small studies show that one out of three older patients previously hospitalized for COVID-19 had an unfavorable transition in Clinical Frailty Scale (CFS) score during a median follow-up of nearly 6 months. Specific interventions **to prevent frailty development or progression** should be considered for patients at risk (Ferrara et al., 2023 ; Morandi et al., 2023).

Parrotta and collaborators (2023) show that hyperactive delirium at hospital admission is related with markers of lung failure among older adults, especially when physical frailty coexists. Delirium is associated with **increased in-hospital mortality risk**, which is doubled by the coexistence of physical frailty. Frailty assessment may help to guide COVID-19 prognosis and individualized care planning, but data relating frailty status to patient-reported outcomes are urgently needed to provide a more comprehensive overview of outcomes relevant to older adults including in case of delirium (Dumitrascu et al., 2022).

Halaweh and Ghannam (2022) show in a systematic review and meta-analysis that age and frailty are important risk factors for mortality among older adults COVID-19 patients. COVID-19 patients with sarcopenia had a higher risk of developing severe conditions, including hospitalization and ICU admission. Findings that support the use of frailty and sarcopenia indicators to help in the decision-making process for medical care in older adults COVID-19 patients.

Yokoro and collaborators (2023) highlight the importance of dietary support for vulnerable populations, such as older and frail adults.

**In conclusion, frailty is an independent predictor of mortality among patients with COVID-19.** Thus, frailty could be a prognostic factor for clinicians to stratify high-risk groups and remind doctors and nurses to perform early screening and corresponding interventions urgently needed to reduce mortality rates in patients infected by SARS-CoV-2 (Zhang et al., 2021). More recently, Keeney and collaborators (2023) show that claims-based frailty was not significantly associated with survival but was associated with follow-up hospitalizations and Medicare expenditures.

This CFS fragility scale could be integrated into the BelRAI® initiative launched by Belgian public health authorities. ([BelRai](#)) in this context.

### CFS - Clinical Frailty Scale

Church et al., 2020; Wernly et al., 2023; Pranata et al., 2020; Rottler et al., 2022; Kastora et al., 2021; Tam et al., 2022; Hussien et al., 2021; Dumitrascu et al., 2021

CLINICAL FRAILTY SCALE		
	<b>1</b>	<b>VERY FIT</b> People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	<b>2</b>	<b>FIT</b> People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.
	<b>3</b>	<b>MANAGING WELL</b> People whose medical problems are well controlled, even if occasionally symptomatic, but often are not regularly active beyond routine walking.
	<b>4</b>	<b>LIVING WITH VERY MILD FRAILTY</b> Previously "vulnerable," this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up" and/or being tired during the day.
	<b>5</b>	<b>LIVING WITH MILD FRAILTY</b> People who often have more evident slowing, and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
	<b>6</b>	<b>LIVING WITH MODERATE FRAILTY</b> People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	<b>7</b>	<b>LIVING WITH SEVERE FRAILTY</b> Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
	<b>8</b>	<b>LIVING WITH VERY SEVERE FRAILTY</b> Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	<b>9</b>	<b>TERMINALLY ILL</b> Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise living with severe frailty. (Many terminally ill people can still exercise until very close to death.)

  

SCORING FRAILTY IN PEOPLE WITH DEMENTIA	
<p>The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.</p>	<p>In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.</p> <p>In severe dementia, they cannot do personal care without help.</p> <p>In very severe dementia they are often bedfast. Many are virtually mute.</p>

  

<p><b>DALHOUSIE UNIVERSITY</b></p>	<p>Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: <a href="http://www.geriatricmedicine.ca">www.geriatricmedicine.ca</a></p> <p>Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.</p>
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## CONCLUSION

According to the data and frailty assessment scales for the elderly available and reviewed in the literature for COVID-19, the SHC proposes **that the cut-off point for eligibility for a screening or diagnostic PCR test for this group of very old and frail patients is CFS scores 5 and above**.

For people with a score of 8 or 9, the performance of a screening or diagnostic PCR test must be considered in respect of the difficult balance to be found between direct benefit (utility, quality of life) for the patient and the need to prevent nosocomial infections via other general hygiene measures in place.

→ For example, a person over 90 with severe comorbidities (terminal cancer), permanently bedridden and with a very unfavorable short- and/or medium-term vital prognosis.

As with the management of the general population, age and the presence of other severe comorbidities are other independent predictive factors of severe outcomes to be evaluated by the treating physician to adapt this general strategy to the specific diagnostic needs of patients, especially for score categories 1 to 4.

→ For example, a 75-year-old with obesity, diabetes and mild to severe hypertension, but who would still be independent in the main aspects of his life.

- **Severe immunocompromised (IC) patients (KRINKO, 2022 - Risk groups 2 and 3)**

Severe immunocompromised patients corresponding to risk groups 2 and 3 (Krinko, 2022) with a **specific attention to patients and units that manage transplanted patients** (especially lung and kidney), patients with hematological cancer, patients with low cellular immunity and patients on immunosuppressive immunotherapy. The specific situation of individual patients and the corresponding risk of infection **can change in the course of treatment**. Individual patients can move between risk groups depending on their clinical treatment situation (e.g. induction vs. consolidation therapy, recurrence of leukaemia, preparation for and execution of stem cell transplantation after conventional treatment). **This means that it may be necessary for doctors to amend the risk group in their risk analysis.** This allocation concept suggested by the KRINKO must not be confused with other clinical risk scores or stages of disease.

**Risk group 1 (moderate immunosuppression/-deficiency)**

- Neutropenia  $<0.5 \times 10^9/L$ ; ( $<500/\mu L$ ) expected to last up to 10 days (comparable to leukopenia  $<1 \times 10^9/L$ ;  $<1,000/\mu L$ )
- Up to three months after day 0 of autologous stem cell transplantation (the day the stem cells are returned to the patient)
- Decrease in CD4-positive T-helper cells to  $<200/\mu L$  (caution: normal levels that are commensurate vary with age for children); up to three months after the intensive treatment phase of autologous stem cell transplantation.

*Patients with more than one of the features of immunosuppression/-deficiency listed for risk group 1 are assigned to risk group 2.*

**Risk group 2 (severe immunosuppression/-deficiency)**

- Neutropenia  $<0.5 \times 10^9/L$ ; ( $<500/\mu L$ ) for more than 10 days (comparable to leukopenia  $<1 \times 10^9/L$ ;  $<1,000/\mu L$ )
- Severe aplastic anaemia or macrophage activation syndrome during intensive immunosuppressive therapy
- Up to 6 months after completion of the intensive treatment phase of allogeneic bone marrow or stem cell transplantation (important: severity of GVHD and intensity of ongoing iatrogenic immunosuppression)
- Acute inpatient treatment phase of autologous stem cell transplantation or after solid organ transplantation (until discharge).

**Risk group 3 (very severe immunosuppression/-deficiency)**

- Intensive treatment phase of allogeneic BMT/PBSCT (until engraftment=regeneration of granulopoiesis)
- Severe grade III or IV GVHD with intensive immunosuppression.

*The decision to assign patients who have undergone allogeneic stem cell transplantation to group 3 is ultimately taken by their haemato-oncologists after a review of all findings.*

- **Donors and recipients of tissue-organ-cells**

Linked to this advice, another specific SHC opinion will be published, providing transplant centers and establishments of substances of human origin with specific recommendations on how to deal with donors and acceptors with anamnesis of COVID-19 or positive SARS-CoV-2 testing.

- **Residents in other (health) care collectivities**
- **Health care workers with direct patient contact:** medical, paramedical, cleaning, maintenance, etc.
- **Other workers in health care settings without direct patient contact:** administrative, kitchen, technical department, laboratory, etc.
- **Visitors and accompanying persons**

## 6. Epidemiological considerations, integrated indicators and thresholds and management tool

The translation of the actual epidemiological situation into the management levels is discussed on a regular basis at the RAG epidemiology meeting, and approved by the RMG. The combination of epidemiological indicators that exist for COVID-19, Influenza (ILI and SARI), RSV, , etc. should progressively be used to define thresholds for signaling the change from levels 1, 2 or 3 of these recommendations. It is RAG's responsibility to define these combined epidemiological thresholds and then guide the decisions of the RMG and the Authorities. This way we could evolve from mere Covid-19 levels to more generic respiratory risk levels. These levels will be re-evaluated on a regular basis. An example could be the launch of the 'Hitteplan' according to temperatures and ozon levels.

For these reasons, the RAG has adapted the indicators and thresholds in a new advice from March 2023. : **INDICATORS AND THRESHOLDS FOR AN INTEGRATED MANAGEMENT TOOL COVID-19 & RESPIRATORY VIRUSES - RAG – February 2023, Update March 2023**

[https://covid-19.sciensano.be/sites/default/files/Covid19/20230403\\_RAG\\_Update\\_Integrated\\_thresholds.pdf](https://covid-19.sciensano.be/sites/default/files/Covid19/20230403_RAG_Update_Integrated_thresholds.pdf)

The Management Tool with 3 management levels serves as a guidance to implement the necessary measures by the competent authorities:

- A) **Management level 1/yellow**: epidemiological situation under control. There is virus circulation but at a low level and with no impact on the healthcare system (first and second line).
- B) **Management level 2/orange**: increasing circulation with incipient pressure on the healthcare system; intervention is needed to reverse the trend again.
- C) **Management level 3/red**: very high virus circulation with a high risk of overloading the healthcare system.

The RAG proposed to decrease the management tool **from level 2 to level 1 on April 13 2023**, which was approved by the RMG and effective as of April 20 2023.

*Remark: the indicators and management tool are regularly evaluated, and the RAG is currently discussing the objectives, the added value and feasibility of such an integrated management tool on the long term (from the autumn/winter season of 2023). For the future it is important to see how these indicators and this management tool evolve and to evaluate if recommendations according to management levels are still relevant for the testing strategy part of all SARIs.*

## 7. Recommendations

**PERMANENTLY** and to be considered as the new ‘standard precautions’

1) **Standards precautions for all**: respiratory hygiene, cough etiquette, hand hygiene.

2) **Standards precautions for anyone (patient and workers) with symptoms of a respiratory infection**: should wear a mask, should apply standards precautions for all and should avoid going to health care institutions, if possible.

2) **Protective precautions for severely immunocompromised (IC)**: masks wearing and possibly single room depending of the individual risk analysis (KRINKO, 2022).

This document concerns only single **COVID-19 testing by polymerase chain reaction (PCR - molecular screening) on nasopharyngeal swab** and does not concern the place of:

- COVID-19 rapid antigenic testing (RAT)
- COVID-19 rapid antigenic testing (Autotest)
- Combined PCR multiple respiratory pathogens testing

### **Levels definition according to the thresholds of SARI determined by RAG for the RMG** **03/05/2023**

Some SARI are seasonal but other less. The late autumn-winter is more critical for the health care system with the onset of some SARI approximatively during the same period. These recommendations should be re-evaluated according to **the epidemic situation, the level of transmission** and in the event of **a new variant with different characteristics** (higher proportion hospitalizations/ICU). Then, the testing strategy might be reviewed again, within the frame of the preparedness strategy as described in March 2022<sup>3</sup>.

**Definition of a symptomatic person with a possible COVID-19 infection is available via**

FR : [COVID-19 - Définition de cas et testing | Coronavirus Covid-19 \(sciensano.be\)](#)

NL : [COVID-19 - Gevalsdefinitie en testing | Coronavirus Covid-19 \(sciensano.be\)](#)

<sup>3</sup> [https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth\\_theme\\_file/note\\_rmg\\_-\\_depistage\\_isolement\\_et\\_quarantaine\\_strategie\\_moyen\\_terme\\_20220307.pdf](https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/note_rmg_-_depistage_isolement_et_quarantaine_strategie_moyen_terme_20220307.pdf)

## Management level 1

Epidemiological situation under control. There is virus circulation but at a low level and with no impact on the healthcare system (first and second line)

The indication is based on both **the expected benefit for the patient concerned and the benefit for the patients who will be in contact with him/her, depending on the local situation** (availability of single rooms, other preventive measures in place, etc.).

**Regardless of the clinical situation and the person concerned, in level 1 risk situations, COVID-19 PCR testing (screening or diagnostic) should be prescribed by the patient's doctor and/or the Hospital Hygiene Committee (HHC) and/or the coordinating physician of LTCF and nursing homes. A positive test must be based on a complete clinical evaluation of the symptoms and accompanied by additional measures to monitor and manage the patient (option to treat), as well as measures tailored to the clinical situation to prevent nosocomial infections.**

For major risk and symptomatic patients, if the COVID-19 PCR test comes back negative, testing for other respiratory viruses (Influenza A/B, RSV, etc.) should be performed for differential diagnostic purposes and appropriate patient management as determined by the patient's physician.

### A) Limited indications for COVID-19 screening of asymptomatic individuals by PCR

In Level 1 risk and management, routine PCR screening of asymptomatic persons is no longer recommended in any clinical situation and in any place of care or residence except for a few very limited indications.

**A.1.) Hospitalisation of severe IC patients**, if possible in dedicated units, and especially **if the local situation does not allow isolation in a single room and puts them in contact with other severe IC patients** (impossible to put these patients in single rooms). Wherever possible, it is important to prioritize access to single rooms for these patients in risk groups 2 and 3, and if possible, in dedicated units (KRINKO, 2022). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9174886/>

The KRINKO recommends: "Accommodating neutropenic patients in risk groups 1 and 2 in a single or twin room with ensuite sanitary facilities, but not larger units (three or more patients per room), and carefully observing basic hygiene measures. As paediatric haemato-oncology patients are regularly admitted with a parent (companion caregiver), their rooms should be large enough for a folding bed to be set up next to the bed without excessively obstructing their care (particularly at night) or creating additional transmission risks. Accommodating patients in risk group 3 in a single room with ensuite sanitary facilities and specific ventilation measures".

Severe immunocompromised patients corresponding to risk groups 2 and 3 (Krinko, 2022) with a **specific attention to patients and units that manage transplanted patients** (especially lung and kidney), patients with hematological cancer, patients with low cellular immunity and patients on immunosuppressive immunotherapy. The specific situation of individual patients and the corresponding risk of infection **can change in the course of treatment**. Individual patients can move between risk groups depending on their clinical treatment situation (e.g. induction vs. consolidation therapy, recurrence of leukaemia, preparation for and execution of stem cell transplantation after conventional treatment). **This means that it may be necessary for doctors to amend the risk group in their risk analysis**. This allocation concept suggested by the KRINKO must not be confused with other clinical risk scores or stages of disease.

**Risk group 1 (moderate immunosuppression/-deficiency)**

- Neutropenia  $<0.5 \times 10^9/L$ ; ( $<500/\mu L$ ) expected to last up to 10 days (comparable to leukopenia  $<1 \times 10^9/L$ ;  $<1,000/\mu L$ )
- Up to three months after day 0 of autologous stem cell transplantation (the day the stem cells are returned to the patient)
- Decrease in CD4-positive T-helper cells to  $<200/\mu L$  (caution: normal levels that are commensurate vary with age for children); up to three months after the intensive treatment phase of autologous stem cell transplantation.

*Patients with more than one of the features of immunosuppression/-deficiency listed for risk group 1 are assigned to risk group 2.*

**Risk group 2 (severe immunosuppression/-deficiency)**

- Neutropenia  $<0.5 \times 10^9/L$ ; ( $<500/\mu L$ ) for more than 10 days (comparable to leukopenia  $<1 \times 10^9/L$ ;  $<1,000/\mu L$ )
- Severe aplastic anaemia or macrophage activation syndrome during intensive immunosuppressive therapy
- Up to 6 months after completion of the intensive treatment phase of allogeneic bone marrow or stem cell transplantation (important: severity of GVHD and intensity of ongoing iatrogenic immunosuppression)
- Acute inpatient treatment phase of autologous stem cell transplantation or after solid organ transplantation (until discharge).

**Risk group 3 (very severe immunosuppression/-deficiency)**

- Intensive treatment phase of allogeneic BMT/PBSCT (until engraftment=regeneration of granulopoiesis)
- Severe grade III or IV GVHD with intensive immunosuppression.

*The decision to assign patients who have undergone allogeneic stem cell transplantation to group 3 is ultimately taken by their haemato-oncologists after a review of all findings.*

**A.2.) Donors and recipients of tissue-organ-cells**

- Deceased donors → YES PCR screening before donation
- Living organ donors → YES PCR screening before donation

For living donors, routine PCR testing of asymptomatic donors is no longer recommended. Diagnostic PCR testing is recommended for symptomatic living donors.

Linked to this advice, another specific SHC opinion will be published, providing transplant centers and establishments of substances of human origin with specific recommendations on how to deal with donors and acceptors with anamnesis of COVID-19 or positive SARS-CoV-2 testing.

For information about blood donation and covid-19 cf. SHC 9579 of 01/06/2020

<https://www.health.belgium.be/fr/avis-9579-systeme-transfusionnel-covid19>

### **A.3.) Possibility of screening asymptomatic people in the event of a cluster (see dedicated table)**

#### **B) Transfer of patients between hospitals and LTCF or Nursing homes**

In level 1 risk and management, systematic PCR screening of asymptomatic persons for transfer between hospital and LTCF or nursing homes or vice versa **can no longer be required by LTCF and nursing homes or hospitals as a criterion for accepting patient mobility.**

#### **C) Surgery and vaccination**

The prevalence of anti-SARS-CoV-2 antibodies in Belgium is > 90.0% (Van den Houte et al. 2022). Belgian vaccination coverage (first booster) [for people over 18 is currently 76%, rising to 91% for people over 65](#) (Sciensano as at 14/05/2023). Omicron variants (and different sublineages) show an overall less severe clinical prognosis, especially for immunocompetent populations. Despite these positive developments, countries such as France, the USA, etc. continue to recommend screening asymptomatic patients before surgery, and still propose postponing non-urgent surgery in the event of positive PCR results by several days to a few weeks when possible, including with the Omicron variant.

For example, according to SH2F in France: « *Tous les patients qui entrent en hospitalisation pour une chirurgie sous anesthésie générale devraient être vaccinés. Les chirurgies lourdes avec ventilation mécanique pour des patients non vaccinés et/ou très immunodéprimés (Pinato et al., 2022) et/ou gériatriques sévères (Zhang et al., 2021) et/ou avec une chirurgie à haut risque respiratoire présentent toujours un risque accru lors d'une chirurgie (SH2F, 28/02/2023) ».*

In these situations, and **despite the additional surgical risk** (El-Boghdadly et al., 2022; Barie et al., 2023; Glasbey et al., 2022; Lieberman et al., 2022), systematic COVID-19 screening by PCR in asymptomatic individuals prior to surgery **is no longer recommended in Belgium by the SHC at level 1 risk** (Garnier et al., 2023).

Nonetheless, unvaccinated individuals **should now sign an informed consent form acknowledging** that the absence of full vaccination could entail an additional surgical risk, even if this is probably less significant with Omicron variants.

To facilitate discussion with patients on this topic, [a model of communication risk when considering surgery within 7 weeks of SARS-CoV-2 infection](#) is given for information (El-Boghdadly et al., 2022).



People <u>asymptomatic</u> for COVID-19 or other ILIs, SARIs (PCR screening)						
Clinical situation	Patients	Patients	HCW	Workers	Residents	Visitors
	<u>without major risk</u>	<u>with major risk</u> limited to some <b>IC patients</b> (risk gr. 2-3) - <b>Tissue Organ Donation</b>	<u>with contact</u>	<u>without contact</u>	<u>without major risk</u> LTCF Nursing Home etc.	
<b>Hospitals</b> * Consultation * Day hospitalization * Conventional hospitalization <u>with or without surgery</u> * Intensive care hospitalization	No PCR screening	No PCR screening <b>except for point A)</b>	No PCR screening	No PCR screening	n.a.	No PCR screening
<b>Other (health) care collectivities</b>	n.a.	No PCR screening	No PCR screening	No PCR screening	No PCR screening	No PCR screening
<b>Medical transport and emergency intervention</b> * Emergency Department	No PCR screening	No PCR screening <b>except for point A)</b>	No PCR screening	No PCR screening	n.a.	No PCR screening
<b>Ambulatory health care</b>	No PCR screening	No PCR screening	No PCR screening	No PCR screening	No PCR screening	No PCR screening

**D) Indications for COVID-19 diagnostic of symptomatic individuals by PCR**

- **Symptomatic patients with a major risk (IC – KRINKO risk groups 2-3 and Geriatric - CFS 5 to 9)** should be tested with a COVID-19 diagnostic PCR test **in any clinical situation** and **in any place of care or residence**.
- **Symptomatic patients without major risk** should be tested with a COVID-19 diagnostic PCR test **before staying in hospitals** (conventional hospitalization with or without surgery and intensive care hospitalization).
- **Symptomatic HCW with patient contact** should be tested with a COVID-19 diagnostic PCR test in any clinical situation and in any place of care.
- **Symptomatic residents without major risk** in LTCF, nursing homes, etc.: particularly for these situations and in order to avoid "unnecessary" tests, COVID-19 PCR testing for diagnostic should be prescribed by the patient's doctor and/or the coordinating physician of LTCF and nursing homes. A positive test must be based on a complete clinical evaluation of the symptoms and accompanied by additional measures to monitor and manage the patient (option to treat), as well as measures tailored to the clinical situation to prevent nosocomial infections.

According to the data and frailty assessment scales for the elderly available and reviewed in the literature for COVID-19, the SHC proposes **that the cut-off point for eligibility for a screening or diagnostic PCR test for this group of very old and frail patients is CFS scores 5 and above**.

For people with a score of 8 or 9, the performance of a screening or diagnostic PCR test must be considered in respect of the difficult balance to be found between direct benefit (utility, quality of live) for the patient and the need to prevent nosocomial infections via other general hygiene measures in place.

→ For example, a person over 90 with severe comorbidities (terminal cancer), permanently bedridden and with a very unfavorable short- and/or medium-term vital prognosis.

As with the management of the general population, age and the presence of other severe comorbidities are other independent predictive factors of severe outcomes to be evaluated by the treating physician to adapt this general strategy to the specific diagnostic needs of patients, especially for score categories 1 to 4.

→ For example, a 75-year-old with obesity, diabetes and mild to severe hypertension, but who would still be independent in the main aspects of his life.

**People symptomatic for COVID-19 or other ILIs, SARIs (PCR diagnostic)**

<b>Clinical situation</b>	<b>Patients</b>	<b>Patients</b>	<b>HCW</b>	<b>Workers</b>	<b>Residents</b>	<b>Visitors</b>
	<u>without major risk</u>	<u>with major risk</u> limited to some <b>IC</b> (risk gr. 2-3) and <b>Geriatric</b> (CFS 5 to 9) patients	<u>with contact</u>	<u>without contact</u>	<u>without major risk</u> LTCF Nursing Home etc.	
<b>Hospitals</b> * Consultation * Day hospitalization	No PCR diagnostic  <b>except medical advice to the contrary</b>	Diagnostic PCR	<b>If possible, no work</b>  - Mask - Cough etiquette - Hand hygiene - etc.  Reduce risk contacts  Diagnostic PCR	<b>If possible, no work</b>  - Mask - Cough etiquette - Hand hygiene - etc.  Teleworking, etc.  No PCR diagnostic	n.a.	<b>If possible, no visit</b>  - Mask - Cough etiquette - Hand hygiene - etc.  No PCR diagnostic
<b>Hospitals</b> * Conventional hospitalization <u>with or without surgery</u> * Intensive care hospitalization	Diagnostic PCR	Diagnostic PCR	<b>If possible, no work</b>  - Mask - Cough etiquette - Hand hygiene - etc.  Reduce risk contacts  Diagnostic PCR	<b>If possible, no work</b>  - Mask - Cough etiquette - Hand hygiene - etc.  Teleworking, etc.  No PCR diagnostic	n.a.	<b>If possible, no visit</b>  - Mask - Cough etiquette - Hand hygiene - etc.  No PCR diagnostic

<p><b>Other (health) care collectivities</b></p>	<p>n.a.</p>	<p>Diagnostic PCR</p>	<p><b>If possible, no work</b></p> <ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>Reduce risk contacts</p> <p>Diagnostic PCR</p>	<p><b>If possible, no work</b></p> <ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>Teleworking, etc.</p> <p>No PCR diagnostic</p>	<p><b>Reinforce cough hygiene measures for everyone!</b></p> <p>Diagnostic PCR If prescribed by the patient's doctor or the coordinating physician.</p> <p>complete <u>clinical evaluation</u></p> <p><u>monitor and manage the patient</u> (option to treat)</p> <p><u>prevent nosocomial infections</u></p>	<p><b>If possible, no visit</b></p> <ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>No PCR diagnostic</p>
<p><b>Medical transport and emergency intervention</b> * Emergency Department</p>	<p>No PCR diagnostic</p> <p><b>except medical advice to the contrary</b></p>	<p>Diagnostic PCR</p>	<p><b>If possible, no work</b></p> <ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>Reduce risk contacts</p> <p>Diagnostic PCR</p>	<p><b>If possible, no work</b></p> <ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>Teleworking, etc.</p> <p>No PCR diagnostic</p>	<p>Diagnostic PCR</p> <p><u>Before</u> in LTCF or <u>After</u> at the arrival to the hospital or emergency department and in case of high probability of hospitalization</p> <p><b>Results Communication !!!!</b></p>	<ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>No PCR diagnostic</p>

<p><b>Ambulatory health care</b></p>	<p>No PCR diagnostic  <b>except medical advice to the contrary</b></p>	<p>Diagnostic PCR</p>	<p><b>If possible, no work</b></p> <ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>Reduce risk contacts</p> <p>Diagnostic PCR</p>	<p><b>If possible, no work</b></p> <ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>Teleworking, etc.</p> <p>No PCR diagnostic</p>	<p><b>Reinforce cough hygiene measures for everyone!</b></p> <p>Diagnostic PCR If prescribed by the patient's doctor or the coordinating physician.</p> <p><u>complete clinical evaluation</u></p> <p><u>monitor and manage the patient</u> (option to treat)</p> <p><u>prevent nosocomial infections</u></p>	<p><b>If possible, no visit</b></p> <ul style="list-style-type: none"> <li>- Mask</li> <li>- Cough etiquette</li> <li>- Hand hygiene</li> <li>- etc.</li> </ul> <p>No PCR diagnostic</p>
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**Cluster : occurrence of at least 2 nosocomial cases (healthcare-associated infections) over a 14-day period**

- **in the same unit**
- **with suspected transmission between patients and/or staff**

**Hospitals**

In the event of a cluster, heightened vigilance and rapid, intensive measures must be taken on all wards **with severe geriatric patients (CFS 5 to 9) and severe IC patients (Krinko risk groups 2 and 3).**

SPECIAL ATTENTION for clusters in geriatrics, oncology, transplantation, etc.

**1) Generic recommendations for everyone and every department**

- PCR diagnosis of **all symptomatic patients and staff**
- Management and monitoring of cluster developments: rapid mobilization of teams and HHC, reporting to authorities, contact tracing, risk level analysis, implementation of management strategy, etc.
- If possible, identification of the source person and possible sites of contamination
- Reinforced rapid protection measures for HCW staff with at least:
  - \* patient and visitor information
  - \* surgical masks
  - \* hand hygiene
  - \* passive ventilation of premises
- **Discharged patients**: inform LTCF and nursing homes, attending physicians and people in charge at the destination of the patient's cluster discharge situation, whether positive or negative.

**2) Management proposals to be adjusted on the basis of local risk assessment**

- Possibility of systematic PCR screening **for asymptomatic patients**, depending on the units at risk and the evolution of the cluster (IC, geriatrics, oncology, transplantation, etc.).
  - \* screening to be carried out at D0 and D5
  - If no new cases, stop screening
  - If new cases, continue screening at D10

	<ul style="list-style-type: none"> <li>- Possibility of systematic PCR screening <b>of asymptomatic HCW staff</b> to be discussed at local level <ul style="list-style-type: none"> <li>* screening at D0 and D5</li> </ul> </li> <li>- Additional <b>reinforced protection measures</b> possible <ul style="list-style-type: none"> <li>* replace surgical masks with FFP2 masks</li> <li>* restricted access to the unit for visitors</li> <li>* isolation and cohorting of patients with dedicated staff <ul style="list-style-type: none"> <li>* increased cleaning</li> <li>* reinforced PPE?</li> </ul> </li> </ul> </li> <li>* aeration/ventilation? (Jefferson et al. 2011 ; Talbot et al. 2023 ; CDC : « Respiratory Infection Control Measures », 2009)</li> <li>- <b>Incoming patients:</b> as far as possible, adjust bed and admission management and consider a full medical history and/or possible pre-admission screening.</li> </ul>
<p><b>Other (health) care collectivities</b></p>	<p>Given the particular challenges of ‘finding the equilibrium between protection and quality of life’, the implementation of these recommendations in the diverse LTCF may need to be discussed with the local responsible (eg. resident’s physician, coordinating physician of the LTCF) and locally relevant stakeholders (e.g. Outbreak Support Teams - OST-teams). An equilibrium needs to be sought between protection of the vulnerable, prevention of transmission and outbreaks and well-being or respectful quality of life.</p> <p><b>1) Generic recommendations <u>for everyone</u></b></p> <ul style="list-style-type: none"> <li>- PCR diagnosis of <b>all symptomatic patients and staff</b></li> <li>- Management and monitoring of cluster developments: rapid mobilization of teams and HHC, reporting to authorities, contact tracing, risk level analysis, implementation of management strategy, etc.</li> <li>- If possible, identification of the source person and possible sites of contamination</li> <li>- Reinforced rapid protection measures for HCW staff <u>with at least:</u> <ul style="list-style-type: none"> <li>* patient and visitor information <ul style="list-style-type: none"> <li>* surgical masks</li> <li>* hand hygiene</li> </ul> </li> <li>* passive ventilation of premises</li> </ul> </li> </ul>

## 2) Management proposals based on local risk assessment

Draw on management proposals for hospitals and adapt them to preserve quality of life as far as possible. Important role for the coordinating physician, OST and the relevant health authorities. Particular attention should be paid to the **proportionate application** of strict isolation measures and to limiting access to visitors and residents' movements in living areas, **as justified by the risks involved**.



**Isolation measures in case of a positive COVID-19 PCR test  
in healthcare activities, nursing homes and long term care facilities**

- **Visitors and accompanying persons:** Apply current rules for the general population (IMC Public Health of 26/04/2023 - No more isolation recommended by the authorities). **If possible, no visit** to hospital and other (health) care collectivities especially with patients or residents at risk. If impossible, mask wearing, cough etiquette, hand hygiene, physical distance (1.5m), etc.
- **HCW without patient contact:** Apply current rules for the general population (IMC Public Health of 26/04/2023 - No more isolation recommended by the authorities). **If possible, no work**. If impossible, mask wearing, cough etiquette, hand hygiene, physical distance (1.5m), teleworking, etc.
- **HCW with patient contact:** **If possible, no work for 7 days (professional distance) + 3 days mask caution** for work-related activities and patient contact. For their private activities, Apply current rules for the general population (IMC Public Health of 26/04/2023 - No more isolation recommended by the authorities). **If professional distance of 7 days is impossible**, HCW with symptoms of respiratory virus contamination may work at their place of work if :
- Wearing a surgical mask in the workplace;
  - Reinforced rate hygiene;
  - Reinforced hand hygiene;
  - Maintaining a physical distance of at least 1.5m from other people (meals, shared activities, etc.);
  - Personal equipment should not be shared (e.g. Bic, pencil, erasers, etc.);
  - Organize work in such a way as to limit contact with immunocompromised and/or fragile patients or colleagues as much as possible;
  - Remain vigilant for the appearance of new symptoms (temperature, cold, fever, cough, headache, loss of smell or taste) and consider isolation 7d + 3d prudence masque if this were the case.
- **All residents in other (health) care collectivities:** Given the particular challenges of ‘finding the equilibrium between protection and quality of live’, the implementation of these recommendations in the diverse LTCF may need to be discussed with the local responsible (eg. resident’s physician, coordinating physician of the LTCF) and locally relevant stakeholders (e.g. Outbreak Support Teams - OST-teams). An equilibrium needs to be sought between protection of the vulnerable, prevention of transmission and outbreaks and well-being or respectful quality of life. Particular attention must be taken to ensure that strict isolation measures and restrictions on visitor access and resident movement in living areas are **proportionate and justified in relation to the risks**.

If possible and justified in terms of risk, the SHC recommends **5 to 7 days' isolation + 3 days' mask-wearing precaution**, especially **for group activities and meals with other frail people**. Outdoor activities, while wearing a mask and maintaining a physical distance of 1.5 m, are of

course still possible, in order to maintain the best possible quality-of-life balance in these special living environments.

- ➔ **All patients in Hospital:** 10 days isolation
  
- ➔ **All geriatric patients:** 10 days isolation + test and if low viral load (Ct - Cycle threshold - estimation of the viral load  $\geq 28$ ) STOP isolation. If viral load is still high, continue isolation and check after 7 days.
  
- ➔ **All IC and ICU patients:** 21 days isolation + test and if low viral load (Ct - Cycle threshold - estimation of the viral load  $\geq 28$ ) STOP isolation. If viral load is still high, continue isolation and check after 7 days.

Notes: **local downward adjustments to these isolation criteria after a positive COVID-19 test are possible** if and only if:

- increased surveillance of nosocomial infections is in place and documented;
- standardized data are collected for local analysis and follow-up;
- if possible, official publication of these data to advance scientific knowledge on this subject for COVID-19 and other SARIs.

CIM Santé publique (26/04/2023 – FR)

<https://www.health.belgium.be/fr/news/cim-sante-publique-36>

**Covid-19 : l'obligation d'isolement après un test positif n'est plus requise.**

« Compte tenu de l'évolution favorable de la pandémie, la Conférence Interministérielle de Santé publique **a mis fin à l'obligation d'isolement automatique de 7 jours après un test COVID positif.** Désormais, une infection au COVID-19 sera abordée comme une grippe.

Les ministres soulignent qu'il est très important que **les personnes présentant des symptômes respiratoires (par ex. toux et fièvre) restent à la maison tant que ceux-ci persistent.** Si les symptômes sont graves, le médecin généraliste doit être contacté. **En cas de test COVID positif en l'absence de symptômes, les personnes ne doivent plus rester chez elles.**

**En cas de symptômes d'infection respiratoire (toux, éternuements...), il est toujours recommandé de porter un masque buccal, surtout en cas de contact avec des personnes âgées ou vulnérables.** D'autres recommandations d'hygiène visant à réduire la transmission des infections respiratoires, telles que **le lavage des mains et une bonne ventilation,** sont également recommandées. Il est important que vous vous protégez, que vous protégez vos collègues et que vous protégez les autres ».

IMC Volksgezondheid (26/04/2023 – NL)

<https://www.health.belgium.be/nl/news/imc-volksgezondheid-36>

**Covid-19: isolatieverplichting na positieve test niet langer vereist.**

“Gezien de gunstige evolutie van de pandemie heeft de Interministeriële Conferentie Volksgezondheid **een einde gemaakt aan de automatische verplichte isolatieperiode van 7 dagen na een positieve COVID-test.** Vanaf heden wordt een COVID-19 infectie benaderd zoals griep.

De Ministers benadrukken dat het zeer belangrijk is dat **mensen die respiratoire symptomen (bv. hoesten en koorts) hebben, thuis blijven zolang de symptomen aanhouden.** Indien de symptomen ernstig zijn, moet contact met de huisarts worden opgenomen. **In geval van een positief COVID-test in afwezigheid van symptomen moet men niet langer thuis blijven.**

**Bij symptomen van luchtweg infectie (hoest, niezen...) is het steeds aanbevolen om een mondneusmasker te dragen, vooral bij contact met oudere of kwetsbare mensen.** Ook andere hygiëneaanbevelingen om de overdracht van luchtweginfecties te beperken, zoals **handen wassen en goede ventilatie,** zijn aanbevolen. De eigen verantwoordelijkheid om je zelf, je collega's en anderen te beschermen is belangrijk”.

## **Management level 2**

Increasing circulation with incipient pressure on the healthcare system; intervention is needed to reverse the trend again

A ADAPTER plus tard fonction options du level 1 – juin-juillet 2023

## **Management level 3**

Very high virus circulation with a high risk of overloading the healthcare system

A ADAPTER plus tard fonction options du level 1 – juin-juillet 2023

## D) Existing guidelines

CDC 2009 : [Respiratory Hygiene/Cough Etiquette in Healthcare Settings | CDC](#)

CDC for HCW: [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\) | CDC](#)  
Comparable difference between high and low covid circulation, with/without symptoms

CDC - Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic – 08/05/2023. [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\) | CDC](#)

CDC - COVID-19 by County », 11/08/2022. <https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html>

ECDC - European Centre for Disease Prevention and Control. Considerations for infection prevention and control in relation to respiratory viral infections in healthcare settings. 6 February 2023. ECDC: Stockholm; 2023.

KRINKO - Commission for Hospital Hygiene and Infection Prevention (KRINKO). Infection prevention requirements for the medical care of immunosuppressed patients: recommendations of the Commission for Hospital Hygiene and Infection Prevention (KRINKO) at the Robert Koch Institute. GMS Hyg Infect Control. 2022 Apr 13;17:Doc07. doi: 10.3205/dgkh000410. PMID: 35707229; PMCID: PMC9174886.

SHC – Superior Health Council. Recommendations for vaccination against SARS-CoV-2 of pregnant women, women wishing to become pregnant, and breastfeeding women with a messenger RNA vaccine. Brussels: SHC; 2020. Report 9622.

SHC – Superior Health Council. Recommendations for prioritization of subgroups of patients under 65 years of age for vaccination against SARS-CoV-2 (phase Ib). Brussels: SHC; 2021. Report 9618.

SHC - Superior Health Council. Booster vaccination against COVID-19 for immunocompromised patients. Brussels: SHC; 2022. Report 9691.

SHC – Superior Health Council. Impact de la pandémie SARSCoV-2 sur le système transfusionnel. Bruxelles: CSS; 2020. Avis n° 9579.

Sciensano. INDICATORS AND THRESHOLDS FOR AN INTEGRATED MANAGEMENT TOOL COVID-19 & RESPIRATORY VIRUSES - RAG – February 2023, Update March 2023.  
[https://covid-19.sciensano.be/sites/default/files/Covid19/20230403\\_RAG\\_Update\\_Integrated\\_thresholds.pdf](https://covid-19.sciensano.be/sites/default/files/Covid19/20230403_RAG_Update_Integrated_thresholds.pdf)

SF2H - Société Française d'Hygiène Hospitalière. *Recommandations relatives aux indications du diagnostic de la COVID-19 par biologie moléculaire en milieu hospitalier - Version 1 \_ 28/02/2023 – France.* <https://www.sf2h.net/publications/recommandations-relatives-aux-indications-du-diagnostic-de-la-covid-19>

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WHO - Bureau Régionale de l'Europe, « Programmes de dépistage guide succinct, Accroître l'efficacité et optimiser le rapport entre bénéfices et effets nocifs », 2020. Licence : CC BY-NC-SA 3.0 IGO. Disponible à l'adresse <http://apps.who.int/iris>

UpToDate : « COVID-19: Epidemiology, virology, and prevention », Feb 16, 2023.

UpToDate : « COVID-19: General approach to infection prevention in the health care setting, Discontinuing infection control precautions for patients with COVID-19 in the healthcare setting », updated: Mar 13, 2023.

Cadre du travail Code - Livre I - Titre 4 - Mesures relatives à la surveillance de la santé des travailleurs. <https://emploi.belgique.be/sites/default/files/content/documents/Bien-%C3%AAtre%20au%20travail/R%C3%A9glementation/Code%20livre%201%20titre%204%20Mesures%20relatives%20%C3%A1%20la%20surveillance%20de%20la%20sant%C3%A9%20des%20travailleurs.pdf>

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## F) Experts approving this Open Urgent Consultation

The following experts were involved in drawing up and endorsing this Open Consultation report during the meeting of 27/01/2023 and by mail. The working group was chaired by **Anne SIMON** and **Hilde JANSENS**. The preparations for this meeting were made by Mr. Jean-Jacques DUBOIS (Born in Mons on 08 May 1969 - Deceased in Sirault on 22 January 2023). The scientific secretarial duties were performed by Ms. Muriel BALTES and Mr. Fabrice PETERS.

<b>BEELE Hilde</b>	Medicine, dermatology	UZ Gent
<b>BYL Baudouin</b>	Hospital hygiene, epidemiology	Erasme
<b>CROKART Zoé</b>	Nursing hospital hygienist	CHR de la CITADELLE
<b>DEMAITER Guido</b>	Nursing hospital hygienist	AZ Groeninge Kortrijk
<b>JANSENS Hilde</b>	Infection prevention and control, medical microbiology	UZA
<b>LAGROU Katrien</b>	Clinical Biologist	UZ Leuven
<b>MAERTENS DE NOORDHOUT Alain</b>	Neurology	CHU Liège
<b>SCHUERMANS Annette</b>	Hospital hygiene	UZ Leuven
<b>SIMON Anne</b>	Infection prevention and control	Groupe Jolimont
<b>STASSIJNS Jorgen</b>	Epidemiology, crisis management	Sciensano
<b>STEENSELS Deborah</b>	Clinical Biologist, infection prevention and control	ZOL
<b>VAN LAETHEM Yves</b>	Infectiology, Vaccinology, Travel medicine, HIV	CHU Saint-Pierre - Strategic Scientific Committee (SSC)
<b>VELGHE Yves</b>	Nursing hospital hygienist	CHU Brugmann

The following administrations and/or ministerial cabinets were heard by mail:

<b>VAN DER BORGHT Stefaan</b>	Adviser-Expert PHE SP - Public Health Emergencies	FPS Public Health RMG
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