

COVID-19: Guidance for the maintaining remobilisation of services within health and care settings

Infection prevention and control recommendations

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Commented [SD1]: Branding needs updated from HPS to ARHAI

About this guidance

The guidance is issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, [Health Protection Scotland \(HPS\)](#)/~~National Services Scotland~~, Public Health England (PHE) and NHS England as official guidance.

Commented [SD2]: ARHAI Scotland

Whilst this guidance seeks to ensure a consistent and resilient UK wide approach, some differences in operational details and organisational responsibilities may apply in Northern Ireland, England, Wales and Scotland.

Please note that this guidance is of a general nature and that an employer should consider the specific conditions of each individual place of work and comply with all applicable legislation, including the [Health and Safety at Work etc. Act 1974](#).

Previous Guidance: Version 3.2 18 June 2020. 'COVID-19: Infection Prevention and Control Guidance' Archived 20 August 2020. This guidance has been superseded by this publication.

Commented [LR3]: This will need updated to the Aug 2020 publication

New Guidance: Version 1 'COVID-19 Guidance for the Remobilisation of services within health and care settings: infection prevention and control (IPC) recommendations' August 20 2020.

Commented [LR4]: As above comment

The IPC principles in this document apply to all health and care settings, including acute, diagnostics, independent sector, mental health and learning disabilities, primary care, care homes, maternity and paediatrics (this list is not exhaustive).

NB: This guidance does NOT apply to adult social care settings in England. Adult social care providers in England should refer to [existing guidance](#) already in place. DHSC/PHE will continuously review this guidance and update as needed.

This IPC guidance will be updated in line with service need and as the evidence evolves. The administrative measures outlined in the guidance are consistent with World Health Organization ([WHO](#)) [guidance](#).

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[Version 1.0](#) First published 20 August 2020 (~~Version 1.0~~) [Version 1.1](#) published XX 2020 date

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COVID-19: infection prevention and control guidance

PHE publications gateway number: GW-1502

Key messages

This guidance is an amendment to the previous version [1.0](#) (20 August 2020). ~~Version 1.0) and the title change reflects the ongoing pandemic situation across the UK.~~

Local and national prevalence and incidence data will continue to be used to guide services as advised by country specific/public health organisations. [The identification of a new variants of concern strain of SARS-CoV-2 VOC-202012/01 and VOC-202012/02 across parts of the UK has been considered in this revision.](#)

This data will continue to be used to ensure patients/individuals treatment, care and support can be managed in the 3 COVID-19 pathways, which remain as:

- **High risk:** This includes patients/individuals who are confirmed COVID-19 positive by SARS-CoV-2 PCR test or [are](#) symptomatic [and](#) suspected to have COVID-19 (awaiting result).
- **Medium risk:** This includes patients/individuals who have a COVID-19 SARS-CoV-2 PCR test result [and but who](#) have no symptoms of COVID-19 and no recent COVID-19 [contact/exposure.](#)
- **Low risk:** [This includes patients/individuals who have been triaged/clinically assessed with no symptoms or known recent COVID-19 contact/exposure. This includes patients/individuals with no COVID-19 symptoms and a negative SARS-CoV-2 PCR test who have self-isolated prior to admission.](#)

[Sessional use of single use PPE/RPE items continues to be minimised and only applies to extended use of facemasks \(all pathways\).](#)

Sessional use of [FRSM](#) can be worn if providing care for cohorted COVID-19 patients, whilst sessional use of [FFP3 respirators \(with eye/ face protection\)](#) can be used [in AGP 'hot spot' areas i.e. where AGPs are frequently undertaken in cohorted areas in the medium and high risk pathway.](#)

[Sessional use of Respiratory Protection Equipment \(RPE\), can be used in areas such as critical care or 'aerosol generating procedures \(AGPs\) hot spot areas', where local or national prevalence/incidence of COVID-19 has increased.](#)

Commented [LR6]: Not sure how much detail needs to go in...

SARS-CoV-2 virus new variants of concerns 1. UK VOC122020/01, lineage B.1.1.7, first identified in Kent on 20/09/2020 2. UK VOC122020/02, lineage B.1.351 or 501Y.V2 first identified in South Africa in October 2020

Commented [MM7]: We still do not take into account risk due to exposure here.

Suggest:
This includes patients/individuals who do not have a COVID-19 SARS-CoV-2 PCR test result, but who have no symptoms of COVID-19 and no recent COVID exposure.

Commented [JM8R7]: Amended if agreed transfer to pathway

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Commented [SD9]: This seems like a less cautious criteria and doesn't match content of low risk pathway requirements below

Commented [SD10]: Doesn't only apply to facemasks as also applies to respirators and visors in AGP hotspots.

Commented [SD11]: Why not medium?

Commented [AG12]: Re-worded. Is this ok?

Commented [MM13]: I'm sure everyone knows by now, but 1st mention so require full terminology followed by brackets.

Commented [AG14]: Do we want to specify whether its national or local?

The use of face masks or face coverings¹ across the UK is recommended in addition to social distancing and hand hygiene for staff, patients/individuals and visitors in both clinical and non-clinical areas to further reduce the risk of transmission.

Patients in all care pathways in healthcare settings should be supported to wear a face mask, providing that it is tolerated and will not impact their medical or care needs. The wearing of facemasks by patients in healthcare settings must be supported by all care areas providing this is tolerated by patients/individuals and ensuring this is not detrimental to medical or care needs of the individual.

Physical distancing of 2 metres is considered standard practice in all health and care settings, unless providing clinical or personal care and wearing PPE.

Patients/individuals on a low risk pathway require Standard Infection Prevention Control Prevention Control Precautions (SICPs) for all care including surgery or procedures.

Testing for a All patients should be tested promptly for SARS-CoV-2 either at point of admission or as soon as possible/practical following admission is recommended in across all care the pathways for SARS-CoV-2.

The IPC principles in this document apply to all health and care settings including acute, diagnostics, independent sector, mental health and learning disabilities, primary care, care homes, care at home, maternity and paediatrics (this list is not exhaustive).

NB. This guidance does NOT apply to Adult Social Care settings in England. Adult social care providers in England should refer to existing guidance already in place. DHSC/PHE will continuously review this guidance and update as needed.

The IPC measures recommended are underpinned by the National Infection Prevention and Control Manual (NIPCM) practice guide and associated literature reviews. NHS England is using this an opportunity to introduce and adopt the NICPM as set out in the "UK Five-year Tackling Antimicrobial Resistance National Action Plan (2019-2024)."

¹ Each UK country has recommend that the general public. You must wear a face covering by law in some public places unless you are exempt from wearing a face covering due to your age, health or other condition. Each country also has guidance for facemasks/face coverings when working outside the clinical area in health and social care settings.

Commented [SD15]: Is this strong enough? Encouraged? Strongly advised?

Commented [GL(HW-N2C16R15)]: Agree as this point was laboured in discussion, and also say especially when mobile in a clinical area and during transport to other wards/depts

Commented [AG17]: Suggest
Patients in all care pathways in healthcare settings should be encouraged or supported to wear a face mask, providing that it is tolerated and will not affect their medical or care needs.

Commented [PG18R17]: OK with that

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Contents

About this guidance	2
Key messages	43
Contents	65
1. Explanation of the updates to infection prevention and control guidance	87
2. Introduction	109
2.1 Scope and purpose	109
3. Governance and responsibilities	121
4. COVID-19 Care pathways	131
4.1 Administration measures for the pathways	151
4.2 Community settings	181
4.3 Outpatient/primary/day care	181
5. Standard Infection Prevention Control Precautions (SICPs): all pathways or settings	201
5.1 Personal Protective Equipment (PPE)	211
6. Aerosol Generating Procedures: procedures that create a higher risk of respiratory infection transmission	252
7. Low Risk Pathway: Key principles	282
7.1 Maintaining physical distancing	282
7.2 Personal protective equipment	292
7.3 Safe management of environment/equipment and blood/body fluids	292
7.4 Aerosol Generating Procedures (AGPs): procedures that create a higher risk of respiratory infection transmission	312
7.5 Visitor guidance	312
8. Transmission Based Precautions (TBPs)	323
9. Medium Risk Pathway: Key principles	343
9.1 Maintaining physical distancing and patient placement	343
9.2 Personal protective equipment	353
9.3 Safe management of care environment/equipment/blood and body fluids	353
9.4 Aerosol Generating Procedures (AGPs) procedures that create a higher risk of respiratory infection transmission	383
9.4.1 Critical care areas	383
9.4.2 Operating theatres	383
9.5 Duration of transmission based precautions	383
9.6 Visitor guidance	383
9.7 Discharge or transfer	393
10. High Risk Pathway: Key principles	413
10.1 Patient placement	413
10.2 Personal protective equipment	423
10.2.1 Respiratory protective equipment (RPE) FFP3 (filtering face piece or hood):	423
10.2.2 Full body gowns or fluid repellent coveralls:	434
10.3 Safe management of care environment/equipment/blood and body fluids	434
10.4 Aerosol Generating Procedures that create a higher risk of respiratory infection transmission and operating theatres (including day surgery)	441
10.5 Duration of precautions	441

10.6 Visitor guidance	<u>4542</u>
10.7 Discharge or transfer	<u>4542</u>
11. Occupational health and staff deployment	<u>4744</u>
12. Glossary of terms	<u>4946</u>
Appendix 1. Sample triage tool	<u>5653</u>

1. Explanation of the updates to infection prevention and control guidance

Process for updating the guidance (as published on August 20 2020 revised version publication date December ...)

Commented [LR19]: January

The guidance is issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS)/National Services Scotland, Public Health England (PHE) and NHS England for health and care organisations as the UK moves to remobilise maintain healthcare services. The content is consistent with the administrative measures outlined in WHO IPC during healthcare when coronavirus disease (COVID-19) is suspected or confirmed: Interim Guidance, June 2020.

Commented [SD20]: ARHAI Scotland

The IPC measures recommended are underpinned by the National Infection Prevention and Control Manual practice guide and associated literature reviews
<http://www.nipcm.hps.scot.nhs.uk/>

Maintaining The remobilisation of services continues to require to require 'new ways' of working during the ongoing the ongoing pandemic. Continual assessment of the of the available evidence and feedback from guidance users, professional bodies and associations, has identified the amendments required to version 1.0 to assist in restoring supporting services in this 'new and changing' environment whilst COVID-19 remains a threat. This is based upon extant and emerging evidence, experience and expert opinion.

The main amendments to this version of the guidance are:

1. Sessional use of single use PPE/RPE items continues to be minimised and only applies to extended use of facemasks (all pathways). Sessional use of face protection (FRSM and eye protection) can be worn if providing care for cohorted COVID-19 patients, whilst sessional use of FFP3 respirators (with eye/face protection (face visors)) can be used in AGP 'hot spot' areas i.e. where AGPs are frequently undertaken in cohorted areas in the medium and high risk pathway
2. The use of facemasks (for staff) and facemasks/coverings (if tolerated by the patient/individual) is recommended across all care pathways in the UK, in addition to social distancing and hand hygiene for staff, patients/individuals and visitors in both clinical and non-clinical areas to further reduce transmission risk. Physical distancing of 2 metres remains standard practice in all health and care settings (unless

Commented [SD21]: As above. Doesn't make sense when we go onto say that it also applies to eye/face protection in AGP hotspots.

Commented [GL(HW-N2C22R21)]: Agree as the medium pathway designates single use or reusable eye protection for all AGP

Commented [SD23]: As above, why not medium?

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- providing clinical or personal care, in which case PPE should be worn in line with the pathway requirements).
3. Addition of a **dental appendix** to support the remobilisation/maintenance of this service across the UK.
 4. Addition of a **mental health/learning disability appendix** (for use in England only) to support remobilisation/maintenance of this service.
 5. AGP list has been clarified for: the neonatal population ~~AND~~ **and that** oral/~~pharyngeal~~ suctioning is not considered an AGP in any healthcare setting.
 6. Addition of the previous ~~stand-alone~~ **standalone** 'COVID-19: Guidance for stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings'
 7. Terminology change from 'shielding' to 'clinically extremely vulnerable' with the definitions highlighted in the glossary.
 8. Advice that valved respirators should not be worn by a healthcare worker/operator in a sterile area ~~s~~ such as theatres/surgical settings or when undertaking a sterile procedure such as a central line insertion, as the exhaled breath ~~is~~ **isn't** unfiltered.

9. 9. Updates to care pathways to recognise testing/exposure

Commented [GL(HW-N2C24): Do we need to say risk of SSI or infection as the risk sounds like its COVID by just saying unfiltered?

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2. Introduction

2.1 Scope and purpose

This document sets out the IPC advice for health and care organisations as the UK continues to ~~remobilise~~ maintain healthcare services during the ongoing pandemic.

The IPC principles in this document apply to all health and care settings, including the independent/private sector, mental health and learning disabilities, primary care areas, care homes, care at home, maternity and paediatrics (this list is not exhaustive, please refer to specific country resources for setting specific guidance). It includes key IPC control recommendations and includes risk assessed patient pathway scenarios to help guide the implementation of measures to provide safe and effective care locally and is based on the best available evidence.

This version is an amendment to the COVID-19 IPC version 1.0 guidance (20 August 2020) and has been updated to continue to support services. The challenge facing the NHS is to maintain ~~remobilise~~ healthcare services and ~~increase~~ NHS capacity whilst providing a safe and equitable service for staff, visitors and patients/individuals including those who may present with COVID-19, those who have recovered from COVID-19 and those with no history of COVID-19 until public health strategies such as mass vaccination are complete and any planned regular staff testing is functioning are complete.

~~The ongoing remobilisation (restarting) of~~ Maintaining services requires continuous review of ways of working to respond to the ~~continued~~ pandemic ~~and and, as COVID-19 becomes endemic;~~ guidance for working in a changing new environment ~~will need to be requires continuous and ongoing~~ development ~~ed and updated~~ based upon emerging evidence, experience and expert opinion.

Whilst this document seeks to ensure a consistent and resilient UK wide approach, some differences in operational details and organisational responsibilities may apply, where current legislation, guidance, for example clinical definitions, already exists. Links can be accessed in the resources below.

NB. This guidance does not apply to Adult Social Care settings in England given ~~existing guidance~~ for adult social care settings has already been provided and continues to be relevant. DHSC/PHE will continuously review this guidance and update as needed.

This document does not provide links throughout the sections, please follow the country specific resources, for example visiting guidance, testing, discharge policies.

IPC COVID-19 resources for:

- England can be found [here](#) and [here](#)
- Scotland can be found [here](#)
- Wales can be found [here](#)
- Northern Ireland can be found [here](#)

Commented [SD25]:

Commented [SD26R25]: Hyperlink to <http://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-infection-prevention-and-control-addendum-for-acute-settings/>

Further updates will be made to this document as new [data](#) emerges and as the COVID-19 alert levels change. -This is a scale of one to five which the UK Government uses to reflect the degree of threat to the country from the current coronavirus [pandemic](#).

Commented [LR27]: Is there a link to the alert levels here?

3. Governance and responsibilities

Organisations and employers including NHS Trusts, NHS Boards, Health and Social Care Trusts (Northern Ireland), Local Authorities, Independent Sector providers, through their Chief Executive Officer (CEO) or equivalent must ensure:

- **monitoring of IPC practices**, as recommended in this guidance, and ensure that resources are in place to implement [and measure adherence to](#) good IPC practice [and compliance](#). This must include all care areas and all staff (permanent, agency and external contractors).
- **testing and self-isolation strategies** are in place with a local policy for the response if transmission rates of COVID-19 increase.
- **training in IPC** measures are provided to all staff, including: the correct use of PPE (including a face fit test if wearing a filtering face piece (FFP3), respirator, and the correct technique for putting on and removing (donning/doffing) safely.
- **risk assessment(s)** is undertaken for any staff members in at risk or clinically extremely vulnerable groups, including pregnant and Black, Asian and Minority Ethnic (BAME) staff. Guidance on carrying out risk assessments can be found by following the links to the country-specific IPC COVID-19 resources on page 8 and 9.
- **patients/individuals at high risk/extremely high risk of severe** illness are protected from COVID-19. This must include consideration of families and carers accompanying patients/individuals for treatments/procedures.
- **health and care settings are COVID-19 secure** workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.

DISCLAIMER

When an organisation adopts practices that differ from those recommended/stated in this national guidance, that individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures, for example Integrated Care System level, Health Board.

4. COVID-19 Care pathways

These pathways (Table 1) are specific to the COVID-19 pandemic and are **examples** of how organisations may separate COVID-19 risks. It is important to note, that these pathways do not necessarily define a service to a particular pathway and should not impact the delivery and duration of care for the patient or individual. Moving patients between pathways should be based on their infectious status, clinical need, availability of services and this should be agreed locally. Implementation strategies must be underpinned by patient/procedure **risk assessment**, appropriate testing regimens (as per organisations or country specific) and epidemiological data.

Additional information on specific settings can be found in: NICE (2020) '**COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services**'

Screening triaging and testing within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. See Appendix 1 for an example of triage questions. Triage should be undertaken by clinical staff who are trained and competent in the application of the **clinical case definition** prior to arrival at a care area, or as soon as possible on arrival, and allocated to the appropriate pathway. This should include screening for other infections/multi-drug resistant organisms, including as per national screening requirements.

Infection risk and infection prevention and control (IPC) precautions, for example Standard Infection Control Precautions (SICPs) or Transmission Based Precautions (TBPs) must be communicated between care areas/pathways, including when discharge planning.

Patients with ~~other~~ respiratory symptoms should be assessed in a segregated area/ideally a single room pending test result to define the causative organism. ~~infections such as Influenza should not be cohorted with COVID-19 suspected or confirmed infections.~~

Commented [MM28]: Suggest removing the word screening and simply using 'triaging and testing'. This is not a screening programme and does not fulfil the criteria for one.

Commented [JM29R28]: We want to keep this consistent with WHO guidance which includes screening/triaging and testing – please keep as is outlined

Commented [MM30R28]: However the WHO guidance footnotes a definition of screening in this context ('refers to prompt identification of patients with signs and symptoms of COVID-19'). For the purposes of UK guidance I suggest this is overkill and easier to just remove the term screening. Particularly as this cuts across much other guidance (both PHE and NHS) where correct usage of the term 'screening' has been stipulated.

Commented [JM31R28]: UK IPC cell can you please advise on your opinion if we remove this

Commented [ED(HW-M32R28): I would support REMOVING the word screening for the same reason as Misha highlights above in UK screening is used for screening programmes and this is not what we are doing here – could add in the words "prompt identification of patients with signs and symptoms of COVID-19 or significant contacts of cases should be undertaken through triaging / testing within all health and other care facilities"

Commented [JM33R28]: removed

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Commented [JM34]: UK cell added this statement can you agree/amend

Commented [ED(HW-M35R34): At presentation you cannot tell always whether the patient is a suspected influenza or suspected COVID-19 therefore agree with the general principle, but would turn the sentence around to say patients with respiratory symptoms should be assessed in segregated area / ideally single room pending test results to define the causative organism.

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Table 1. Care pathways

High-Risk COVID-19 Pathway Section 10: SICPs & TBPs	Medium Risk COVID-19 Pathway Section 9: SICPs & TBPs	Low Risk COVID-19 Pathway Section 7: SICPs
Any care facility where: a) untriaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 PCR positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals who decline testing	Any care facility where: a) triaged/clinically assessed individuals are asymptomatic and are waiting a SARS-CoV-2 PCR test result OR b) triaged/clinically assessed individuals are asymptomatic with COVID-19 contact/exposure identified OR c) testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR d) asymptomatic individuals who decline testing	Any care facility where: a) triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact/exposure AND have a negative SARS-CoV-2 PCR test within 72 hours of treatment and, for planned admissions, have self-isolated <u>for from the required period or</u> from test date. OR b) Individuals who have recovered <u>(14 days)</u> from COVID-19 and have had at least 48 hours without fever or respiratory symptoms OR c) patients or individuals are part of a regular testing plan and remain negative and asymptomatic
• Designated areas within Emergency/Resuscitation Departments • GP surgeries/walk in centres • Facilities where confirmed or suspected/symptomatic COVID-19 individuals are cared, for example ◦ emergency admissions to inpatient areas (adult and children) ◦ Mental health ◦ Maternity ◦ Critical Care Units ◦ Renal dialysis units	• Designated areas within Emergency/Resuscitation, GP surgeries and walk-in centres • Non elective admissions • Primary care facilities, for example general dental and general practice • Facilities where individuals are cared, for example inpatients; adult and children, Mental health, Maternity, Critical Care Units • Outpatient depts. including Diagnostics and Endoscopy • Care homes* • Prisons • Renal Dialysis units	• Planned/elective surgical procedures including day cases • Oncology/chemotherapy patients and/or facilities • Planned in-patient admissions (adult and children), Mental health, Maternity • Outpatients including Diagnostics/Endoscopy • Care homes* • Prisons

Examples of patient (individual) groups/facilities within these pathways: these lists are not exhaustive

*This does NOT apply to Adult Social Care settings in England

4.1 Administration measures for the pathways

1. Establish separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas:
 - care areas (for example, ward, clinic, GP practice, care home) may designate self-contained area(s) or ward(s) for the treatment and care of patients/individuals at high, medium and low risk of COVID-19. Temporal separation may be used in clinics/primary care settings
 - as a minimum in smaller facilities or primary care outpatient settings physical/or temporal separation of patients/departments at high risk of COVID-19 from the rest of the facility/patients
2. Ensure that hygiene facilities IPC measures and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:
 - hand hygiene facilities including instructional posters
 - good respiratory hygiene measures
 - maintaining physical distancing of 2 metres at all times (unless wearing PPE due to clinical or personal care as per pathways)
 - Increased frequency of the decontamination of equipment and environment
 - consider improving ventilation by opening windows (natural ventilation) if mechanical ventilation is not available even if for short periods of time throughout the day
 - clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas. This will include:
 - use of face masks/ coverings by all outpatients (if tolerated) and visitors when entering a hospital, GP/dental surgery or other care settings.
 - Encouraging the use of a surgical facemask ~~(Type II or Type IIR)~~ by all ~~inpatients across all pathways in the medium and high risk pathways~~ if this can be tolerated and does not compromise their clinical care, such as when receiving oxygen therapy. This will help to minimise the dispersal of respiratory secretions and reduce environmental contamination.
 - extended use of facemasks by all staff in both clinical and non-clinical areas within the healthcare or care settings.
 - ~~all visitors should wear a face covering in healthcare settings~~

where visitors are unable to wear face coverings due to physical or mental health conditions or a disability, clinicians should consider what other IPC measures are in

Commented [LS36]: I would remove

Commented [JM37R36]: It links to the next bullet which has been raised via the cell many times

place, such as physical distancing (and environmental cleaning), to ensure sufficient access depending on the patient's condition and the care pathway.

o

3. Where possible and clinically appropriate remote consultations rather than face-to-face should be offered to patients/individuals-

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4. Ensure restricted access between pathways if possible (depending on size of the facility or prevalence/incidence rates) by other patients/individuals, visitors or staff, including patient transfers, and in communal staff areas (changing rooms/restaurant). [IfAs](#) the prevalence/incidence rates decline this may not be necessary between pathways providing the IPC measures are [reliably](#) maintained.
5. Ensure areas/wards are clearly signposted, using physical barriers as appropriate to ensure patients/individuals and staff understand the different risk areas.
6. Ensure local standard operating procedures detail the measures to segregate equipment and staff, including planning for emergency scenarios, as the prevalence/incidence of COVID-19 may increase or decrease until cessation of the pandemic.
7. Ensure a rapid and continued response through ongoing surveillance of rates of infection within the local population and for hospital/organisation onset cases (staff and patients/individuals). Positive cases identified after admission who fit the criteria for healthcare associated investigation should trigger a case investigation. Two or more [positive](#) cases linked in time and place trigger an outbreak investigation, refer to country specific definitions.
8. If the prevalence/incidence rate for COVID-19 is high, where possible, assign separate teams of health and other care workers including and domestic staff, according to pathway setting, to care for individuals in isolation/cohort rooms or areas/pathways. If a member of staff is required to move between sites/hospitals/cohort areas due to the unique function of their role, all IPC measures including physical distancing must be [maintained](#).
9. Providers of planned services should be responsive to local and national prevalence/incidence data on COVID-19 and adapt processes so that services can be stepped-up or down. This can be assessed using the respective countries weekly COVID-19 surveillance report/SARS-CoV-2 positivity data on admission, and local capacity and resources.
10. Safe systems of working including administrative, environmental and engineering controls are an integral part of IPC measures.

Commented [GL(HW-N2C38): I did ask previuously about stating if possible moving from green to red

4.2 Community settings

Areas where triaging for COVID-19 is not possible for example, community pharmacies:

- signage at entry points advising of the necessary precautions
- staff should maintain 2 metres physical distance with customers / service users, using floor markings, clear screens or wear surgical face masks (Type IIR) where this is not possible. Patients/individuals with symptoms should be advised not to enter the premises.

4.3 Outpatient/primary/day care

In outpatient, primary care and day care settings:

- where possible and appropriate services should utilise virtual consultation
- if attending outpatients or diagnostics, service providers should consider timed appointments and strategies such as asking patients/individuals to wait to be called to the waiting area with minimum wait times
- patients/individuals should not attend if they have symptoms of COVID-19 [or are isolating as a contact](#) and communications should advise actions to take in such circumstances for example for patients/individuals receiving chemotherapy and renal dialysis
- communications prior to appointments should provide advice on what to do if patients/individuals suspect they have come into contact with someone who has COVID-19 prior to their appointment
- outpatient letters should be altered to advise patients/individuals of parking, entrances, IPC precautions and COVID-19 symptoms
- patients/individuals must be instructed to remain in waiting areas and not visit other parts of the facility
- prior to admission to the waiting area, all patients/individuals and accompanying persons should be [screened](#) / triaged for COVID-19 symptoms and assessed for exposure to contacts
- patients/individuals and accompanying persons will also be asked to wear a mask / face covering at all times.

Commented [GL(HW-N2C39): Or traveller – not juts contact

NB. SARS-CoV-2 confirmed positive patients/individuals or those self-isolating should still be assessed and reviewed following the high/medium care pathway in these settings, to ensure urgent treatment/appointments are [accommodated](#). This is important to avoid unwarranted poor patient outcomes.

NB. In some clinical outpatient settings, such as vaccination/injection clinics, where contact with individuals is minimal, the need for [single-use](#) PPE items for each

encounter, for example gloves and aprons, ~~is not necessary. Gloves and aprons~~ are only recommended when there is (anticipated) exposure to blood/body fluids or non-intact skin. Staff administering vaccinations/injections must apply hand hygiene between patients and wear a sessional facemask.

- Commented [LS40]: This may cause confusion – it initially looks like you are suggesting that gloves/apron can be worn more than once. I would switch it around: For settings such as vaccination/injection clinics where contact with individuals is minimal, the use of a mask (worn sessionally) is sufficient PPE together with good hand hygiene. However, if there is anticipated exposure to blood/body fluids or non-intact skin, single use gloves and apron should be worn, removed after the procedure and hand hygiene performed.
- Commented [JM41R40]: This statement was agreed by vaccination colleagues and the cell
- Commented [MM42R40]: Perhaps this is clarified with a change to 'Gloves and aprons are <only> recommended when....'
- Commented [JM43R40]: UK IPC cell agree
- Commented [ED(HW-M44R40): Agree with Liz's suggestion above.
- Commented [DC45R40]: I agree with Liz suggestion
- Commented [AG46R40]: Will this be changed?
- Commented [SD47R40]: Agree with Liz's suggestion
- Commented [GL(HW-N2C48): And risk assessed eye protection

5. Standard Infection Prevention Control Precautions (SICPs): all pathways or settings

SICPs are the basic IPC measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection and are required across ALL COVID-19 pathways.

Sources of (potential) infection include blood and other body fluids secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated.

The application of SICPs during care delivery is determined by an assessment of risk to and from individuals and includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.

SICPs must therefore be used by all staff, in all care settings, at all times and for all patients/individuals, whether infection is known or not, to ensure the safety of patients/individuals, staff and visitors. This section highlights the key measures for the COVID-19 pathways. Please refer to the practice guide* for additional information on the other elements which remain unchanged.

The elements of SICPs are:

- patient placement and assessment for infection risk (screening/triaging/testing)
- hand hygiene
- respiratory and cough hygiene
- personal protective equipment (**see below**)
- safe management of the care environment (**see below**)
- safe management of care equipment (**see below**)
- safe management of healthcare linen
- safe management of blood and body fluids
- safe disposal of waste (including sharps)
- occupational safety: prevention and exposure management
- maintaining social/physical distancing is also a key standard precaution for COVID-19 (new SSCP due to COVID-19)

*Practice guides and literature reviews to support SICPs can be found for **England and Scotland, Wales and Northern Ireland**.

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5.1 Personal Protective Equipment (PPE)

For the purpose of this document, the term 'personal protective equipment' is used to describe products that are either PPE or medical devices that are approved by the Health and Safety Executive (HSE) and the Medicines and Healthcare products Regulatory Agency (MHRA) as protective solutions in managing the COVID-19 pandemic.

Local or **national uniform policies** should be considered when wearing PPE.

All PPE should be:

- located close to the point of use (where this does not compromise patient safety, for example, mental health/learning disabilities). In domiciliary care PPE must be transported in a clean receptacle
- stored safely and in a clean, dry area to prevent contamination
- within expiry date (or had the quality assurance checks prior to releasing stock outside this date)
- single use unless specified by the manufacturer or as agreed for extended/sessional use including surgical facemasks
- changed immediately after each patient and/or after completing a procedure or task ([unless sessional use has been agreed and local risk assessment undertaken](#))
- disposed into the correct waste stream depending on setting, for example domestic waste/offensive (non-infectious) or infectious clinical waste
- discarded if damaged or contaminated
- safely doffed (removed) to avoid self-contamination. See [here](#) for guidance on donning (putting on) and doffing (removing)
- decontaminated after each use following manufactures guidance if reusable PPE is used, specifically non-disposable goggles/face shields/visors

Gloves must:

- be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely²
- [be changed immediately after each patient and/or after completing a procedure/task even on the same patient](#)
- [be put on immediately before performing an invasive procedure and removed on completion of procedure after](#)
- [not be decontaminated with alcohol based hand rub \(ABHR\) or soap between use](#)

² [Vinyl medical gloves should only be worn in care situations where there is no anticipated exposure to blood and/or body fluids](#)

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NB. Double gloving is NOT recommended for routine clinical care of COVID-19 cases [in any pathway](#).

Aprons must be:

- worn to protect uniform or clothes when contamination is anticipated or likely
- worn when providing direct care within 2 metres of suspected/confirmed COVID-19 cases
- changed between patients and/or after completing a procedure or task

Full body gowns or fluid repellent coveralls must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids
- worn when undertaking aerosol generating procedures
- worn when a disposable apron provides inadequate cover for the procedure or task being performed (surgical procedures)
- changed between patients /individuals and immediately after completing a procedure or task

Eye or face protection (including full-face visors) must:

- be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely – for example, by members of the surgical theatre team and always during [aerosol generating procedures](#).
- not be impeded by accessories such as piercings or false eyelashes
- not be touched when being worn

Commented [GL(HW-N2C52)]: Also for all COVID-19 positives as per medium pathway within 2m delivering care

NB. Regular corrective spectacles are not considered eye protection

Fluid resistant surgical face mask (FRSM Type IIR) masks must:

- be worn with eye protection if splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa (nose and mouth) is anticipated or likely

- be worn when delivering direct care within 2 metres of a suspected/confirmed COVID-19 case
- be well-fitting and fit for purpose, fully cover the mouth and nose at all times (manufacturers' instructions must be followed to ensure effective fit and protection)
- not be touched once put on or allowed to dangle around the neck
- be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through

Commented [GL(HW-N2C53): Do we need to say something about adaptions or local solutions to poor fit

Surgical face masks Type II may ~~must~~ be:

- worn for extended use by healthcare workers when entering the hospital or care setting when not in a clinical area and not providing direct care, a Type IIR is also suitable. Type I are suitable in some settings, refer to the resource section for country specific guidance. ~~-(England and Scotland)-~~

Commented [GL(HW-N2C54): Should we add Type 1 and 2 here , then link to guidance. Its important to say when they cannot be used

Commented [SD55]: Don't think this is strong enough?

Head/footwear:

- headwear is not routinely required in clinical areas (even if undertaking an AGP) unless part of theatre attire or to prevent contamination of the environment such as in clean rooms
- headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example, theatres
- foot/shoe coverings are not required or recommended for the care of COVID-19 cases

NB. PPE may restrict communication with some individuals and other ways of communicating to meet their needs should be considered.

6. Aerosol Generating Procedures: procedures that create a higher risk of respiratory infection transmission

An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.

~~This is the~~The following list of medical procedures for COVID-19 ~~that~~ have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

- tracheal intubation and extubation
- manual ventilation
- tracheotomy or tracheostomy procedures (insertion or removal)
- bronchoscopy
- dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills)
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- high flow nasal oxygen (HFNO)
- high frequency oscillatory ventilation (HFOV)
- induction of sputum using nebulised saline
- respiratory tract suctioning^{3*}
- upper ENT airway procedures that involve respiratory suctioning^{3*}
- upper gastro-intestinal endoscopy where open suction of the upper respiratory tract^{3*} occurs

³ The available evidence relating to Respiratory Tract Suctioning is associated with ventilation. In line with a precautionary approach open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current (COVID-19) AGP list. —It is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is currently considered an AGP i.e. oral/pharyngeal suctioning is not an AGP. The evidence on respiratory tract suctioning is currently being reviewed by the AGP Panel which is an independent panel set up by the four CMO's to review new or further evidence for consideration. ~~I thought AGP panel had agreed~~

- high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

*

Certain other procedures or equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk for COVID-19. Procedures in this category include administration of humidified oxygen, administration of Entonox or medication via nebulisation.

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The New and Emerging Respiratory Viral Threat Assessment Group (NERVTAG) advised that during nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks. In addition, [the current expert consensus from NERVTAG](#) is that chest compressions are not considered to be procedures that pose a higher risk for respiratory infections including COVID-19.

Further information on AGPs for neonates can be accessed [here](#).

The literature review for AGPs during COVID-19 can be found [here](#).

Commented [LS56]: Again, not currently working...

7. Low Risk Pathway: Key principles

This pathway applies to any care facility where:

- [a\) triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact/exposure](#)
[AND](#)
[have a negative SARS-CoV-2 PCR \(COVID-19\) test within 72 hours of treatment and, for planned admissions, have self-isolated for the required period or from the test date](#)
- [OR](#)
[b\) Individuals who have recovered \(14 days\) from COVID-19 and have had at least 48 hours without fever or respiratory symptoms](#)
- [OR](#)
[c\) patients or individuals are part of a regular testing plan and remain negative and asymptomatic](#)

Clinicians should advise people who are at greater risk of getting COVID-19, or having a poorer outcome from it, that they may want to self-isolate for a longer than 14 days before a planned procedure. The length of self-isolation will depend on their individual risk factors and requires individualised care and shared decision making.

~~* Individuals who are immunosuppressed may remain positive for longer but may not be considered infectious this may require specialist infectious disease/virologist advice refer to section 10.5 LINK~~ **NB: Some individuals who have recovered from COVID-19 may continue to test positive for SARS-CoV-2 by PCR for up to 90 days from their initial illness onset. If they do not have any new symptoms and have not had any COVID-19 exposure, no further public health action would be required as they are unlikely to be infectious. Re-testing within 90 days is not recommended. However, advice should be sought from an infection specialist for severely immunosuppressed individuals who continue to test positive. Refer to re-testing for section in the following guidance for further information.**

7.1 Maintaining physical distancing

All staff and other care workers must maintain social/physical distancing of 2 metres where possible **(unless providing clinical or personal care and wearing PPE as per care pathway).**

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Commented [AG57]: Should there be an asterisk in the table?

Commented [AG58]: do you think we need to give a time frame?
It reads as remain longer than 14 days? ECDC - They could be infectious for up to 20 days

Commented [MM59R58]: I don't think we need to give a time frame but I think this statement is incorrect. Immunosuppressed may be both positive and infectious for longer?

Commented [JM60R58]: Amended

Commented [AG61R58]: Need to double check this – as they could be infectious for longer?

Commented [AG62]: I have combined this with the sentence below on prolonged PCR positives

Commented [LR63]: Where does this refer/ relate to?

7.2 Personal protective equipment**

PPE required for SICPs when following the low risk pathway is as follow (see table below).

SICPs/PP E (all settings/all patients/indi viduals)	Disposable gloves	Disposable apron/gown	Face masks	Eye/face protection(visor)
If contact with blood and/or body fluids is anticipated	Single use	Single use apron (gown if risk of spraying / splashing)	FRSM Type IIR for direct patient care *	Risk assess and use if required for care procedure/task where anticipated blood/body fluids spraying/splashes

*extended use of facemasks across the UK for HCWs when in any healthcare facility

NB: **Airborne precautions are NOT required for AGPs on patients/individuals in the low risk COVID-19 pathway, providing the patient has no other known or suspected infectious agent transmitted via the droplet or airborne route.

7.3 Safe management of environment/equipment and blood/body fluids

During the pandemic, the frequency of cleaning of both the environment and equipment in patient areas should be increased to at least twice daily or more depending on patient throughput, in particular, frequently touched sites/points and communal facilities e.g. shared toilet facilities.

Commented [LR64]: Delete?

In the low risk COVID-19 pathway organisations may choose to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants (with the exception of blood and body fluids, where a chlorine releasing agent (or a suitable alternative) solution should be used).

7.3.1 Safe management of waste

Waste must be segregated in line with the respective [countries'](#) national regulation and there is no requirement to dispose of all waste as infectious waste in the low risk pathway.

7.3.2 Operating theatres and procedure rooms

Within the low risk COVID-19 pathway, standard theatre cleaning and time for air changes provides appropriate levels of IPC and there is no requirement for additional cleaning or theatre down time unless the patient has another infectious agent that requires additional IPC measures.

7.4 Aerosol Generating Procedures (AGPs): procedures that create a higher risk of respiratory infection transmission

Airborne precautions are NOT required for AGPs on patients/individuals in the low risk COVID-19 pathway, providing the patient has no other known or suspected infectious agent transmitted via the droplet or airborne route.

There is no additional requirement for ventilation or downtime in this pathway, providing safe systems of work, including engineering controls are in place.

7.4.1 Critical care areas

Providing suspected/confirmed COVID-19 cases can be cared for in single rooms or isolation rooms, the department should no longer be classified as an AGP 'hot spot' or 'high risk area.' This should be defined locally depending on prevalence/incidence data and the subsequent pathway assigned. This negates the requirement for the routine wearing of airborne PPE including a respirator in the low risk COVID-19 pathway.

7.4.2 Operating theatres

Patients/individuals in the low risk COVID-19 pathway do not need to be anaesthetised or recovered in the operating theatre if intubation/extubation (AGP) is required.

7.5 Visitor guidance

As outlined in Section 4.1 (2), hand hygiene and respiratory hygiene, and the wearing of a face covering (if tolerated) along with social distancing should be promoted and maintained and therefore visitors require no additional PPE unless they are supporting with direct care and as directed by clinical staff. Visitors should be ~~screened~~ triaged for COVID-19 infection.

7.6 Discharge or transfer

There is no restriction on discharge unless the patient/individual is entering a long-term care facility where testing may be required. If someone in the patients household has COVID-19 or is a contact of a COVID-19 case and is self-~~isolating~~ isolating, the discharge guidance will be provided by the clinician.

Please note discharge arrangements may differ between countries. ~~...please check.~~

~~Refer to country links on pages 8&9.~~

~~In England, to ensure testing does not delay a timely discharge, PCR testing for patients due to be discharged to a care home will need to be planned up to 48 hours before the scheduled discharge time. The information from the PCR test results, with any supporting care information, must be communicated and transferred to the relevant care home. No-one should be discharged from hospital directly to a care home without the involvement of the local authority. Refer to Section 9.7 if previous positive re-testing. [LINK](#).~~

In England, to ensure testing does not delay a timely discharge, all patients who have previously tested negative should be re-tested for SARS-CoV-2 again 48 hours prior to discharge to a care home. Immunocompetent patients who have tested positive within the previous 90 days, and remain asymptomatic, do not need to be re-tested. The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home. No-one should be discharged from hospital directly to a care home without the involvement of the local authority.

8. Transmission Based Precautions (TBPs)

Transmission based precautions (TBPs) are **additional** measures (to SICPs) required when caring for patients/ individuals with a known or suspected infection such as COVID-19.

TBPs are based upon the route of transmission and include:

a) Contact precautions

Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment).

This is the most common route of ~~cross~~ infection transmission. **COVID-19 can be spread via this route.**

b) Droplet precautions

Used to prevent and control infections spread over short distances (at least 3 feet/1 metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surfaces or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. **COVID-19 is predominantly spread via**

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Commented [CB65]: This will now be 72 hours as per senior medical group/CMO decision, may be worth turning this past DHSC ASC team just to confirm when this will go live

Commented [CB66R65]: You could also say:

Refer to the 'safe discharge from the NHS to social care settings' section in the Department of Health and Social Care (DHSC) adult social care plan.

Commented [JM67R65]: Ask Susie S

Commented [JM68R65]: Still awaiting this

Commented [LR69R65]:

Commented [AG70R65]: DHSC have reported that this will now remain at 48 hours

Commented [LR71]: To remain 48 hours

Commented [AG72R71]: Correct

And 48 hours will also remain for the fever free period after covid infection. As the IPC guidance changed it to 3 days in line with WHO guidance- however, we have confirmed this with Susan – and this will remain as 48 hours. (so this version of the IPC guidance will change to 2 days from 3)

Commented [MM73R71]: Please liaise with ASC team immediately prior to publication

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Commented [AG74]: Would need to mention 90 day rule.

Commented [JM75R74]: Can you send me this guidance – I saw a draft but it is not on the gov site. If this is UK wide we can add if not we need to revert to country specific testing.

Commented [MM76R74]: Still awaiting sign off

Commented [JM77R74]: Inserted text in section 9.7

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Commented [AG78]: Could we refer to the HCW management guidance instead here?

E.g further information of when to re-test individuals please refer to section x in following guidance.

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Commented [GL(HW-N2C79)]: Ned to check on Wales – Eleri can advise

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Commented [SD81]: Bit more detailed than this in Scotland. Would suggest leave as applicable to England if works for all.

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Commented [AG82]: Is this the same policy across all four nations? If so can keep and remove "in england"

this route and the precautionary distance has been maintained at 2 metres in care settings.

c) Airborne precautions

Used to prevent and control infection spread without necessarily having close patient contact via aerosols ($\leq 5\mu\text{m}$) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. **COVID-19 has the potential to spread via this route when AGPs are undertaken.** Aerosol transmission may also occur in poorly ventilated indoor [or enclosed](#) spaces, particularly if individuals are in the same room together for an extended period of time.

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Transmission Characteristics

Transmission of SARs-CoV-2 implications for infection prevention precautions is contained within the WHO [scientific briefing paper](#) and CDC Scientific Brief: Sars-CoV-2 and Potential Airborne Transmission. Dated 5th October 2020 and CDC's scientific brief dated 5th October (<https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html>)

Commented [GL(HW-N2C83)]: Need to add linke to new variants to reaffirm same trasmission

Commented [JM84]: Can this link be added

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Literature reviews to support TBPs can be found [here](#)

9. Medium Risk Pathway: Key principles

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9.1 Maintaining physical distancing and patient placement

This pathway applies to any care facility where

- a) -triaged/clinically assessed individuals are asymptomatic and are awaiting a SARS-CoV-2 PCR test result
OR
- b) ~~F~~triaged/clinically assessed individuals are asymptomatic with COVID-19 contact/exposure identified
OR
- c) testing is not required or feasible on asymptomatic individuals and therefore infectious status is unknown
OR
- d) asymptomatic individuals -decline testing

It is important to:

- maintain physical distancing of 2 metres at all times (unless the member of staff is wearing appropriate PPE to provide clinical care) and to advise other patients/visitors to comply
- ensure cohorted patients/individuals are physically separated from each other, for example use a 'chair, locker, bed' formation, screens, privacy curtains between the beds to minimise opportunities for close contact, this should be locally risk assessed to ensure patient safety is not compromised

Commented [GL(HW-N2C86)]: add may need bed spacing – taking out beds to achieve

9.2 Personal protective equipment

Patients/Individuals with no COVID-19 symptoms and no test results	Disposable gloves	Disposable apron/gown	Face masks	Eye/face protection (visor*)
Droplet/Contact PPE for direct patient care <2 metres	Single use	Single use apron (gown required if risk of spraying / splashing)	FRSM Type IIR ¹	Single use or re-usable*
Airborne PPE (When undertaking AGPs) AGPs or if AGPs are likely)	Single use	Single use apron or gown	FFP3 ² or Respirator/ Hood for AGPs	Single use or re-usable Eye/face protection (visor)

¹FRSM can be worn sessionally if providing care for COVID-19 cohorted patients/individuals

² FFP3 can be worn sessionally in AGP 'hot spot' areas i.e. where AGPs are frequently undertaken in for COVID-19 cohort ed areas patients/indiudals

can be worn sessionally if providing care for COVID-19 cohorted patients/individuals

* Risk assess and use if required for care procedure/task where anticipated blood/body fluids spraying/splashes below single use/reusable

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9.3 Safe management of care environment/equipment/blood and body fluids

9.3.1 Equipment

Important considerations in the use of equipment are:

- patient care equipment should be single-use items where practicable
- reusable (communal) non-invasive equipment should be allocated to an individual patient or cohort of patients/individuals
- all reusable (communal) non-invasive equipment must be decontaminated:
 - between each and after patient/individual
 - after blood and body fluid contamination
 - at regular intervals as part of routine equipment cleaning
- decontamination of equipment must be performed using either:

- a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
 - a general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl.
- alternative cleaning agents/disinfectant products may be used with agreement of the local IPC Team/HPT

9.3.2 Environment

Important considerations for environmental cleaning and disinfection are:

- cleaning of care equipment as per manufacturers guidance/instruction and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products
- an increased frequency of decontamination should be considered for all reusable non-invasive care equipment when used in isolation/cohort areas
- the use of fans in high and medium risk pathways should be risk assessed. Refer to Estates guidance
- cleaning frequencies of the care environment in COVID-19 care areas must be ~~enhanced-increased~~ and single rooms, cohort areas and clinical rooms (including rooms where PPE is removed) cleaned at least twice daily
- routine cleaning must be performed using either:
 - a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
 - a general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl
- alternative cleaning agents/disinfectants may be used with agreement of the local IPC/HPT
- the increased frequency of decontamination/cleaning should be incorporated into the environmental decontamination schedules for all COVID-19 areas, including where there may be higher environmental contamination rates, including for example:
 - toilets/commodore ~~particularly if patients/individuals have diarrhoea~~
 - 'frequently touched' surfaces such as medical equipment, door/toilet handles, locker tops, patient call bells, over bed tables, bed rails, phones, lift buttons/communal touch points and communication devices (for example, mobile phones, tablets, desktops, keyboards) particularly where these are used by many people, should be cleaned at least twice daily with solution of detergent and 1000ppm chlorine or an agreed alternative when known to be contaminated with secretions, excretions or body fluids
 - all shared care equipment – manual handling equipment, BP cuffs, stethoscopes, tympanic thermometer machine
- dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination
- reusable equipment (such as mop handles, buckets) must be decontaminated after use with a chlorine-based disinfectant or locally agreed disinfectant
- single (isolation) rooms must be terminally cleaned as above following resolution of symptoms, discharge or transfer (this includes removal and laundering of all curtains and bed screens)

9.4 Aerosol Generating Procedures (AGPs) procedures that create a higher risk of respiratory infection transmission

AGPs should only be carried out when essential and only staff who are needed to undertake the procedure should be present, wearing airborne PPE/ RPE precautions (See section 10: High Risk Pathway).

9.4.1 Critical care areas

Droplet precautions apply. However, consideration may need to be given to the application of airborne precautions where the number of cases of suspected/confirmed COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms.

9.4.2 Operating theatres

Patients/individuals should be anaesthetised and recovered in the operating theatre if intubation/extubation (AGP) is required. For local, neuraxial or regional anesthesia the patient is not required to be anaesthetised/ recovered in theatre.

9.5 Duration of transmission based precautions

Transmission based precautions should only be discontinued in consultation with clinicians and should take into consideration the individual's PCR test results and clinical symptoms. If test results are not available (for example the patient/individual declines) TBPs can be discontinued after 14 days (inpatients) depending on contact exposure and providing the patient/individual remains symptom free.

9.6 Visitor guidance

Visiting may be limited during increases in incidence and prevalence of COVID-19 however as cases decline and restrictions ease, visitors should be permitted to enter the facility and be educated in the IPC measures required as outlined in Section 4.1 (2). All visitors should be ~~screened and~~ triaged.

This includes accompanying individuals when attending outpatient appointments such as, antenatal appointments and therapy groups.

9.7 Discharge or transfer

There is no restriction on discharge if the patient/individual is well, unless the patient/individual is entering a long-term facility and testing may be required. If someone in the patients household has COVID-19 or is a contact of a COVID-19 case and is self-isolating, the discharge guidance will be provided by the clinician.

Please note discharge arrangements may differ between countries, ~~please check~~. Refer to country links on pages 8&9.

Discharge information for patients/individuals should include an understanding of their need for any self-isolation and/or quarantine, as well as their family members (where applicable).

In England, to ensure testing does not delay a timely discharge, ~~testing for all patients who have previously tested negative should be re-tested for SARS-CoV-2 again 48 hours prior to discharge to a care home. Immunocompetent patients who have tested positive within the previous 90 days, and remain asymptomatic, do not need to be re-tested.~~

~~due to be discharged to a care home will need to be planned up to 48 hours before the scheduled discharge time.~~ The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home. No-one should be discharged from hospital directly to a care home without the involvement of the local authority.

SARS-CoV-2 PCR Re-testing in staff, patients and residents in social care settings

~~Immunocompetent staff, patients and residents who have tested positive for SARS-CoV-2 by PCR should be exempt from routine re-testing (e.g. repeated whole setting screening or screening prior to hospital discharge) within a period of 90 days from their initial illness onset or test (if asymptomatic), unless they develop new COVID-19 symptoms. This is because fragments of inactive virus can be persistently detected by PCR in respiratory tract samples following infection, well after a person has completed their isolation period and is no longer infectious.~~

~~If a person is re-tested within 90 days from their initial illness onset or test date and found to still be positive for SARS-CoV-2, a clinically led approach should be used to interpret the result and inform subsequent action taking into account several factors, such as COVID-19 symptoms, underlying clinical conditions, immunosuppressive treatments and conditions, and additional information such as cycle threshold values. Seek advice from an infection specialist as required.~~

~~If a person is re-tested by PCR after 90 days from their initial illness onset or test and is found to be positive, this should be considered as a possible new infection. If they have developed~~

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Commented [DC92]: Something that has been raised as an issue which impacts discharge is where patients are scheduled for discharge but the transport service is delayed. If this takes them outside of the 48hrs by even a few hours they are then having to re-test the patient and await results to discharge. Not sure if there is anything that can be included within the guidance to address this

Commented [AG93R92]: Lisa -can you advise if need to address this?

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~~new COVID-19 symptoms, they would need to self-isolate again and their contacts should be traced.~~

~~All hospitalised care home residents who have previously tested negative as part of routine screening or the investigation of a recent illness should be tested for SARS-CoV-2 again 48 hours prior to discharge and the result of this repeat test relayed to the receiving organisation. Immunocompetent residents who have tested positive within the previous 90 days, and remain asymptomatic, do not need to be re-tested. Any resident who tests positive and is being discharged within their 14 day isolation period should only be discharged to a Designated Setting.¹~~

Ambulance services and the receiving facilities must be informed of the infectious status of the individual.

Commented [AG94]: I had added in a comment last week to suggest linking to this section in the following guidance <https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings#patient-exposures-in-hospital>

This is not only relevant to the medium pathway – so if you did want to include a section on testing it would need to be separate – as it applicale to all pathways.

Commented [PG95R94]: Agree only need it in once what about after pathway descriptions before Occupational Health???

Commented [AG96R94]: Or above – before all the care pathways. Or could have have one sentence to refer to guidance as mentioned earlier?

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10. High Risk Pathway: Key principles

This pathway applies to any emergency/urgent care facility where:

- a) untriaged individuals present for assessment or treatment (symptoms unknown*)
- OR
- b) confirmed SARS-CoV-2 (COVID-19) PCR positive patients are cared for
- OR
- c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case who have been triaged / clinically assessed and are waiting test results
- OR
- d) symptomatic individuals who decline testing

*Once assessed, if asymptomatic with no contact history, patients/individuals may move to the Medium risk pathway awaiting test result.

10.1 Patient placement

If the patient/individual has symptoms or a history of contact/[exposure](#) with a case, they should be prioritised for single room isolation **OR** [cohorted](#) (if an isolation room is unavailable) until their test results are known, for example use '[chair, locker, bed](#)' [formation, screens](#), privacy curtains between bed spaces to minimise opportunities for close contact between patients/individuals. This should be locally risk assessed to ensure this does not compromise patient safety.

If single rooms are in short supply, priority should be given to patients with excessive cough and sputum production, diarrhoea or vomiting and to those in the high risk/extremely high risk of severe illness.

Local risk assessments and clinical decisions must be made regarding placement of patients/individuals with availability of single rooms taken into consideration.

Commented [GL(HW-N2C97): Need to add bubbles – this was discussed the importance of not mixing contact from different bubbles

10.2 Personal protective equipment

If suspected/confirmed COVID-19 patient/individual	Disposable gloves	Disposable apron/gown	Face masks	Eye/face protection (visor)
Droplet/Contact PPE	Single use	Single use apron and gown if risk of spraying / splashing)	FRSM Type IIR for direct patient care ¹	Single use or re-usable
Airborne PPE (When undertaking AGPs or if AGPs are likely)	Single use	Single use gown	FFP3 ^{1,2} or respirator /Hood for AGPs	Single use or re-usable

¹FRSM/FFP3 can be worn sessionally if providing care for COVID-19 cohorted patients/individuals

¹ FRSM can be worn sessionally if providing care for COVID-19 cohorted patients/individuals

² FFP3 can be worn sessionally in AGP 'hot spot' areas i.e. where AGPs are frequently undertaken in cohort areas for COVID-19 cohorted patients/individuals

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Commented [GL(HW-N2C98)]: Sessional eye protection as well

10.2.1 Respiratory protective equipment (RPE) FFP3 (filtering face piece or hood):

Respirators are used to prevent inhalation of small airborne particles arising from AGPs.

Respirators should:

- be well fitting, covering both nose and mouth
- always worn when undertaking an AGP on a COVID-19 confirmed or suspected patient/individual
- not be allowed to dangle around the neck of the wearer or hang from one ear after or between each use
- not be touched once put on
- be removed outside the patient's/individual's room or cohort area or COVID-19 ward
- respirators can be single use or single session use (disposable or reusable) and fluid-resistant
- valved respirators are not fully fluid-resistant unless they are also 'shrouded'. Valved non-shrouded FFP3 respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated. Valved respirators should not be worn by a [healthcare worker](#)/operator in a sterile area such as theatres/surgical settings [or](#)

[undertaking a sterile procedure such as central line insertion](#), as the exhaled breath is unfiltered.

- all staff who are required to wear an FFP3 respirator must be fit tested for the relevant model to ensure an adequate seal or fit (according to the manufacturers' guidance). Fit checking (according to the manufacturers' guidance) is necessary when a respirator is put on (donned) to ensure an adequate seal has been achieved
- where fit testing fails, suitable alternative equipment must be provided, or the healthcare worker should be moved to an area where FFP3 respirators are not required
- respirators should be compatible with other facial protection used (protective eyewear) so that this does not interfere with the seal of the respiratory protection
- the respirator should be discarded and replaced and NOT be subject to continued use if the facial seal is compromised, it is uncomfortable, or it is difficult to breathe through
- reusable respirators can be utilised by individuals if they comply with HSE recommendations. Reusable respirators should be decontaminated according to the manufacturer's instructions

Literature on RPE can be found [here](#).

10.2.2 Full body gowns or fluid repellent coveralls:

Full body gowns or fluid repellent coveralls must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids;
- worn when undertaking **aerosol generating procedures**
- worn when a disposable apron provides inadequate cover for the procedure or task being performed e.g. surgery
- changed between patients/individuals and immediately after completing a procedure or task. ~~If unless~~ sessional use is [considered this must have a local risk assessment and agreement in place and should be minimised](#). ~~advised due to local/national data~~

10.3 Safe management of care environment/equipment/blood and body fluids

Please refer to Section 9.3.

In addition if there are clusters or outbreaks of COVID-19 (2 or more cases linked by time and place) with significant respiratory symptoms in communal settings cleaning frequencies should be [increased](#). ~~to a minimum of twice daily~~.

Commented [GL(HW-N2C99): Same comment as before as risk is not COVID

Commented [SD100]: What is the position of the PPE DMG on this? We have previously agreed that manufacturers instructions are not appropriate.

Commented [SD101]: This has been updated to state that decon is not recommended as follows; Work is currently underway by the UK Re-useable Decontamination Group examining the suitability of respirators, including powered respirators, for decontamination. This literature review will be updated to incorporate recommendations from this group when available. In the interim, ARHAI Scotland are unable to provide assurances on the efficacy of respirator decontamination methods and the use of re-useable respirators is not recommended.

Commented [SD102]: Suggest keep

Commented [GL(HW-N2C103R102): Agree keep at least twice a day

10.4 Aerosol Generating Procedures that create a higher risk of respiratory infection transmission and operating theatres (including day surgery)

10.4.1 Critical care

Droplet precautions would apply however, consideration may need to be given to the application of airborne precautions where the number of cases of COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms.

10.4.2 Operating theatres

Patients/individuals should be anaesthetised and recovered in the theatre if intubation/extubation (AGP) is required using airborne precautions. This is not required for regional, neuraxial or local anaesthesia.

Ventilation in both laminar flow and conventionally ventilated theatres should remain in full operation during surgical procedures where patients/individuals have suspected/confirmed COVID-19. Air passing from operating theatres to adjacent areas will be highly diluted and is not considered to be a risk.

10.5 Duration of precautions

In general, patients with COVID-19 who are admitted to hospital will have more severe disease than those who can remain in the community, especially if they have been severely unwell or have pre-existing conditions such as severe immunosuppression. Therefore, it is recommended that these individuals should be isolated within hospital or remain in self-isolation on discharge for 14 days from their first positive SARS-CoV-2 PCR test.

Whilst in hospital patients/individuals should remain in isolation/cohort with TBPs applied for at least 14 days after onset of symptoms and should be 48 hours without a fever (without use of antipyretic medication) or respiratory symptoms. The decision to modify the duration of, or 'stand down' TBPs (contact/droplet/airborne) should be made by the clinical team managing the Individuals care.

For clinically suspected COVID-19 patients who have tested negative or have not been tested for SARS-CoV-2 and whose condition is severe enough to require hospitalisation, then the 14 day isolation period should be measured from the day of admission.

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Testing for virological clearance is encouraged in severely immunosuppressed patients. For these patients, IPC measures should be continued unless either there has been virological evidence of clearance prior to discharge or there has been complete resolution of all symptoms. This is different to other advice sections but reflects the complex health needs of such patients and likelihood for prolonged shedding, with risk of spread in healthcare settings. Upon discharge such patients may be retested at first follow-up appointment to help inform actions at any next medical appointment.

10.6 Visitor guidance

In this pathway, visiting should continue to be limited to only essential visitors, for example **birthing partner**, carer/parent/guardian. Hospitals/organisations will provide advice and guidance to support patients during these restrictions.

Whilst facemasks/coverings are recommended the need for visitors to wear additional PPE will be individually assessed.

10.7 Discharge or transfer

Discharge from an inpatient facility can occur when the individual is well enough and the clinician has provided them with discharge such as advice to self-isolate for at least **14 days** from the date of the positive SARS-CoV-2 PCR test (providing their symptoms resolve during this period). [Refer to country specific guidance links on page 8 & 9.](#)

Advice should include written information such as, patients with a cough or a loss of, or change in, normal sense of smell or taste (anosmia), may persist in some individuals for several weeks following COVID-19 recovery, and is not currently considered an indication of ongoing infection when other symptoms have resolved.

Prior to discharge (if the patient is within the 14 days) clinicians should ascertain if there are any [clinically extremely vulnerable](#) individuals who live in the household and are currently not infected. It is highly advisable for patients to be discharged to a different home until they have finished their self-isolation period. If these individuals cannot be moved to a different household, then ensure that the discharged patient is advised on infection prevention control measures as outlined in the [following guidance](#) ('Stay at home' guidance).

Advice on ongoing medical needs should be provided for patients who are discharged within their self-isolation period. If patients deteriorate at home or in a care setting, they or their carer should seek advice from [NHS 111 online](#) or by telephone, or through pre-existing services such as GP practice links with care homes. In an emergency, 999 should be called. In either case, they should inform the call attendant that they have been recently discharged from hospital with confirmed COVID-19.

Commented [MM104]: Note legislation requiring positive individuals to self isolate muddies this. Suggest align wording with NHSE/I maternity team visiting guidance. Clarifications were being sought from DHSC, so suggest end this week/early next week (Sue Tranka may be sighted)

Commented [JM105R104]: Added a section as there is visitors guidance for all but this will vary on the pathways

Commented [MM106R104]: Does visitor 'policy' need to be addressed here? This is likely to change and may be different for each nation. For longevity I suggest this sticks to IPC guidance for visitors and remove the first para.

Commented [JM107R104]: UK cell can you advise

Commented [AG108R104]: Was this discussed at the cell? Still needs clarification.

Commented [SD109R104]: Scottish Government have a visiting policy which is regularly updated and we link out to this.

Commented [GL(HW-N2C110R104): Wales also has visitor guidance

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Commented [SD111]: This should be ten days if the patient is discharging. Only 14 days if staying in hospital

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Please note discharge arrangements may differ between countries. ~~...please check.~~
[Refer to country links on pages 8&9.](#)

In England, to ensure testing does not delay a timely discharge, [only patients who have tested negative should be re-tested for SARS-CoV-2 again 48 hours prior to discharge to a care home](#). ~~Testing for patients due to be discharged to a care home~~ All SARS-CoV-2 positive patients who are discharged within their 14 day self-isolation period will need to be discharged to a designated setting. ~~...will need to be planned up to 48 hours before the scheduled discharge time.~~ The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home. No-one should be discharged from hospital directly to a care home without the involvement of the local authority.
[Refer to Section 9.7 on retesting](#) [LINK](#)

Discharge to another care area may be dependent on testing and/or isolation facilities available.

Discharge information for patients/individuals should include an understanding of their need for any self-isolation and/or quarantine, as well as their family members.

Ambulance services and the receiving facilities must be informed of the infectious status of the individual and the ongoing need to continue with infection control precautions.

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Commented [JM112]: This is the retest information

Commented [AG113R112]: See comment on re-testing. It doesn't necessarily flow where it is placed.

Commented [PG114]: Not sure if this sentence

Commented [AG115R114]: Need to update it

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11. Occupational health and staff deployment

Prompt recognition of cases of COVID-19 among healthcare staff is essential to limit the spread.

Health and social care staff with symptoms of COVID-19 or a positive COVID-19 SARS-CoV-2 PCR test result should not come to work.

Commented [GL(HW-N2C116): Or lateral flow teste until; PCR confirms

As a general principle, healthcare staff who provide care in settings for suspected or confirmed patients/individuals should not care for other patients. However, this has to be a local decision based on local epidemiology and the configuration of the organisation.

-A risk assessment is required for health and social care staff at high risk of complications from COVID-19 or clinically extremely vulnerable groups, including pregnant staff and Black, Asian and Minority Ethnic (BAME) staff. Guidance on carrying out risk assessments can be found by following the links to the country-specific IPC COVID-19 resources on Page 8 and 9.

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Employers should:

- discuss with employees who are clinically (extremely) vulnerable or are pregnant the need to be deployed away from areas used for the care of those who have, or are clinically suspected of having, COVID-19; or, in the primary care setting, from clinics set up to manage people with COVID-19 symptoms
- ensure that advice is available to all health and social care staff, including specific advice to those at risk from complications

Commented [MM117]: Why has this been separated out from other clinically vulnerable groups?

Commented [JM118R117]: This is to remain as agreed wording

Bank, agency and locum staff who fall into these categories should follow the same deployment advice as permanent staff.

As part of their employer's duty of care, providers have a role to play in ensuring that staff understand and are adequately trained in safe systems of working, including donning and doffing of personal protective equipment. A fit testing programme should be in place for those who may need to wear respiratory protection.

In the event of a breach in infection control procedures, staff should be reviewed by occupational health.

Occupational health departments should lead on the implementation of systems to monitor staff illness, ~~and~~ absence and vaccination against COVID-19.

12. Glossary of terms

Aerosol-generating procedures (AGPs)

Certain medical and patient care activities that can result in the release of airborne particles (aerosols). AGPs can create a risk of airborne transmission of infections that are usually only spread by droplet transmission.

Airborne transmission

The spread of infection from one person to another by airborne particles (aerosols) containing infectious agents.

Airborne particles

Very small particles that may contain infectious agents. They can remain in the air for long periods of time and can be carried over long distances by air currents. Airborne particles can be released when a person coughs or sneezes, and during aerosol generating procedures (AGPs). 'Droplet nuclei' are aerosols formed from the evaporation of larger droplet particles (see droplet transmission). Aerosols formed from droplet particles in this way behave as other aerosols.

Airborne precautions

Measures used to prevent and control infection spread without necessarily having close patient contact via aerosols (less than or equal to 5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols can penetrate the respiratory system to the alveolar level.

BS/EN standards

Mandatory technical specifications created by either the British Standards Institute (BS) or European Standardisation Organisations (EN) in collaboration with government bodies, industry experts and trade associations. They aim to ensure the quality and safety of products, services and systems.

Clinically vulnerable or extremely clinically vulnerable

People who are defined as clinically extremely vulnerable are at very high risk of severe illness from coronavirus. Those included in this category will be identified by:

1. [h](#)Having one or more of conditions list, or
2. [a](#)A clinician or GP has added the individual to the Shielded Patient List

Commented [JM119]: Add definition if step down is removed

Commented [MM120R119]: Should have this anyway? Referred to in occupational health section

Commented [JM121R119]: Will add Monday

LINK: <https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19#cev>

Cohort area

An area (room, bay, ward) in which 2 or more patients (a cohort) with the same confirmed infection are placed. A cohort area should be physically separate from other patients.

Contact precautions

Measures used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment). This is the most common route of infection transmission.

Contact transmission

Contact transmission is the most common route of transmission and consists of 2 distinct types: direct contact and indirect contact. Direct transmission occurs when microorganisms are transmitted directly from an infectious individual to another individual without the involvement of another contaminated person or object (fomite). Indirect transmission occurs when microorganisms are transmitted from an infectious individual to another individual through a contaminated object or person (fomite) or person.

COVID-19

COVID-19 is a highly infectious respiratory disease caused by a novel coronavirus. The disease was discovered in China in December 2019 and has since spread around the world.

Droplet precautions

Measures used to prevent, and control infections spread over short distances (at least 1 metre or 3 feet) via droplets (greater than 5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. **COVID-19 is predominantly spread via this route and the precautionary distance has been maintained at 2 metres in care settings.**

Droplet transmission

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The spread of infection from one person to another by droplets containing infectious agents.

Eye or face protection

Worn when there is a risk from splashing of secretion (including respiratory secretions). Eye or face protection can be achieved by the use of any one of:

- a surgical mask with integrated visor
- a full face visor or shield
- polycarbonate safety spectacles or equivalent

Fluid-resistant (Type IIR) surgical face mask (FRSM)

~~Fluid-resistant (Type IIR) surgical face mask (FRSM)~~

A disposable fluid-resistant mask worn over the nose and mouth to protect the mucous membranes of the wearer's nose and mouth from splashes and infectious droplets. FRSMs can also be used to protect patients. When recommended for infection control purposes a 'surgical face mask' typically denotes a fluid-resistant (Type IIR) surgical mask.

Fluid-resistant

A term applied to fabrics that resist liquid penetration, often used interchangeably with 'fluid-repellent' when describing the properties of protective clothing or equipment.

Frequently touched surfaces

Surfaces of the environment which are commonly touched or come into contact with human hands.

Healthcare or clinical waste

Waste produced as a result of healthcare activities for example soiled dressings, sharps.

High-flow nasal cannula (HFNC) therapy

HFNC is an oxygen supply system capable of delivering up to 100% humidified and heated oxygen at a flow rate of up to 60 litres per minute.

Higher risk acute care area risk units

Intensive care units, intensive therapy units, high dependency units, emergency department resuscitation areas, wards with non-invasive ventilation; operating theatres;

endoscopy units for upper Respiratory, ENT or upper GI endoscopy; and other clinical areas where AGPs are regularly performed.

Incubation period

The period between the infection of an individual by a pathogen and the manifestation of the illness or disease it causes.

Induction of sputum

Induction of sputum typically involves the administration of nebulised saline to moisten and loosen respiratory secretions (this may be accompanied by chest physiotherapy (percussion and vibration)) to induce forceful coughing. Infectious linen
Linen that has been used by a patient who is known or suspected to be infectious and or linen that is contaminated with blood and or other body fluids, for example faeces.

Long term health condition

This covers:

- chronic obstructive pulmonary disease, bronchitis, emphysema or asthma
- heart disease
- kidney disease
- liver disease
- stroke or a transient ischaemic attack (TIA)
- diabetes
- lowered immunity as a result of disease or medical treatment, such as steroid medication or cancer treatment
- a neurological condition, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS), cerebral palsy, or a learning disability
- any problem with the spleen, including sickle cell disease, or had spleen removed
- a BMI of 40 or above (obese)

Personal Protective Equipment (PPE)

Equipment a person wears to protect themselves from risks to their health or safety, including exposure to infection agents. The level of PPE required depends on the:

- suspected or known infectious agent
- severity of the illness caused
- transmission route of the infectious agent
- procedure or task being undertaken

Respiratory droplets

A small droplet, such as a particle of moisture released from the mouth during coughing, sneezing, or speaking.

Respiratory protective equipment

Respiratory protection that is worn over the nose and mouth designed to protect the wearer from inhaling hazardous substances, including airborne particles (aerosols). There are 2 types of respiratory protection that can be used, tight-fitting disposable FFP respirators and loose-fitting powered hoods (TH2).

FFP stands for filtering face piece. There are 3 categories of FFP respirator: FFP1, FFP2 and FFP3. FFP3 and loose fitting powered hoods provide the highest level of protection and are recommended when caring for patients in areas where high risk aerosol generating procedures (AGPs) are being performed.

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Commented [JM122]: Delete no longer to be used

Respiratory symptoms

Respiratory symptoms include:

- rhinorrhoea (runny nose)
- sore throat
- cough
- difficulty breathing or shortness of breath

Segregation

Physically separating or isolating from other people.

SARS-CoV

Severe acute respiratory syndrome coronavirus, the virus responsible for the 2003 outbreak of human coronavirus disease.

SARS-CoV-2

Severe acute respiratory syndrome coronavirus 2, the virus responsible for the COVID-19 pandemic.

~~Severly immunosuppressed~~ **Severly immunosuppressed** is defined in the Green Book on Immunisation as:

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- immunosuppression due to acute and chronic leukaemias and lymphoma (including Hodgkin's lymphoma)
- severe immunosuppression due to HIV/AIDS (**British HIV Association advice**)
- cellular immune deficiencies (such as severe combined immunodeficiency, Wiskott-Aldrich syndrome, 22q11 deficiency/DiGeorge syndrome)
- being under follow up for a chronic lymphoproliferative disorder including haematological malignancies such as indolent lymphoma, chronic lymphoid leukaemia, myeloma and other plasma cell dyscrasias
- having received an allogenic (cells from a donor) stem cell transplant in the past 24 months and only then if they are demonstrated not to have ongoing immunosuppression or graft versus host disease (GVHD)
- having received an autologous (using their own stem cells) haematopoietic stem cell transplant in the past 24 months and only then if they are in remission

- those who are receiving, or have received in the past 6 months, immunosuppressive chemotherapy or radiotherapy for malignant disease or non-malignant disorders
- those who are receiving, or have received in the past 6 months, immunosuppressive therapy for a solid organ transplant (with exceptions, depending upon the type of transplant and the immune status of the patient)
- those who are receiving or have received in the past 12 months immunosuppressive biological therapy (such as monoclonal antibodies), unless otherwise directed by a specialist
- those who are receiving or have received in the past 3 months immunosuppressive therapy including:
 - adults and children on high-dose corticosteroids (>40mg prednisolone per day or 2mg/ kg/day in children under 20kg) for more than 1 week
 - adults and children on lower dose corticosteroids (>20mg prednisolone per day or 1mg/kg/day in children under 20kg) for more than 14 days
 - adults on non-biological oral immune modulating drugs, for example, methotrexate >25mg per week, azathioprine >3.0mg/kg/day or 6-mercaptopurine >1.5mg/kg/day
 - children on high doses of non-biological oral immune modulating drugs

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Standard infection control precautions (SICPs)

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmission of an infectious agent from both recognised and unrecognised sources of infection.

Single room

A room with space for one patient and usually contains (as a minimum) a bed, a locker or wardrobe and a clinical wash-hand basin.

Staff cohorting

When staff care for one specific group of patients and do not move between different patient cohorts. Patient cohorts may include for example 'symptomatic', 'asymptomatic and exposed', or 'asymptomatic and unexposed' patient groups.

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Transmission based precautions

Additional precautions to be used in addition to SICPs when caring for patients with a known or suspected infection or colonisation.

Appendix 1. Sample triage tool

Example of triage questions for COVID-19

If No to all questions proceed with treatment/testing and follow low risk pathway.

	YES	NO
1. Do you or any member of your household/ family have a confirmed diagnosis of COVID-19? If yes, wait for 10 days or 14 days (if admitted to hospital with COVID-19) from the agreed period of time depending on date of onset of symptoms (10 days, 14 if the admission is due to COVID infection) before treatment or if urgent care is required, follow the High/Medium pathway.		
2. Are you or any member of your household/family waiting for a COVID-19 test result? If yes, ascertain if treatment can be delayed until results are known. If urgent care is required, follow the High/Medium risk pathway.		
3. Have you travelled internationally in the last 10 days? If yes, confirm where and if this is a country that has been agreed as safe for travel by the government. If this is not on the list then 10 days quarantine will apply. If urgent care is required, follow the High/Medium risk pathway.		
4. Have you had contact with someone with a confirmed diagnosis of COVID-19, or been in isolation with a suspected case in the last 10 days? If yes, wait for the agreed period of time depending on what date of the isolation period the patient is at (ideally, 10 days) before treatment or if urgent care is required, follow High/Medium risk pathway.		
5. Do you have any of the following symptoms? • high temperature or fever • new, continuous cough • a loss or alteration to taste or smell If yes, provide advice on who to contact (GP/NHS111) or, if admission required, follow High/Medium risk pathway		

Commented [AG123]: To double check

Commented [MM124]: We have asked for clarification of this from Senior clinicians group

Commented [AG125R124]: Any update to this?