

Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022

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Guidance Update

- Updated 24 November 2021
- This guidance is intended to prevent transmission of seasonal respiratory viral infections focussing on influenza, SARS-CoV-2, and respiratory syncytial virus (RSV) in health and care settings while continuing to support the recovery of services.
- The IPC principles in this document apply to UK health and care settings. This includes the independent/private sector, mental health and learning disabilities, primary care, care homes, care at home, maternity, and paediatrics
- This guidance supersedes the previous UK IPC COVID-19 guidance for maintaining services within health and care settings to allow organisations to assess and manage the ongoing delivery of service provision throughout the winter period 2021 to 2022.

Main changes/updates:

- removal of the 3 COVID-19 specific care **pathways** (high, medium and low). The use of, or requirement for, care pathways should be defined locally
- addition of a section on the criteria to be applied within the '**hierarchy of controls**' to further support organisations.
- recommendation for **universal use of face masks** for staff and face masks/ coverings for all patients/visitors to remain as an IPC measure within health and care settings over the winter period. This is likely to be until at least March/April 2022
- recommendation that physical distancing should be **at least 1 metre**, increasing whenever feasible to 2 metres across all health and care settings where patients with suspected or confirmed respiratory infection are being cared for or managed

- recommendation that screening, triaging and testing for SARS-CoV-2 continues over the winter period. Testing for other respiratory pathogens will depend on the health and care setting.



Governance and responsibilities

- application of IPC practices is **monitored** and that resources are in place to implement and measure adherence to good IPC practice.
- **training** in IPC measures are provided to all staff, including: the correct technique for putting on and removing (donning/doffing) PPE safely
- **risk assessment(s)** is undertaken for health and care staff who may be at high risk of complications from respiratory infections such as influenza, and severe illness from COVID-19 (for example pregnant and Black, Asian, and Minority Ethnic (BAME) staff)
- **screening, triaging and testing** are in place for SARS-CoV-2 or other respiratory infections.

- **patients** at high risk or extremely high risk of severe outcomes of respiratory infection are **protected from COVID-19** and other respiratory infections. This must include consideration of their families and carers accompanying them for treatments/procedures
- health and care settings continue to **apply COVID-19 secure workplace requirements** as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.
- a respiratory season/winter plan is in place to ensure, for example, appropriate **segregation of cases** depending on the pathogen and management of increasing case numbers where they occur



Signage should be displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving/reception staff immediately on their arrival.

Universal masking

- Universal masking with face coverings or surgical masks (Type II or IIR) to prevent the transmission of SARS-CoV-2 and other respiratory infectious agents in health and care settings, as a source control measure, should continue to be applied for all staff, patients and visitors.
- Patients with suspected or confirmed respiratory infection should be provided with a surgical facemask (Type II or Type IIR)



Screening

- Screening for early recognition of patients with COVID-19 should be undertaken wherever possible prior to attendance at the health or care facility to ensure rapid implementation of recommended control measures. An example screening tool is available in [Appendix 1](#).

Triaging

- Patients with respiratory symptoms should be assessed in a segregated area, **ideally a single room**, and away from other patients pending their test result.



Standard Infection Control Precautions

- patient placement and assessment for infection risk (screening/triaging/testing)
- hand hygiene
- respiratory and cough hygiene
- PPE
- safe management of the care environment
- safe management of care equipment
- safe management of healthcare linen
- safe management of blood and body fluids
- safe disposal of waste (including sharps)
- occupational safety: prevention and exposure management



Physical distancing

- In health and care settings physical distancing is the recommended distance that should be maintained between staff, patients and visitors unless mitigations are in place such as the use of PPE. WHO continues to advise that a physical distance of at least 1 metre should be maintained between and among patients, staff, and all other persons in healthcare settings. This distance should be increased wherever feasible, especially in indoor settings. Physical distancing is recommended to remain at 2 metres where infectious respiratory patients are cared for.



Primary care and outpatient settings

- Where patient treatment or appointment cannot be deferred, patients with symptoms of respiratory infection should be triaged to a segregated waiting and assessment area with physical distancing at 2 metres. This may be achieved by:
 - creating separate waiting and reception areas or use of physical barriers. Patients should be instructed to stay in these areas and not visit public areas such as cafes. Signage should be used as appropriate
 - staggering clinic times for patients with and without respiratory symptoms, ensuring disinfection of communal areas between clinics



Safe management of care equipment and the care environment

- The care environment must be kept visibly clean, well maintained and in a good state of repair. The care environment must be free from non-essential items and equipment to facilitate effective decontamination. All care equipment must be clean and well maintained. Reusable non-invasive equipment should be allocated to the individual patient or cohort of patients where possible.
- Decontamination of reusable patient care equipment and the care environment must be performed using either: a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (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.

Frequency of decontamination of reusable patient care equipment

- Reusable (communal) non-invasive care equipment must be decontaminated:
- between each patient and after patient use
- after blood and body fluid contamination
- at regular intervals as part of scheduled, routine equipment cleaning
- An increased frequency of decontamination should be considered for reusable patient care equipment when used in isolation/cohort areas.



Frequency of decontamination of the care environment

- In outpatient departments and primary care settings the extent of decontamination between patients will depend on the duration of the consultation/assessment, the patient's presenting symptoms and any visible environmental contamination.

Personal protective equipment

- compliant with the relevant BS/EN standards
- located close to the point of use
- stored to prevent contamination in a clean/dry area until required for use (expiry dates must be adhered to)
- single-use only, unless specified by the manufacturer
- changed immediately after each patient and/or following completion of a procedure or task
- disposed of after use into the correct waste stream of healthcare waste

Table 1: PPE required while providing direct care for patients with suspected or confirmed respiratory infection

PPE required by type of transmission/exposure	Disposable gloves	Disposable/reusable fluid-resistant apron/gown	FRSM/RPE	Eye/face protection (goggles or visor)
Droplet PPE	Single use	Single use apron or fluid-resistant gown if risk of extensive spraying/splashing	Single use FRSM Type IIR for direct patient care (1)	Single use or reusable (1)
Airborne PPE (When undertaking or if AGPs are likely) (3) Or if an unacceptable risk of transmission remains following rigorous application of the hierarchy of controls (4)	Single use	Single use fluid-resistant gown	Single use FFP3 (2) or reusable respirator/powerd respirator hood (RPE)	Single use or reusable (2)

Hierarchy of controls

- The hierarchy of controls can be used to help implement effective controls and reduce the spread of respiratory pathogens in health and care settings, these are applied in order and are used to identify the appropriate controls. Safe systems of work outlined in the hierarchy of controls, including **elimination, substitution, engineering, administrative controls and PPE/RPE**, are an integral part of IPC measures. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area.

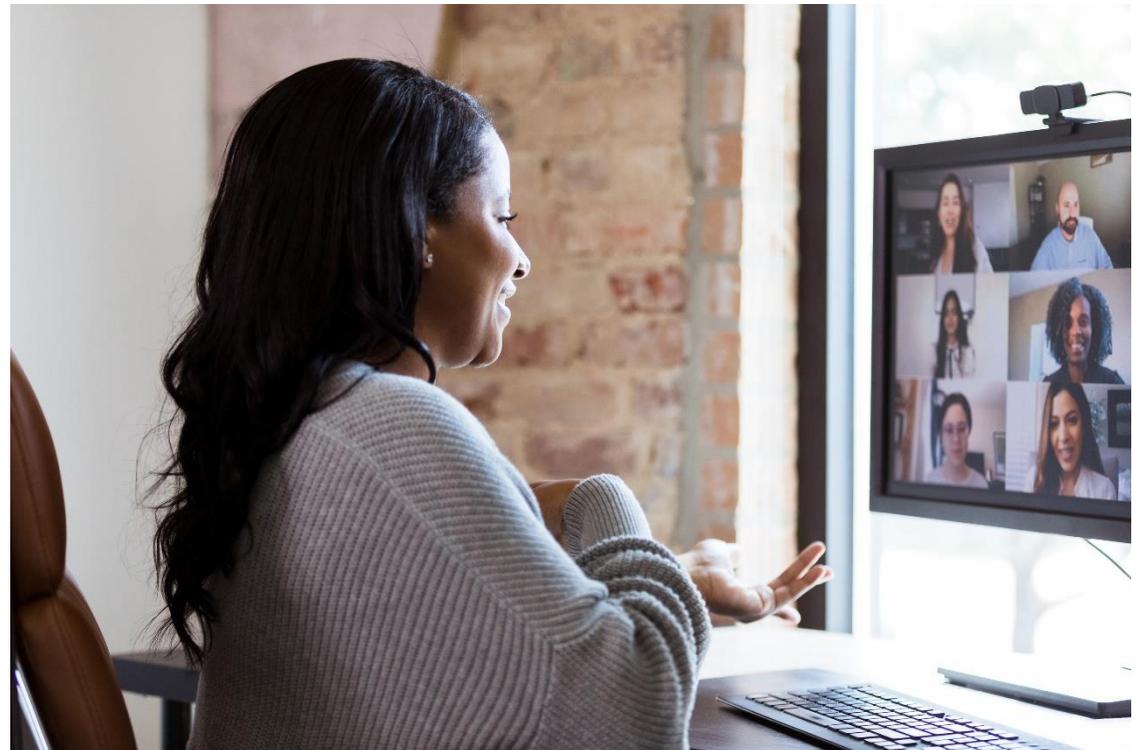


Elimination (physically remove the hazard)

- The most effective measures in the hierarchy of controls are those that eliminate the risk. This requires organisations/employers to redesign the activity so that the risk is removed or eliminated, key mitigations may include:
- screening, triaging and/or testing for SARS-CoV-2 and other respiratory pathogens relevant to the setting, for example RSV or influenza. This must be undertaken to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. See appendix 1 for an example screening tool
- where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes
- staff should not attend work if symptomatic/infectious

Substitution (replace the hazard)

- When a source of infection cannot be eliminated substitutions should be implemented to reduce or control the risk. This is sometimes not possible for health or care to achieve.
- However, some services may be able to consider the use of virtual consultations (telephone or video).



Engineering controls

Engineering controls are used to reduce or control the risk of exposure at source.

- ensuring **ventilation** systems, mechanical or natural, meet national recommendations for minimum air changes.
- dilute air with natural ventilation by **opening windows** and doors where possible
- When using **screens/partitions** in reception/waiting areas, ensure air flow is not affected and cleaning schedules are in place
- assess whether room provision is sufficient if there were to be an increase in patients requiring **isolation** for respiratory infection.
- assess the function of care areas. Patients with respiratory infections should not be cared for in poorly ventilated /overcrowded areas.

Administrative controls (change the way people work)

- Administrative controls are implemented to help prevent the introduction of infection and to control and limit the transmission of infection in health and care facilities. They include:
- screening, triaging, and testing
- maintaining separation in space and/or time between patients with and without suspected respiratory infection by:
 - * appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients
 - * appropriate patient placement for infectious patients in isolation
- regular assessments of physical distancing
- provision of appropriate education for staff, patients and visitors in IPC

- provision of additional hand hygiene stations (alcohol-based hand rub) and signage – to ensure good hygiene practices in staff, patients, and visitors
- providing safe spaces for staff breaks areas/changing facilities
- ensuring regular cleaning regimes are followed, and compliance monitored including that of reusable patient care equipment
- ensuring staff and patients' adherence with IPC guidance including face masks/coverings and physical distancing measures



Personal protective equipment

PPE is considered to be the least effective measure of the hierarchy of controls. PPE should be considered in addition to all previous mitigation measures in the hierarchy of controls, however it is acknowledged that not all elements of the hierarchy of controls will be possible in some settings for example in a patient's home. PPE considerations include:

- adequate supply and availability
- all staff required to wear an FFP3 mask have been fit tested (this is a legal requirement)
- face masks/coverings should be worn by staff and patients in all health and care facilities
- all staff (clinical and non-clinical) are trained in putting on removing and disposing of PPE
- visual reminders are displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distancing

- PPE must be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated in line with SICPs and TBP's
- Where an unacceptable risk of transmission remains following the application of the hierarchy of controls risk assessment, it may be necessary to consider the extended use of Respiratory Protective Equipment for patient care in specific situations.

Further information regarding fitting and fit checking of respirators can be found on the Health and Safety Executive website.



Do you have
any
Questions?

