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1. About this guidance

This guidance is issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, NHS National Services Scotland, UK Health Security Agency (UKHSA) and NHS England as official guidance. The guidance is published on their behalf by UKHSA.

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. This guidance considered the recommendations of:

- Health Protection Scotland. Interim infection control precautions to minimise transmission of respiratory tract infections (RTIs). V1.0 September 2015 (archived)
- Public Health England. Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings

Additionally, the guidance incorporates policy recommendations from:

- DHSC. Pandemic Influenza: guidance for infection prevention and control in healthcare settings. Final draft 2019. Produced by Health Protection Scotland with expert input from the UK 4 nations working group. Due to COVID-19 this remains unpublished but is available on request.
- ARHAI Scotland. National Infection Prevention and Control Manual
- World Health Organization (WHO). Infection prevention and control during health care when coronavirus disease (COVID-19) is suspected or confirmed. Interim guidance

The evidence reviews from ARHAI Scotland rapid reviews were also considered.

Out of scope for this guidance:

- high consequence infectious diseases (HCID) transmitted by the airborne route such as emerging pandemic influenza or other novel respiratory viruses

This guidance outlines the infection prevention and control (IPC) principles required to prevent transmission of COVID-19 and other respiratory viruses and minimise disruption to health and care services. It should be used to inform operational implementation at country, regional and local levels to ensure appropriate application across different services/sectors.

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 list is not exhaustive, please refer to specific country resources for setting specific guidance).

Please note:

- adult social care providers in England should refer to existing COVID-19 care home guidance already in place. DHSC will continuously review this guidance and update as needed

- this guidance is of a general nature. Employers should consider the specific conditions of each individual place of work and comply with all applicable legislation and regulations, including the Health and Safety at Work etc. Act 1974. This guidance does not supersede existing legislation or regulations across the UK

The use of the word individual can be used instead of patient when using this document in non-healthcare settings.

2. Main messages

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.

This guidance considers SARS-CoV-2 (including variants of concern) and other seasonal respiratory infections, including influenza and RSV. The use of local and national prevalence and incidence data during the winter months should be used to guide local service delivery.

2.1 Main changes and updates

Removal of the 3 COVID-19 specific care pathways (high, medium and low). This is in response to stakeholder feedback and to facilitate local application of the guidance by organisations/employers. 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/services with maximum workplace risk mitigation.

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.

Recommendation that physical distancing should remain at 2 metres 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 according to local/country-specific testing strategies/frameworks and data.

In response to Omicron and other variants of concern (VOCs) it is recommended that staff and organisations continue to undertake risk assessments using the hierarchy of controls which include an evaluation of the ventilation in the area, operational capacity, physical distancing and prevalence of COVID-19. Where a risk assessment indicates it, RPE should be available to all relevant staff. Staff should be provided with training on correct use. The text has been updated to make this clearer.

Recommendation that the inpatient isolation period for COVID-19 cases or contacts is reduced from 14 days to 10 days. There are some exceptions to reducing the isolation period and this should be considered as part of a clinical risk assessment.

3. Introduction

3.1 Scope

The COVID-19 pandemic remains a threat (see COVID-19 alert levels) and as such there continues to be a need to be cautious in order to prevent and control transmission of the virus. New variants of SARS-CoV-2 remain a risk as do other respiratory infections, specifically influenza and RSV which are likely to present over winter 2021 to 2022.

The COVID-19 vaccination programme across the UK continues at pace and this has been successful in reducing the most severe consequences of the disease. Delivery of health and care services must continue to be underpinned by patient/procedure risk assessment, appropriate screening/triaging/testing regimens (as per organisation or country-specific guidance) and available epidemiological data.

This guidance should be used by organisations and employers to support local implementation to ensure appropriate application.

3.2 Purpose

This guidance is written for countries/organisations/employers for adoption, adaptation and implementation in accordance with existing local governance procedures.

Whilst this document seeks to ensure a consistent and resilient UK wide approach, some differences in operational detail and organisational responsibilities may apply, where current legislation or guidance, for example clinical definitions, already exists. Country-specific policy and guidance for:

- England can be found in the Compendium of guidance and resources: COVID-19
- Scotland can be found within the National Infection Prevention and Control Manual (NIPCM)

- Wales can be found at Health and social care professionals: coronavirus and NIPCM - Public Health Wales
- Northern Ireland can be found at Guidance for professionals and organisations

4. Governance and responsibilities

Organisations may adopt practices that differ from those recommended/stated in this national guidance. Organisations are responsible for ensuring safe systems of work, including managing the risk associated with infectious agents through the completion of risk assessments approved through local governance procedures, for example Integrated Care System level, Health Board. This national guidance outlines the recommended principles to support local decision making within individual organisations.

Organisations and employers including NHS Trusts, NHS Boards, Health and Social Care Trusts (Northern Ireland), local authorities, independent sector providers, and other care providers through their Chief Executive Officer (CEO) or equivalent must ensure that:

- application of IPC practices is monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors)
- training in IPC measures are provided to all staff, including: the correct use of personal protective equipment (PPE) including a face fit test/check 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 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 according to local / country-specific testing strategies / frameworks and data
- 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. This will entail local risk assessments based on the measures as prioritised in the hierarchy of controls in the context of managing infectious agents and should be communicated to staff
- 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

5. Infection control precautions for seasonal respiratory infections

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.

5.1 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) to be worn in multi-bedded bays and communal areas if this can be tolerated. Surgical facemasks are not required to be worn by patients in single rooms unless another person enters, or the room door is required to remain open. All patients transferring to another care area should wear a surgical facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination. Patients should be provided with a new surgical mask at least daily or when soiled or damaged. The requirement for patients to wear a surgical facemask must never compromise their clinical care, such as when oxygen therapy is required.

Organisations in NHS Scotland should refer to Coronavirus (COVID-19): Guidance on the extended use of facemasks and face coverings in hospitals, primary care and wider community care settings.

5.2 Screening for COVID-19

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.

Screening for other infections /multi-drug resistant organisms should be included as per national screening guidance/requirements.

5.3 Triaging

Organisations/employers may wish to utilise care pathways – examples of this could include respiratory/emergency/elective pathways.

Triaging within all healthcare facilities must be undertaken to enable early recognition of patients with respiratory infections. Triage should be undertaken by clinical staff who are trained and competent in the application of clinical case definitions prior to the patient's arrival at a care area, or as soon as possible on arrival, and used to inform patient placement to the appropriate care area or pathway.

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

Patients with excessive cough and sputum production and those at higher risk of severe outcomes should be prioritised for placement in single rooms whilst awaiting testing.

Placement in any care area should not impact the delivery and duration of care for the patient. Patients should not be transferred unnecessarily between care areas unless, for example, there is a change in their infectious status, clinical need, or availability of services. This should be agreed locally.

If treatment can be deferred, and this is not detrimental to the patient's care, then this should be considered.

5.4 Testing

Organisations/employers should where available include testing (ideally rapid or near-patient testing) as part of their IPC risk mitigation strategy at times of increased infection prevalence. The choice of which tests, how and when these are deployed, and how the results are actioned, including whether confirmatory testing is required before actions such as patient triage/placement occur, should be part of the local IPC policy for Accident and Emergency Department or Admissions.

For further testing guidance refer to country-specific guidance.

5.5 Standard infection control precautions

Patients attending for an appointment/admission who have been screened (and have answered 'no' to all screening questions), triaged (and have no clinical signs or symptoms of respiratory infection) and tested (with a negative result) as per country or local testing strategies only require the application of standard infection control precautions (SICPs) at the point of care.

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. Transmission-based precautions (TBPs) as outlined in this guidance are not routinely required. However, the application of IPC measures must be assessed, and risks mitigated as outlined under the hierarchy of controls.

The elements of SICPs are:

- 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

National (country-specific) policies for SICPs are available for Wales, Northern Ireland, and Scotland. NHS England is developing a national IPC manual for England as set out in the UK 5-year Tackling Antimicrobial Resistance National Action Plan (2019 to 2024). See glossary for further definitions of SICPs and TBPs.

6. Transmission-based precautions

This section describes specific actions that should be taken when applying TBPs. TBPs are applied when SICPs alone are insufficient to prevent transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a suspected or confirmed infectious agent. TBPs are categorised by the route of transmission of the infectious agent. See glossary for further definitions.

6.1 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.

6.2 Patient placement in inpatient settings

Following screening, triaging and testing, patients should be regularly reviewed for respiratory symptoms throughout their care/stay.

Bed spacing (defined within (HBN 04-01) Adult in-patient facilities: planning and design or country-specific derivative) should be appropriate for patient care activities to be carried out. Inpatient bed spacing requirements may increase in care areas where additional equipment or greater staff numbers are needed, for example critical care.

6.2.1 Isolation for patients with respiratory symptoms

In the hospital setting the patient should, wherever possible, be placed in a single room, ideally with en-suite facilities. A specialised isolation suite/room is not necessary but where available should be used for patients undergoing aerosol generating procedures (AGPs). If single/isolation rooms are in short supply, and cohorting is not yet possible (awaiting laboratory confirmation), prioritise patients who have excessive cough and sputum production for single room placement.

The transfer of patients outside of their rooms should be limited to medically necessary activities wherever possible.

Prioritisation for isolation in a single room should consider the availability of single rooms for patients with other infectious agents, for example gastrointestinal infections or multi-drug resistant organisms. Those with underlying health conditions who are at higher risk of severe outcomes should be prioritised for placement in single rooms whilst awaiting testing.

6.2.2 Cohorting patients with confirmed respiratory infection

If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.

Physical distancing is recommended to remain at 2 metres where patients with suspected or confirmed respiratory infection are cared for and patients should be reminded to remain within their bed space.

The cohorting of staff as an additional infection control measure may also be considered in isolation/cohort rooms/areas. This can only be implemented if there are sufficient levels of staff available to not negatively impact patient care.

Ensure patients are wearing surgical masks where tolerated.

6.3 Patient placement in care homes, primary care, and outpatient settings

6.3.1 Care homes

Individuals in care homes with suspected or confirmed respiratory infection should ideally be isolated in their own room with an associated en-suite. However, where this is not possible local arrangements should be made based on the available estate and following a risk assessment, ideally in consultation with local IPC teams, health protection teams or other appropriate agencies.

6.3.2 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

6.4 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.

Check manufacturer's instructions for suitability of cleaning products especially when dealing with electronic equipment. If the item cannot withstand chlorine releasing agents consult the manufacturer's instructions for a suitable alternative to use following or combined with detergent cleaning. Alternative cleaning agents/disinfectant products may be used with agreement of the local IPC team or health protection team. Manufacturer's guidance/instructions and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products.

Further information on the processes of decontamination are found in the national cleaning guidelines for healthcare settings for each country:

- England: National Standards of Healthcare Cleanliness
- Scotland: NHS Scotland National Cleaning Services Specification
- Wales: National Standards for Cleaning in NHS Wales, see also COVID-19 addendum: Key standards for environmental cleanliness
- Northern Ireland: NI Regional IPC Manual: Cleaning and Disinfection

6.4.1 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.

6.4.2 Frequency of decontamination of the care environment

An increased frequency should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. Decontamination of inpatient rooms (isolation rooms and cohort areas) must be carried out at least twice daily. Surfaces where there may be higher environmental contamination rates, including toilets/commodes (particularly if patients have diarrhoea), and frequently touched surfaces such as nurse call buttons, medical equipment, door/toilet handles and locker tops, over-bed tables and bed rails should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.

Inpatient rooms must also be terminally cleaned:

- following resolutions of symptoms and removal of precautions
- when vacated following discharge or transfer (this includes removal and disposal or laundering of all curtains and bed screens)
- following an AGP if the room is vacated. Clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room. Refer to (HTM) 03-01 Specialised ventilation for healthcare buildings or country-specific derivative. Advice should be sought from the IPC team and/or the estates department/team

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.

6.5 Personal protective equipment

6.5.1 Principles of personal protective equipment

Before undertaking any procedure, staff should assess any likely blood and body fluid exposure risk and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken.

All PPE should be:

- compliant with the relevant BS/EN standards (technical standards as adopted in the UK post-Brexit)
- 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

Hand hygiene must be performed after removal of PPE.

Any reusable PPE/RPE must have a decontamination and maintenance process in place and responsibility assigned.

6.5.2 Disposable gloves

Gloves are not an alternative to hand hygiene. Inappropriate use of gloves, including not changing them as recommended above, risks the gloves contributing to the transfer of infectious agents and cross infection.

Gloves are not required unless exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely. Gloves are not required when undertaking administrative tasks (for example using the telephone, using a computer or tablet), writing in the

patient chart, giving oral medications or vaccinations, distributing or collecting patient dietary trays. The unnecessary use of gloves generates excessive waste.

Disposable gloves must:

- 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
- be changed if damaged or punctured
- not be decontaminated with alcohol based hand rub (ABHR) or soap between use

Double gloving is only recommended during some exposure prone procedures (EPPs), for example orthopaedic and gynaecological operations, when attending major trauma incidents or when caring for a patient with a suspected or confirmed HCID. Double gloving is not necessary at any other time.

6.5.3 Aprons and gowns

Disposable plastic aprons must be worn to protect staff uniform or clothes from contamination when providing direct patient care for patients with suspected or confirmed respiratory infection and during environmental and equipment decontamination.

Aprons are not required when: undertaking administrative tasks, (for example using the telephone, using a computer or tablet), writing in the patient chart, giving oral medications or vaccinations, distributing or collecting patient dietary trays. The unnecessary use of aprons generates excessive waste.

Fluid-resistant gowns must be worn:

- when a disposable plastic apron provides inadequate cover of staff uniform or clothes for the procedure/task being performed

- when performing AGPs on patients with a suspected or confirmed respiratory infection
- when there is a risk of extensive splashing of blood and/or other body fluids for example during AGPs

Disposable aprons and gowns must be changed between patients and immediately after completion of a procedure or task.

6.5.4 Eye and face protection

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

- be worn if blood or body fluid contamination to the eyes or face is anticipated or likely
- be worn by staff when caring for patients with a suspected or confirmed infection spread by the droplet or airborne route as deemed necessary by a risk assessment
- be worn during AGPs
- not be impeded by accessories such as piercings or false eyelashes
- not be touched when being worn

Regular corrective spectacles are not considered as eye protection.

6.5.5 Surgical face masks

In addition to universal masking, a fluid-resistant surgical mask (Type IIR) must be worn by staff when caring for patients with a suspected or confirmed infection spread by the droplet route.

Surgical masks must:

- be well fitted covering both nose and mouth
- not be allowed to dangle around the neck at any time
- not be touched once put on
- be changed when they become moist or damaged

- be worn once and then discarded in line with country-specific guidance or policy (hand hygiene must always be performed after disposal)

6.5.6 Respiratory protective equipment (RPE)/FFP3 (filtering face piece) or powered air purifying respirator (PAPR) hood

A respirator with an assigned protection factor (APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when:

- caring for patients with a suspected or confirmed infection spread by the airborne route (during the infectious period)
- when performing AGPs on a patient with a suspected or confirmed infection spread by the droplet or airborne route

Where a risk assessment indicates it, RPE should be available to all relevant staff. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area. The hierarchy of controls can be used to inform the risk assessment. Staff should be provided with training on correct use.

An FFP3 respirator or powered respirator hood must never be worn by an infectious patient.

Respirators can be single use or sessional use (disposable or reusable).

All tight fitting RPE, that is, FFP3 respirators must:

- be fluid-resistant
- be fit tested on all health and care staff who may be required to wear a respirator to ensure an adequate seal/fit according to the manufacturer's guidance*
- be fit checked (according to the manufacturer's guidance) every time a respirator is donned to ensure an adequate seal has been achieved

- be compatible with other facial protection used (protective eyewear) so that this does not interfere with the seal of the respiratory protection
- be disposed of and replaced if breathing becomes difficult, the respirator is damaged or distorted, the respirator becomes obviously contaminated by respiratory secretions or other body fluids, or if a proper face fit cannot be maintained
- not be touched once put on, if adjustments are needed ensure hand hygiene is undertaken
- be removed outside the patient's room or cohort area

In the absence of an anteroom/lobby, remove RPE and eye protection in a safe area (for example outside the isolation/cohort room/area). All other PPE should be removed in the patient care area. Perform hand hygiene after removing and disposing of RPE.

*Where fit testing fails, suitable alternative equipment must be provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions, this may be country specific.

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

Respirators with exhalation valves are not fluid-resistant unless they are also 'shrouded'. Valved non-shrouded respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated.

Respirators and powered respirator hoods with exhalation valves are ineffective for source control. These should not be worn by a healthcare worker/operator when sterility directly over the surgical field is required, for example in theatres/surgical settings or when undertaking a sterile procedure, as the exhaled breath is unfiltered (see CAS alert for more information).

6.5.7 Summary of PPE required for direct care of patients with suspected or confirmed respiratory infection

If there is no direct contact with the patient or their environment, gloves and aprons/gowns are not required.

Refer to guidance on donning (putting on) and doffing (removing) PPE for droplet and airborne precautions.

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
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)
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/powered respirator hood (RPE)

(1) FRSM can be worn sessionally (includes eye/face protection) if providing care for cohorted patients. All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

(2) RPE can be worn sessionally (includes eye/face protection) in high risk areas where AGPs are undertaken for cohorted patients (see footnote 4). All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

(3) Consideration may need to be given to the application of airborne precautions where the number of cases of respiratory infections requiring AGPs increases and patients cannot be managed in single or isolation rooms.

(4) Where a risk assessment indicates it, RPE should be available to all relevant staff. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area. The hierarchy of controls can be used to inform the risk assessment. Staff should be provided with training on correct use.

6.6 Aerosol generating procedures

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 confirmed to be suffering from an infectious agent transmitted by the airborne or droplet route. Only staff who are needed to undertake the procedure should be present, wearing airborne PPE/RPE precautions.

The list of medical procedures that are considered to be aerosol generating or associated with an increased risk of respiratory transmission is:

- 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*
- upper ear, nose, and throat (ENT) airway procedures that involve respiratory suctioning*
- upper gastro-intestinal endoscopy where open suction of the upper respiratory tract* occurs beyond the oro-pharynx
- high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

*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, that is oral/pharyngeal suctioning is not an AGP.

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.

Further information on AGPs for neonates and a literature review for AGPs during COVID-19 are available. The defined list of AGPs is

currently under review, this is expected to be finalised by end November 2021 at which point this guidance will be updated.

Airborne precautions are not required for AGPs on patients/individuals if screening, triaging and testing have confirmed the absence of respiratory infection.

6.7 Duration of precautions

In general, patients should remain in isolation or cohorted, and TBPs should be applied until resolution of fever and respiratory symptoms, or until they are established on or have completed an appropriate course of treatment. This will be dependent on the infectious agent.

Some patients with more severe illness or underlying immune problems may remain infectious for a longer period. The duration of TBPs may require modification based on available pathogen-specific guidance and patient information.

TBPs should only be discontinued in consultation with clinicians (including microbiology/IPC team) and should take into consideration the infectious agent, individual's test results (if available) and resolution of clinical symptoms.

6.7.1 Stepping down COVID-19 isolation precautions if the patient is staying in hospital

For in-patients with COVID-19, isolation should continue until 10 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms), provided the clinical criteria below have been met.

Clinical criteria:

- clinical improvement with at least some respiratory recovery

- absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication
- no underlying severe immunosuppression

Patients do not routinely need to be re-tested by PCR test before stepping down isolation. Additional mitigations such as the use of LFD testing may be considered before stepping down isolation.

A cough or a loss of, or change in, normal sense of smell or taste (anosmia), may persist in some individuals for several weeks, and are not considered an indication of ongoing infection when other symptoms have resolved.

This guidance does not apply if there are any additional indications for ongoing isolation and transmission based precautions (for example MRSA carriage, C.difficile infection, diarrhoea).

For clinically suspected COVID-19 patients who have tested negative and whose condition is severe enough to require hospitalisation, the isolation period should be measured from the day of admission.

6.7.1.1 Severely immunocompromised patients

It is possible for severely immunocompromised patients to remain infectious for prolonged periods, even if they do not display any symptoms of COVID-19. The isolation period for these patients whilst in hospital should be at least 14 days.

In severely immunocompromised patients resolution of symptoms should not be used as a marker of decreased infectiousness and these patients should be isolated in side rooms, cubicles or cohorted until they return a negative PCR test. Staff should strictly adhere to recommended IPC measures throughout the inpatient stay.

Severely immunocompromised patients can end their isolation after a single negative PCR test result taken no earlier than 14 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms).

6.7.2 Stepping down COVID-19 precautions for exposed patient contacts in hospital settings if the patient is staying in hospital

Inpatients who are considered contacts of SARS-CoV-2 cases should isolate for 10 days from the date of exposure (unless symptoms occur, or positive test result). Testing may be used following this period as per country policy if the patient remains in hospital.

6.8 Care of the deceased

The principles of SICPs and TBPs continue to apply when caring for the deceased. This is due to the ongoing risk of transmission although the risk is usually lower than for living patients. Organism-specific requirements for use of body bags, viewing, hygienic preparations, post-mortem examinations and embalming are described by the Health and Safety Executive. Additional guidance on the COVID-19: guidance for care of the deceased is available.

7. Visitors

Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported. If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. Gloves and aprons are not routinely required unless providing direct patient care. Visitors should also be instructed on effective hand hygiene.

Visitors should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment, for example carer/parent/guardian.

It may be considered appropriate to restrict visiting because of outbreaks of respiratory infection in health and care settings. This is a local outbreak management team decision.

Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (for example parent/child) a risk assessment should be undertaken, and mitigations put in place to support visiting wherever possible.

Refer to country-specific guidance.

8. Occupational health and vaccination

Prompt recognition of cases of respiratory infection among health and care staff is essential to limit transmission. All staff should be vigilant for any signs of respiratory infection and should not come to work if they have respiratory symptoms. They should seek advice from their IPC teams/occupational health department/GP or employer as per the local policy. Symptomatic staff should avoid contact with people both in the hospital and in the general community. Bank, agency, and locum staff should follow the same deployment advice as permanent staff.

Systems should be in place to ensure that country-specific vaccination and testing policies are in place as advised by occupational health/public health teams. Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 may be allowed to return to work without the need to self-isolate. There are country-specific variations on the requirements for polymerase chain reaction (PCR) and lateral flow device (LFD) testing, and these policies are under continual review.

Refer to country-specific policy for:

- England – COVID-19 management of exposed healthcare workers and patients in hospitals and an accompanying letter issued by NHS England
- Scotland - Coronavirus (COVID-19) – exemption of fully vaccinated social care staff from isolation: information for providers
- Wales - COVID-19 contacts: guidance for health and social care staff
- Northern Ireland - management of self-isolation of close contacts of COVID-19 cases who are fully vaccinated - additional safeguards for health and social care staff

As part of an employer's duty of care, they have a role to play in ensuring that staff understand and are adequately trained in safe systems of working, including donning and doffing of PPE. 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 for illness and absence
- facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce
- lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19
- encourage staff vaccine uptake

The vaccination status of staff may be considered when making staffing decisions for cohort areas. Regardless of whether staff have had and recovered from or have received vaccination for a specific respiratory pathogen they must continue to follow the infection control precautions, including PPE, as outlined in this document.

A risk assessment is required 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. Employers should:

- discuss and complete a risk assessment with employees who are in the COVID-19 at risk groups, for example, those who are pregnant or of BAME origin
- ensure that advice is available to all health and care staff, including specific advice to those at risk from complications. Bank, agency and locum staff who fall into these categories should follow the same deployment advice as permanent staff

9. Surveillance and monitoring

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) must continue.

Positive cases of COVID-19, influenza or RSV (or other respiratory infections) identified after admission who fit the criteria for a healthcare associated infection (HCAI) should trigger a case investigation. If two or more cases are linked in time and place, an outbreak investigation should be conducted.

10. Hierarchy of controls

This section is included to support organisations/employers who have a responsibility to assess, manage and monitor risk in the context of managing infectious agents based on the measures as prioritised in the hierarchy of controls.

Risk assessments must be carried out in all areas by a competent person with the skills, knowledge and experience to be able to recognise the hazards associated with respiratory infectious agents. This can be the employer, or a person specifically appointed to complete the risk assessment. During development and on completion this risk

assessment needs to be communicated to employees. This can be used to populate local risk management systems.

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.

Some of the key areas and measures that could be considered are outlined below.

10.1 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

10.2 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).

10.3 Engineering controls (control, mitigate or isolate people from the hazard)

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

They include design measures such as ventilation/barriers/screens. Priority should be given to measures that provide collective/maximal protection rather than those that just protect individuals or a small group of people, for example:

- ensuring ventilation systems, mechanical or natural, meet national recommendations for minimum air changes refer to country-specific guidance. This should be carried out in conjunction with organisational estates teams/specialist advice from ventilation group and /or authorised engineer
- dilute air with natural ventilation by opening windows and doors where possible
- if considering screens/partitions in reception/waiting areas, ensure air flow is not affected and cleaning schedules are in place, consult with Estates/facilities teams
- assess whether room provision is sufficient if there were to be an increase in patients requiring isolation for respiratory infection. Work in a multidisciplinary team with hospital leadership,

engineering, and clinical staff to plan for creation of adequate isolation rooms/units

- assess the function of care areas. Patients with respiratory infections should not be cared for in poorly ventilated/overcrowded areas. Where a clinical space has very low air changes and it is not practical to increase dilution effectively then consider alternative technologies with Estates/ventilation group
- see Adult in-patient facilities: planning and design (HBN 04-01)

Refer to (HTM 03-01) Specialised ventilation for healthcare buildings and (HBN 00-09) Infection control in the built environment or country-specific derivative for further information.

Organisations in Scotland should refer to SHTM 03-01 Ventilation for Healthcare Premises Part A – Design and Validation.

10.4 Administrative controls (change the way people work)

Administrative controls (for example the design and use of appropriate processes, systems and engineering controls, and provision and use of suitable work equipment and materials) 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 to enable early recognition of SARS-CoV-2 and other infectious agents, for example influenza, RSV
- 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 or cohorts
- regular assessments of physical distancing and bed spacing, taking into account potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements)
- for patients who are suspected or confirmed to be positive with a respiratory pathogen including SARS-CoV-2 and their treatment cannot be deferred, care should be provided from services able to operate in a way which minimises the risk of spread of the virus to other patients/individuals
- 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

10.5 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 of PPE including RPE to protect staff, patients, and visitors
- 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 TBPs

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 RPE 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.

11. Glossary

Aerosol generating procedures (AGPs)

Certain medical and patient care activities that can result in the release of airborne particles (aerosols). AGPs can increase the risk transmission of infections.

Airborne transmission

The spread of infection from one person to another by airborne particles (aerosols) containing infectious agents. Airborne particles are 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 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 are measures used to prevent, and control infection spread without necessarily having close patient contact via aerosols 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.

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). Contact transmission 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 (fomite) or person.

COVID-19

COVID-19 is a highly infectious respiratory disease caused by a novel coronavirus (SARS-CoV-2). 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) via droplets 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.

Droplet transmission

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 using any one of:

- a fluid-resistant surgical mask (FRSM) (Type IIR) with integrated visor
- a full face visor or shield
- goggles plus a FRSM (Type IIR)

A disposable FRSM 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. When used to describe a surgical mask this specifically refers to a type IIR surgical mask and not a type II surgical mask.

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.

Hierarchy of controls

The hierarchy of controls are used to identify the appropriate controls with elimination, substitution, engineering controls, administrative controls, PPE.

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/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. Referred to as 'AGP hot spots'.

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 suspected or confirmed to be infectious and or linen that is contaminated with blood and or other body fluids, for example faeces.

Overcrowding

In a healthcare setting overcrowding occurs when more persons (patients, staff, or visitors) or equipment are present in a care area than is comfortable or safe. Safety is determined by risk assessment with particular reference in acute settings to (HBN 04-01) Adult in-patient facilities.

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 confirmed 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 (RPE)

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 respirator hoods (TH2). FFP stands for filtering face piece. There are 3 categories of FFP respirator: FFP1, FFP2 and FFP3. FFP3 and loose-fitting powered respirator hoods provide the highest level of

protection and are recommended when caring for patients in areas where high risk AGPs are being performed.

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.

Screening

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. The NHS offers a range of screening tests to different sections of the population. In this guidance screening is used to identify patients before or at entry to the care area who may have COVID-19 but who are not demonstrating symptoms. This is distinct from triaging (see below).

Shrouded valved respirator

In relation to valved respirators, a shroud refers to the material covering the valve outlet. The material must meet the same standards for fluid-resistance as a fluid resistant (Type IIR) surgical mask. A respirator with a shrouded valve can be used for the same activities as an unvalved

respirator, that is to protect the wearer against splash and spray in addition to airborne infection risks.

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.

Source control

Source control refers to use of well-fitting cloth masks, FRSMs, or respirators (must be unvalved or shrouded) to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

Standard infection control precautions (SICPs)

SICPs are the basic IPC measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. 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.

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.

Terminal clean

A terminal clean is defined as: a procedure required to ensure that an area has been cleaned/decontaminated following transfer or discharge of a patient suspected or confirmed to be infected or colonised with an infectious pathogen (that is, alert organism or communicable disease) in order to ensure a safe environment for the next patient.

Transmission-based precautions (TBPs)

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

Triaging

Prioritisation of care according to severity using a validated tool. In this guidance those with respiratory symptoms should be prioritised for isolation/single room care whilst awaiting test results.

Universal masking

Universal masking in health facilities is defined as the requirement for all persons (staff, patients, visitors, service providers and others) to wear a mask at all times except for when eating or drinking.

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