Public Health England

NHS

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

Infection prevention and control recommendations

Uncontrolled if printed.

NHS National Services Scotland

Health Protection Scotland

HSC Public Health Agency

GIG CYMRU NHS WALES

Iechyd Cyhoeddus Cymru Public Health Wales

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.

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 This guidance has been superseded by this publication.

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.

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.

First published 20 August 2020 (Version 1.0)

PHE publications gateway number: GW-1502

Key messages

This guidance supersedes the COVID-19 UK IPC guidance (18 June 2020).

Local and national prevalence and incidence data will be used to guide returning services as advised by Country specific/public health organisations.

Patients/Individuals treatment, care and support to be managed in 3 COVID-19 pathways:

- **High risk:** There is no change in recommendations for IPC or for the use of PPE by staff when managing patients**/**individuals who have, or are likely to have, COVID-19
- **Medium risk:** This includes patients/individuals who have no symptoms of COVID-19 but do not have a COVID-19 SARS- CoV-2 PCR test result.
- **Low risk:** Patients/individuals with no symptoms and a negative COVID-19 SARS-CoV-2 PCR test who have self-isolated prior to admission for example following NICE guidance

Sessional use of single use personal protective equipment (PPE) items has been minimised and only applies to extended use of facemasks for healthcare workers.

The use of face masks (for staff) or face coverings[1] (England and Scotland) 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 redcue the risk of transmission.

Physical distancing of 2 metres is considered standard practice in all health and care settings.

Patients/individuals on a low risk pathway require Standard Infection Prevention Control Precautions for surgery or procedures.

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).

[1] 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.

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).”

Contents

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

Process for updating the guidance (as published on August 20 2020)

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 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.

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/

The remobilisation of services will require ‘new ways’ of working during the continued pandemic. Having assessed the available evidence and the feedback received from guidance users, professional bodies and associations, this guidance outlines the changes required to assist in restoring services in this ‘new’ health and care environment whilst COVID-19 remains a threat. This is based upon emerging evidence, experience and expert opinion.

The main changes to the guidance are:

1. Local and national prevalence and incidence data will be used to guide returning services as advised by Country specific/public health organisations.
2. Patients/individuals to be managed in 3 COVID-19 pathways, high, medium and low risk.
3. Sessional use of single use PPE items has been minimised and only applies to extended use of facemasks for healthcare workers.
4. The use of facemasks (for staff) and face coverings (if tolerated by the individual) is recommended in England and Scotland, 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.
5. Physical distancing of 2 metres is considered standard practice in all health and care settings.
6. Patients/individuals on a low risk pathway require Standard Infection Prevention & Control Precautions for surgery or procedures.

2. Introduction

2.1 Scope and purpose

This document sets out the infection prevention and control (IPC) advice for health and care organisations as the UK moves to remobilise healthcare services.

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 revised guidance supersedes the COVID-19 IPC guidance (18 June 2020) on the GOV.UK website and has been drafted to support services to restart safely. The challenge facing the NHS is to 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.

The remobilisation (restarting) of services requires new ways of working during the continued pandemic and, as COVID-19 becomes endemic; guidance for working in a new healthcare environment will need to be developed 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

Further updates may be made to this document as new detail/evidence on COVID-19 emerges and as the pandemic phases/levels change. Link to current Alert Levels

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 good IPC practice. 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 shielding groups, including Black, Asian and Minority Ethnic (BAME) staff.
- **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. Care pathways

These pathways 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. 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 and triaging 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 precautions, for example Standard Infection Control Precautions (SICPs) or Transmission Based Precautions (TBPs) must be communicated between care areas.

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 (COVID-19) 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 (COVID-19) test result with no known recent COVID-19 contact OR **b)** testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR **c)** asymptomatic individuals decline testing	Any care facility where: **a)** triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact who have isolated/shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the test date OR **b)** Individuals who have recovered from COVID-19 and have had at least 3 consecutive days without fever or respiratory symptoms and a negative COVID-19 test OR **c)** patients or individuals are regularly tested (remain negative)

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

• 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 in-patient 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 in-patients; adult and children, Mental health, Maternity, Critical Care Units
	• Outpatient depts. including Diagnostics and Endoscopy
	• Care homes*
	• Prisons
		• 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

*This guidance 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:
   - hospital 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)
   - frequent decontamination of equipment and environment
   - 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 coverings by all outpatients (if tolerated) and visitors when entering a hospital or GP/dental surgery
     - use of a surgical facemask (Type II or Type IIR) by all inpatients 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, to minimise the dispersal of respiratory secretions and reduce environmental contamination
     - extended use of facemasks by all staff (England /Scotland) in both clinical and non-clinical areas within the healthcare setting
     - 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 place, such as physical distancing, to ensure sufficient access depending on the patient's condition and the care pathway

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

4. Ensure restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff, including patient transfers, communal staff areas (changing rooms/restaurant). As the prevalence/incident rates decline this may not be necessary between pathways providing the IPC measures are 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 and decrease until cessation of the pandemic.

7. Ensure a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation.

8. If prevalence/incidence rate for COVID-19 is high, where possible, assign teams of medical/nursing and domestic staff to care for individuals in isolation/cohort rooms/areas/pathways. If a member of staff is required to move between sites/hospitals 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 weekly COVID-19 surveillance report from the respective countries and depending on the data, the pressure on the healthcare services and local capacity and resources.

10. Safe systems of working including administrative, environmental and engineering controls are an integral part of IPC measures. Standards for ventilation[2] will apply to specific areas in a healthcare setting for example, theatres and endoscopy suites.

[2] A number of UK short life working groups led by NHS Estates are undertaking further work on theatre, endoscopy, dental ventilation requirements and fallow periods following Aerosol Generating Procedures (AGPs) which will be published on completion.

4.2 Community settings

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

- 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 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 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 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

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 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.

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.

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 practical 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)
- 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 (new SICP due to COVID-19)

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

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
- 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, such as 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 likely
- changed immediately after each patient and/or after completing a procedure/task even on the same patient
- never decontaminated with Alcohol Based Hand Rub (ABHR) or soap between use

NB. Double gloving is NOT recommended for routine clinical care of COVID-19 cases and vinyl medical gloves should only be worn in care situations where there is no anticipated exposure to blood and/or body fluids

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
- changed between patients /individuals and immediately after completing a procedure or task unless sessional use is advised due to local/national data

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, regular corrective spectacles are not considered eye protection
- not be impeded by accessories such as piercings or false eyelashes
- not be touched when being worn

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 (manufacturers' instructions must be followed to ensure effective fit and protection)
- not touched once put on or allowed to dangle around the neck
- be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through

Surgical face masks Type II must be:

- worn for extended use by healthcare workers when entering the hospital or care setting, 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)

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 Aerosol Generating Procedure (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 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
- upper ENT airway procedures that involve respiratory suctioning
- upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
- 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.

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.

Literature review for AGPS during COVID-19 can be found here:

7. Low Risk Pathway: Key principles

This pathway applies to:

a) Individuals triaged/clinically assessed prior to treatment (inpatient/outpatient) with no COVID-19 contacts or symptoms who have isolated/shielded

AND

b) patients who have a negative SARS-CoV-2 (COVID-19) test result within 72 hours of care and, for planned admissions, have self-isolated since the test date

OR

c) individuals who have recovered from COVID-19 AND have had at least 3 consecutive days without fever or respiratory symptoms AND a negative SARS-CoV-2 test result

OR

d) patients or individuals in any care facility where testing is undertaken regularly (remains negative)

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 period before a planned procedure. The length of self-isolation will depend on their individual risk factors and requires individualised care and shared decision making.

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).

7.2 Personal protective equipment**

Personal Protective Equipment required for SICPs is as follows: this includes the use of a surgical face mask for extended use.

SICPS/PPE (all settings/all patients/individuals)	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)	Surgical mask Type II for extended use* 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 in England/Scotland for HCW when in any healthcare facility
**Airborne precautions are NOT required for AGPs on patients/individuals in the low risk COVID-19 pathway, providing the patient has no other 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, in particular, frequently touched sites/points.

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 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 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

As numbers of COVID-19 cases decline, 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.

7.6 Discharge or transfer

There is no restriction on discharge unless the patient/individual is entering a long-term care facility when testing may be required.

In England, to ensure testing does not delay a timely discharge, 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 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 **additiona**l 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/1metre) 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 this route and the precautionary distance has been increased to 2 metres.**

c) Airborne precautions

Used to prevent and control infection spread without necessarily having close patient contact via aerosols (≤5μm) 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 Aerosol Generating Procedures (AGPs) are undertaken**

Transmission Characteristics

Transmission of SARs-CoV-2 implications for infection prevention precautions is contained within the WHO scientific briefing paper

Literature reviews to support TBPs can be found here

9. Medium Risk Pathway: Key principles

This pathway applies to the following:

a) any facility where triaged/clinically assessed individuals are asymptomatic and are waiting a SARS-CoV-2 (COVID-19) test result and have no known recent COVID-19 contact

OR

b) any care facility where testing is not required or feasible on asymptomatic individuals and therefore infectious status is unknown

OR

c) asymptomatic individuals who decline testing in any care facility

9.1 Maintaining physical distancing and patient placement

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 advise other patients/visitors to comply
- ensure cohorted patients/individuals are physically separated from each other, for example use 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

9.2 Personal protective equipment

DROPLET/CONTACT PPE	Disposable gloves	Disposable apron/gown	Face masks	Eye/face protection (visor)
PATIENTS/INDIVIDUALS WITH NO COVID-19 SYMPTOMS and NO TEST RESULT	Single use	Single use apron (gown required if risk of spraying / splashing)	FRSM Type IIR for direct patient care[1]	Single use or re-usable
AIRBORNE	Disposable gloves	Disposable apron/gown	Respirator	Eye/face protection (visor)
WHEN UNDERTAKING AGPS ON PATIENTS/INDIVIDUALS with NO COVID-19 SYMPTOMS AND NO TEST RESULT	Single use	Single use gown	FFP3 or Hood for AGPs	Single use or re-usable

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

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 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
- 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 this frequency should be increased to a minimum of twice daily
- 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/commodes 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
- 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/ respiratory protective equipment (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 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 has been limited during the peak of the pandemic 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)

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.

In England, to ensure testing does not delay a timely discharge, 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 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.

Advice on any self-isolation post discharge will be provided by the clinician if this is required.

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.

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) 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 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 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 surgical patients/individuals with availability of single rooms taken into consideration.

10.2 Personal protective equipment

DROPLET/CONTACT PPE	Disposable gloves	Disposable apron/gown	Face masks	Eye/face protection (visor)
IF SUSPECTED/ CONFIRMED COVID-19 PATIENT/INDIVIDUAL	Single use	Single use apron (gown required if risk of spraying / splashing)	FRSM Type IIR for direct patient care[1]	Single use or re-usable
AIRBORNE*	Disposable gloves	Disposable apron/gown	Respirator	Eye/face protection (visor)
WHEN UNDERTAKING AGPS ON CONFIRMED OR SUSPECTED COVID-19 PATIENTS/INDIVIDUAL	Single use	Single use gown	FFP3 or Hood for AGPs	Single use or re-usable

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

10.2.1 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 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
- 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
- changed between patients/individuals and immediately after completing a procedure or task unless sessional use is advised due to local/national data

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

Please refer to Section 9.3.

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

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 (including day surgery)

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 fully on 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

Patients/individuals should remain in isolation/cohort with TBPs applied for at least 14 days after onset of symptoms and at least 3 consecutive days without a fever or respiratory symptoms. For asymptomatic patients/individuals, TBPs may be discontinued 14 days after initial positive result. The decision to modify the duration of, or ‘stand down’ TBPs (Contact/Droplet/Airborne) should be made by the clinical team managing the Individual s care.

Step down of TBPs for COVID-19 for home discharge may require some individual clinical assessment at local level depending on the severity of the disease and underlying conditions, including testing requirements.

10.6 Visitor guidance

In this pathway, visiting should continue to be limited to only essential visitors, for example birthing partner, carer/parent/guardian.

The need for visitors to wear PPE should be 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 advice to self -isolate for 14 days post discharge from the date of the positive SARS-CoV-2 PCR test (providing their symptoms resolve).

In England, to ensure testing does not delay a timely discharge, 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 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.

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.

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 should not come to work.

As a general principle, healthcare staff who provide care in areas 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, including pregnant staff. Employers should:

- discuss with employees who are at risk 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 – refer to the guidance published by the Royal College of Obstetricians & Gynaecology
- ensure that advice is available to all health and social care staff, including specific advice to those at risk from complications

Bank, agency and locum staff 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.

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.

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.

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 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)

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. Where the risk assessment shows an FFP2 respirator is suitable, they are recommended as a safe alternative. N95 respirators are tested against different standards but are broadly equivalent to a FFP2.

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.

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.

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 the agreed period of time depending on date of onset (10-14 days) 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 14 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 14 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 14 days? If yes, wait for the agreed period of time depending on what date of the isolation period the patients is at (ideally, 14 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		