ARHAI Scotland

Antimicrobial Resistance and Healthcare Associated Infection

NHS National Services Scotland

Winter (21/22), Respiratory Infections in Health and Care settings

Infection Prevention and Control Addendum

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COVID-19 Screening question	Yes	No
If POCT positive on admission or at any point during the subsequent 10 days, proceed to respiratory pathway. If there is no access to rapid diagnostic testing, contacts of cases still within the 10 day contact isolation period should have a PCR undertaken on admission. These patients should ideally be placed in a single room with transmission based precautions applied for the remainder of the contact isolation period unless rapid diagnostic testing (including POCTs) or LFD can be accessed during this time. If the individual answers **yes** and they are not fully vaccinated, undertake a PCR test and place on the respiratory pathway with TBPs applied for the remainder of the contact isolation period. If the individual answers **no**, undertake a Rapid Diagnostic Testing (including POCT) or LFD test. If negative, proceed to non respiratory pathway. If Rapid Diagnostic Testing (including POCT) or LFD test positive, proceed to respiratory pathway and undertake a follow up PCR test. If there is no access to rapid diagnostic testing a PCR test should be undertaken on admission. Provided the patient has answered no to the previous screening questions above they may be placed on the non-respiratory pathway.		

Table 4: Respiratory Screening Questions for use in outpatient departments and primary care settings including dentistry

The screening questions below apply to all service users

COVID-19 Screening question	Yes	No
Have you had a confirmed diagnosis of COVID-19 in the last 10 days? If the individual answers **yes**, consider delaying appointment where the matter is non urgent. Where appointment must proceed, do so via the respiratory pathway. If the individual answers **no**, proceed to next question;		
Do you have any of the following symptoms; • High temperature or fever? • New, continuous cough? • A loss or alteration to taste or smell? • Any other symptoms of a respiratory virus? If the individual answers **yes**, consider delaying appointment where the matter is non urgent. Where appointment must proceed, do so via the respiratory pathway. If the individual answers **no**, proceed to next question;		
Have you had contact with someone with a confirmed diagnosis of COVID-19 in the last 10 days? If individual answers **yes**, clinicians to undertake individual risk assessment to determine if it is appropriate to go ahead with the planned appointment and take account of daily LFD testing requirements in the community. Where the appointment takes place as planned, the patient may be placed on the non-respiratory pathway provided daily LFDs are negative.		

Primary Care and Community Health and Social Care settings – Respiratory screening questions & triage

If following telephone consultation, the individual meets criteria for the respiratory pathway and if the matter is non urgent, face to face consultation should be deferred until the COVID-19 self-isolation period has elapsed or until non COVID-19 respiratory viral symptoms have resolved. Health and care professionals should see individuals face to face or via remote consultation, whichever is felt most appropriate where they have

deemed further clinical assessment is required. If it is necessary to review individuals on the respiratory pathway by means of a face to face consultation (regardless of the presenting problem) then they should be advised of the most suitable way to transfer to the facility, enter the health and care facility, and on arrival, should be directed to a suitable waiting area identified for symptomatic individuals.

NB: children with mild bronchiolitis and lower respiratory tract infections should be managed in primary care settings where possible to ensure a holistic primary care assessment. Planning should include the implementation of locally appropriate models of care enabling secondary care clinicians to support primary care colleagues. The expectation should be that children with mild and moderate bronchiolitis or lower respiratory tract infection are initially reviewed in primary care settings.

For patients who have been identified as a contact of a COVID-19 case, an individual risk assessment should be undertaken to determine if it is appropriate to go ahead with the planned appointment and this should take account of daily LFD testing requirements in the community. Where the appointment takes place as planned, the patient may be placed on the non-respiratory pathway provided daily LFDs are negative including an LFD undertaken on the day of the appointment.

If providing a home visit, staff should contact the individual by telephone at home prior to the visit to undertake the respiratory screening if time allows. These should be repeated on arrival at the individual's home. If an individual lacks ability to answer questions by telephone, an assessment should be made on arrival ensuring that a Type IIR FRSM is worn. If this is not possible, treat as having respiratory viral symptoms until a direct assessment can be made by the care provider. Scottish Government advice on providing care at home is available.

Individuals living in residential facilities should be closely monitored for onset of respiratory viral symptoms by local care staff.

Dental settings – Respiratory screening questions & triage

If following telephone consultation, the patient meets criteria for the respiratory pathway, , and if the matter is non urgent, face to face consultation should be deferred until the COVID-19 self isolation period has elapsed or other non COVID-19 respiratory viral symptoms have resolved. If the matter is urgent, the patient may be seen within the dental

setting but ideally should be provided with an appointment at the end of the day/session to reduce any post Aerosol Generating Procedure (AGP) fallow time (if an AGP is performed) impacting on the remaining patient consultation list.

For patients who have been identified as a contact of a COVID-19 case, an individual risk assessment should be undertaken to determine if it is appropriate to go ahead with the planned appointment and this should take account of daily LFD testing requirements in the community. Where the appointment takes place as planned, the patient may be placed on the non-respiratory pathway provided daily LFDs are negative including an LFD undertaken on the day of the appointment.

See section 5.15.6 Determining the IPC precautions required for AGPs.

Secondary Care settings – Respiratory screening and triage questions

Patients should be assessed for respiratory symptoms at the earliest opportunity to direct them to the safest route within the facility in line with the respiratory screening questions.

SAS staff should undertake the respiratory screening questions prior to arrival at the receiving Emergency Department and accompany the patient to the appropriate waiting area dependant on outcome.

It is recognised that patient placement will be dependent on clinical need in addition to respiratory status. Where a patient with respiratory symptoms cannot be placed in the respiratory cohort for clinical reasons, avoid placing the patient next to anyone high risk and previously considered to be on the shielding list, keep curtains pulled as a physical barrier if safe to do so and ensure thorough cleaning as per respiratory care pathway described in the environmental cleaning section.

Reception areas must display signage encouraging service users to report respiratory symptoms immediately on arrival and reception staff should ask all service users on arrival using the respiratory screening questions regardless of the reason for presentation at the facility and where it is safe to do so without delaying any lifesaving interventions.

Only the service user requiring a consultation should attend health and care facilities unless a carer or escort is required.

5.8 Placement and management of a service user with respiratory symptoms

The COVID-19 patient pathways/categories will now be replaced with a respiratory pathway. This is determined as a route to which patients symptomatic of respiratory infection should be directed.

The pathway should be further split into appropriate cohorts determined by presenting symptoms and when available, test results to determine the causative pathogen. Rapid Diagnostic Testing (including POCT) or LFD testing may be undertaken in addition to a PCR test to support rapid patient placement assessment on the respiratory pathway.

Entrances to facilities must clearly display the requirement for individuals entering the facility to don a face covering and alcohol based hand rub (ABHR) should be provided for use prior to entry for those who are able to do so.

Waiting areas should be segregated with an area set aside for use by service users who present with respiratory symptoms. Markers to identify segregation should be clear and service users must be advised not to circulate around waiting areas and remain seated until called. Cleaning within waiting areas segregated for respiratory patients should be undertaken as laid out in environmental cleaning section. Removing toys and books may help prevent children circulating in these areas and instead parents may be advised to bring a toy or book belonging to the child to help keep them occupied during the wait time. Children should be supported by parents/carers with hand and respiratory hygiene.

Primary Care and Community Health and Social Care settings – Patient/Individual Service user placement

Health and care facilities should identify in advance areas/routes/consultation rooms for individuals who require to follow the respiratory pathway and who have been assessed as requiring a face to face consultation. It is recognised that some small practices will not have space to facilitate separate waiting areas for individuals on the respiratory pathway. In this case, a local risk assessment should be undertaken to determine how best to manage these individuals and whether it is suitable for them to attend for face to face consultations.

Where possible, consultation/treatment rooms should be identified for placement of individuals who require placement on the respiratory pathway. Some health and care facilities may be very small with limited consultation rooms and the ability to dedicate a room to respiratory individuals may not be possible. If this is the case, consider allocating respiratory cases to the end of a session. Ensure cleaning of touch surfaces within the consultation room is undertaken thoroughly immediately after the patient/individual leaves the room. Particular attention should be paid to anything touched by the individual and anything within short range of individuals who are coughing/sneezing.

Primary Care and Community Health and Social Care settings – Individual Service user placement in residential facilities

All admissions from the community to a residential health and care setting should be assessed first by the health and care setting team using the respiratory screening questions outlined above for care homes, prisons and social community and residential care settings . This applies to all types of residential heath and care setting admissions (including for respite).

For those residents who are displaying respiratory symptoms, the admission should be delayed if possible until they have completed their COVID-19 self-isolation period, OR if COVID-19 negative, until symptoms are resolving provided the admission is non urgent.

If the admission cannot be delayed, a local risk assessment should be conducted with the support of the local HPT to ensure all necessary mitigations can be accommodated for the individual as well as other residents, some of whom may be more vulnerable to COVID-19, in as safe a manner as possible. See PHS Social Care and Residential Care COVID-19 guidance for further information on admissions to these settings including for respite.

Isolation of a resident within their own room, if required, would ideally include provision of meals to their room, en suite facilities if available and measures to prevent the sharing of communal items and spaces. In some settings where there are limited vulnerabilities amongst the residential group, full isolation may not be required and the suspected/confirmed COVID-19 case may follow general population advise for self isolation.

Only essential staff wearing appropriate PPE should enter the rooms of residents with respiratory symptoms. All necessary care should be carried out within the resident's room.

Dental settings – Patient Service user placement

Where possible, waiting areas should be segregated with an area set aside for use by patients who require placement on the respiratory pathway. Markers to identify segregation should be clear and patients must be advised not to circulate around waiting areas and remain seated until called. Cleaning within areas segregated for the respiratory pathway should be undertaken as per guidance laid out in environmental cleaning section.

It is recognised that some small practices will not have space to facilitate separate waiting areas for patients on the respiratory pathway. In this case, a local risk assessment should be undertaken to determine how best to manage these patients e.g. wait in car until called or schedule for end of a session, or whether it is suitable for them to attend for face to face consultations.

Dental services should identify in advance areas/routes/consultation rooms for patients who are required to be placed on the respiratory pathway and who have been assessed as requiring treatment. Ideally, these patients should be seen at the end of the day/session to reduce any post Aerosol Generating Procedure (AGP) fallow time (if an AGP is performed) impacting on the remaining patient consultation list. Where space allows, a dedicated consultation/treatment rooms should be identified for placement of patients on the respiratory pathway. Some dental practices may be very small with limited consultation rooms and the ability to dedicate a room to respiratory patients may not be possible.

Secondary care settings - Inpatient placement

At the point of admission to the facility it is unlikely to be known what pathogen is the cause of respiratory symptoms. Respiratory pathways should be developed in hospitals in a bid to separate patients with respiratory viral symptoms/confirmed respiratory pathogen from all other patients as far as possible. Respiratory pathways may be dedicated wards, dedicated bed bays within wards or individual single rooms within wards.

Patients with suspected or known respiratory viruses should be placed in a single side room. Where single side rooms facilities are lacking, patients with the same confirmed pathogen should be cohorted together. Rapid Diagnostic Testing (including POCT) or LFD testing may be used to help support patient placement risk assessments on the respiratory pathway.

Where test results are not yet available to determine the viral pathogen causing the respiratory symptoms it may be necessary to cohort suspected respiratory infections together in the same multi bed bay. NB: This carries the risk of transmitting multiple respiratory viruses to multiple patients and should be avoided wherever possible and only used as a last resort during times of extreme bed pressures.

The following principles should be followed when considering cohorting of respiratory cases still awaiting test results;

- Ensure a respiratory screen including COVID-19 has been undertaken ideally prior to entry into the cohort or at the earliest opportunity.
- Rapid Diagnostic Testing (including POCT) or LFD testing may be used to help support patient placement risk assessments.
- Ensure the beds within the multi bedded area are adequately spaced
- Ensure patients are provided with a Type IIR FRSM to wear where tolerated
- Ensure there are adequate hand hygiene facilities for staff and patients
- Advise all patients to remain within their bed space at all times
- Ensure patients are advised of good respiratory etiquette and are provided with tissues and waste disposal bags.
- Where safe to do so, curtains could be drawn between patients to create a barrier

Patients who should not be placed in multi bed bay cohorts;

- Patients considered high risk and previously on shielding list
- Patients undergoing an AGP

- Patients known to have another known infectious pathogen or symptoms of a suspected infectious pathogen e.g. C.difficile, Norovirus, loose stools, MRSA
- Patients who are unlikely to comply with the requirements of the cohort described above

Patients on the respiratory pathway who require AGPs should be prioritised for a single side room. Critical care areas and wards where AGPs are undertaken more routinely should also prioritise single side rooms for those with on the respiratory pathway undergoing AGPs. However, where single side room capacity is lacking and patients with respiratory symptoms on the unit increases, unit-wide application of airborne precautions should be considered where all the patients in the same bed bay are test positive for the same respiratory pathogen. Where patients are positive for different respiratory pathogens there is a risk of transmission of multiple pathogens to multiple patients.

Secondary Care Settings – Paediatric inpatient placement

The principles applied within this guidance aim to mitigate the risk of transmission of all respiratory viruses including RSV. The UK are experiencing a surge in RSV cases amongst the paediatric population this winter season and RSV season has commenced earlier than previous years.

Many paediatric settings will have well established RSV pathways. Wherever possible, both COVID-19 and RSV point of care testing should be undertaken as a minimum on admission to help allocate patient placement and ensure that cohorts of RSV are segregated from cohorts of COVID-19. See also cohorting principles for secondary care inpatients above.

Regardless of the infectious pathogen detected, whilst the patient is symptomatic, they should be managed in line with the TBPs within this guidance. If single room capacity is limited/ being exceeded, prioritise clinically vulnerable children to a single room (See RCPCH guidance on clinically extremely vulnerable children). Children with bronchiolitis requiring a continuous AGP should be prioritised to a single room over those not requiring a continuous AGP if possible.

When children require an inpatient stay, local policy should be followed regarding resident carers. Education and written information for resident carers should be made available

regarding respiratory virus, local policies, and include use of communal facilities, face coverings (unless exempt), hand hygiene and PPE.

Secondary Care Settings - Elective care pre admission planning

Whilst the COVID-19 pandemic continues, it is important that any risk associated with acquiring COVID-19 pre/intra/post operatively for patients being admitted for elective surgical procedures be reduced as far as possible. Some studies have shown that patients diagnosed with COVID-19 around the time of a surgical procedure have a higher than predicted mortality however, it is not possible to determine precise risk for each individual patient. In advance of patients attending for elective surgery they should be advised of ways in which they may be able to reduce their post-operative risk. The following patient information leaflet explains some of the risk reduction measures and can be provided to patients in advance of their planned admission alongside testing advice.

Appendix 19 of the NIPCM provides details of Elective Surgery IPC principles which have been developed in conjunction with the Scottish COVID-19 Clinical cell and aim to reduce COVID-19 transmission risk during the ongoing COVID-19 pandemic. These should be read alongside the patient information leaflet accessed here.

Care Home Settings – Admissions and resident placement

Full guidance for admission to a care home during the COVID-19 pandemic can be found in PHS COVID-19: Information and Guidance for Care Home Settings (Adults and Older People).

Any resident who answers yes to any of the respiratory screening questions for care home settings should be placed in their own individual room until a full assessment can take place to determine the cause.

Where single rooms are limited cohorting may be considered. Cohorting in care homes should be undertaken with care. Residents who are high risk and previously considered to be on the shielding list must not be placed in cohorts and should be prioritised for single occupancy rooms.

Where all single room facilities are occupied and cohorting is unavoidable, then cohorting could be considered in conjunction with the local Health Protection Team (HPT).

- Residents who are awaiting test results to confirm which pathogen is causing respiratory symptoms, should not be placed together in cohorts if at all possible
- Ensure a respiratory screen including COVID-19 has been undertaken ideally prior to entry into the cohort or at the earliest opportunity.
- Ensure residents are provided with a Type IIR FRSM to wear where tolerated

5.8.1 Staff cohorting

Efforts should be made as far as reasonably practicable to dedicate assigned teams of staff to care for service users on the respiratory pathways where TBPs are applied.

There should be as much consistency in staff allocation as possible, reducing movement of staff and the crossover between the respiratory pathway and all other service users.

Rotas should be planned in advance wherever possible, to take account of the respiratory pathway and staff allocation.

For staff groups who need to go between pathways, efforts should be made to see service users on the non-respiratory pathway first.

Type IIR FRSMs should be changed if wet, damaged, soiled or uncomfortable and must be changed after having provided care for a service user with any other suspected or known infectious pathogens and when leaving respiratory pathway areas.

5.8.2 Transfer of service users with respiratory symptoms/confirmed respiratory pathogen

Wherever possible, service users with respiratory symptoms or a confirmed respiratory pathogen should remain on the respiratory pathway until they meet criteria for discontinuation of precautions. There may however be instances where it is necessary to transfer a service user whilst TBPs are ongoing including;

- The service user no longer requires critical care and the critical care bed is required for another patient
- The service user requires escalation of care to a secondary care facility or a critical care unit

- The service user requires urgent treatment in a regional specialist unit and postponement would have a detrimental effect on the patient and the care cannot be provided on the ward they currently reside in
- The service user requires an urgent procedure or investigation to be undertaken and postponement would have a detrimental effect on the individual

Communication with the receiving department/NHS Board/Care provider is vital to ensure appropriate IPC measures are continued during and after transfer. The service user must continue to be managed on the respiratory pathway. Communications must include;

- Service user symptom onset date
- Service user positive test date (if confirmed)
- Causative pathogen if known
- Date when service user may discontinue TBPs
- Current symptom status and any test results still awaited
- Any service user details which prevent or impact on the TBPs required i.e. falls risk requiring door to remain open, service user does not adhere to isolation
- Confirm if local IPCT (or HPT where appropriate) has been informed of transfer

Ensure transferring ambulance or portering staff are advised of the necessary precautions required for PPE and decontamination of transfer equipment.

There is no need to test the service user again on transfer provided symptomatic cases have already had a test taken where the health and care setting has the ability to do so.

5.8.3 Day /Overnight Pass

Service users who have been allowed to leave the healthcare facility for the day or for an overnight stay should be assessed using the respiratory screening questions in advance of their immediate return to the facility and again on arrival at the facility to determine any known or potential exposure whilst out of the healthcare facility on pass and subsequently which pathway they should be placed on.

5.9 Respiratory Testing for service users

In order to ensure prompt safe placement and treatment of service users with respiratory symptoms, testing will help to inform the clinical/care team of the causative pathogen. This will help to avoid placing multiple service users with different respiratory pathogens in the same room for extended periods of time risking transmission of multiple pathogens between service users. Testing for other respiratory pathogens beyond SARS-CoV-2 may not be routinely necessary in all settings such as residential care areas and care homes.

5.9.1 COVID-19 testing

To ensure patients are placed appropriately within health and care settings, COVID-19 testing is required.

Rapid Diagnostic Testing (including POCT) or LFD testing may now be used in some health and care settings (see sector specific content below) to help determine any requirements for transmission based precautions and to support IPC risk assessments including patient placement, patient transfers, management of contacts and outbreak management. Various Rapid Diagnostic Testing (including POCT) or LFD kits have been approved for use within acute and community hospital settings to date and NHS Boards should seek to understand which Rapid Diagnostic Testing (including POCT) or LFD testing are available for use in their areas. Some Rapid Diagnostic Testing (including POCT) or LFD testing are of greater quality and these should be considered for use wherever possible and where the risk of COVID-19 transmission and resulting severe disease is greatest e.g admissions to high risk departments such as heam onc. Rapid Diagnostic Testing (including POCT) or LFD testing should not be used as a standalone tool for risk assessment but in conjunction with symptom and clinical assessment. Rapid Diagnostic Testing (including POCT) or LFD testing alone must not be used for clinical diagnostic purposes.

Anyone who has previously tested positive for SARS-CoV-2 by PCR should be **exempt from being re-tested within a period of 90 days** from their initial symptom onset, or the first positive test, if asymptomatic, unless they develop new possible COVID-19 symptoms. This is because fragments of inactive virus can be persistently detected by PCR in respiratory tract samples for up to 90 days following infection.

If an asymptomatic person is inadvertently re-tested and tests positive by PCR within 90 days of a previous positive PCR result, a risk assessment will likely conclude there is no need to do a

confirmatory PCR, isolate or contact trace again, as long as the person with the repeat positive test:

- remains asymptomatic;
- is not a contact of a confirmed case (in which case reinfection must be considered);

See section for determining the precautions required for AGPs and the associated testing.

Primary Care and Community Health and Social Care settings – COVID-19 testing

If an individual has COVID-19 symptoms they should visit the NHS inform website for advice on testing and self isolation.

GPs who have arranged a face to face consultation with an individual who has symptoms of COVID-19 should proceed following the respiratory pathway and following treatment, and advise that they visit NHS Inform for advice on testing if they have not already done so.

Dental settings – COVID-19 testing

Dental teams who have arranged a face to face consultation with a patient which cannot be postponed and who has symptoms of COVID-19 should proceed following the respiratory pathway and following treatment, advise that the patient should visit NHS Inform for advice on testing and self isolation if they have not already done so.

Secondary care Settings – COVID-19 testing

A letter was issued to NHS Scotland Chief Executives DL (2022) 07 detailing changes to admission testing as follows;

- All admissions with respiratory viral symptoms should have a PCR undertaken on admission. A Rapid Diagnostic Testing (including POCT) or LFD testing may also be performed in addition to PCR to support rapid patient placement assessments for the respiratory pathway.
- All admissions with absence of respiratory symptoms require a Rapid Diagnostic Testing (including POCT) or LFD testing on admission. Repeat testing on day 5 of admission may be undertaken if agreed necessary following a risk assessment by the local NHS Board. Efforts should be made to determine vaccination status on

admission to hospital. Individuals who are not fully vaccinated have the greatest risk of negative outcomes should they acquire COVID-19 and therefore, where a patient is known to be unvaccinated, NHS Boards may choose to undertake a follow up PCR test.

- A new respiratory screen including PCR test must be performed at any point in the inpatient stay if new onset of respiratory symptoms are recognised or there is a clinical indication to do so (PCR). A POCT may be used in addition to PCR to support rapid patient placement decisions.

A table containing a summary of testing requirements in NHS Scotland is available. When using this table the following applies;

- Screening undertaken out with national programmes which are detailed at the links above should be based on decision of clinical services e.g. screening in critical care settings.

Care home settings – COVID-19 testing

Guidance on COVID-19 testing in care home settings can be found in the PHS COVID-19: Information and Guidance for Care Homes (Adults and Older People).

5.9.2 Testing for other respiratory pathogens

It may be necessary to test for other respiratory pathogens including COVID-19 to support service user placement but also ensure optimal treatment provision.

GPs may choose to perform a respiratory screen on an individual if clinical assessment indicates this is necessary. If so, they should continue to do so via routine processes. There is no expectation to perform respiratory testing in primary care, or dentistry beyond routine processes indicated by clinical assessment.

Secondary Care settings – Testing for other Respiratory Pathogens

On arrival at a secondary care facility, all patients should have COVID-19 testing performed as per section 5.9.1.

Clinical teams may choose to perform a full respiratory screen if clinical assessment indicates this is necessary to support diagnosis.

Care Home Settings – Testing for other Respiratory Pathogens

Residents who test negative for COVID-19 but who have ongoing respiratory symptoms do not routinely require any additional testing. However, should a resident require a consultation with a GP, the GP may choose to perform a full respiratory screen if a clinical assessment indicates this is necessary. Or if there is considered to be a cluster of cases and these are COVID-19 negative then additional testing by multiplex PCR can be performed to identify the pathogen.

Where respiratory screens are performed and the service user tests positive for COVID-19 within 90 days of previous positive test, this will require careful consideration and interpretation by clinicians with microbiology support where required.

5.10 Respiratory screening for HCWs

HCW COVID-19 testing continues in some settings. Detailed information on respiratory screening for HCWs can be found on the Scottish Government website.

There is no requirement for any other respiratory pathogen beyond COVID-19 screening amongst HCWs unless recommended by an Incident Management Team, HPT, or occupational health.

Respiratory screening for Health and care workers – care home settings

Information on COVID-19 testing amongst care home workers can be found in the PHS Care home guidance.

Care home staff should use the COVID testing portal - see http://www.covidtestingportal.scot to arrange this.

5.11 Duration of Transmission Based Precautions for respiratory pathogens (excl COVID-19)

Before control measures are stepped down for respiratory pathogens, clinical teams and care teams must first consider any ongoing need for TBPs necessary for any other alert organisms,

e.g. MRSA carriage or *C. difficile* infection, or other symptoms suggestive of possible infection such as diarrhoea.

The A-Z of pathogens within the NIPCM details the duration of TBPs required for individual pathogens where this information is available. Clinical teams and care teams should refer to this before any TBPs are discontinued. Duration of precautions for COVID-19 are given in more detail. A more cautious approach is taken when considering when to discontinue precautions for individuals with COVID-19 during the ongoing pandemic.

5.12 Duration of transmission based precautions for COVID-19

It is important to note that service users with COVID-19 deemed clinically fit for discharge **can and should** be discharged before resolution of symptoms.

The tables below set out number of isolation days required, the clinical requirements for discontinuing TBPs and any testing required.

Table 5: Duration of precautions for hospital inpatients remaining in hospital and residents in residential care areas

Hospital Inpatients and residents in residential settings	Number of isolation days required	COVID-19 Clinical requirement for stepdown	Testing required for stepdown
Hospital Inpatients (including critical care patients)	**10 days** from symptom onset (or first positive test if symptom onset undetermined)	Clinical improvement with at least some respiratory recovery. Absence of fever (>37.8oC) for 48 hours without use of antipyretics.	Not routinely required
Residents in residential settings	**10 days** from symptom onset (or first positive test if symptom onset undetermined)	Clinical improvement with at least some respiratory recovery. Absence of fever (>37.8oC) for 48	Not routinely required

Hospital Inpatients and residents in residential settings	Number of isolation days required	COVID-19 Clinical requirement for stepdown	Testing required for stepdown
		hours without use of antipyretics.	
Individuals severely Immunocompromised as determined by Chapter 14a of the Green Book	**14 days** from symptom onset (or first positive test if symptom onset undetermined)	Clinical improvement with at least some respiratory recovery. Absence of fever (>37.8oC) for 48 hours without use of antipyretics. Individual risk assessment by clinical teams taking account of symptoms, clinical presentation, intended setting for stepdown.	Local clinical teams may consider testing as part of the stepdown process and where undertaken, 1 negative test would be acceptable for stepdown.

Table 6: Stepdown requirements for inpatients being discharged from hospital

Discharging service users	Number of isolation days required	Does isolation need to be completed in hospital?	COVID-19 Clinical requirement for stepdown	Testing required for stepdown
Patient discharging to a residential setting	10 days from symptom onset (or first positive test if symptom onset undetermined). If they have completed the 10 day isolation in hospital, no further isolation should be required on return/admission to the care home.	No. If a COVID-19 recovered patient is discharged to a care home before 10 day isolation has ended then 2 negative PCR tests are required before discharge at least 24 hr apart. If not completed 10 days isolation in hospital, they can do so in care home and do not require to start new isolation period on admission, nor require further testing.	Clinical improvement with at least some respiratory recovery. Absence of fever for 48 hours without use of antipyretics	If a COVID-19 recovered patient discharged to care home before 10 day isolation has ended then 1 negative PCR test is required preferably within 48 hours prior to discharge If not completed 10 days isolation in hospital, they can do so in care home and do not require to start new isolation period on admission, nor require further testing. See PHS COVID-19: information and guidance for care home settings for discharge testing details if the COVID-19 recovered patient has completed their 10 day isolation period in hospital

Discharging service users	Number of isolation days required	Does isolation need to be completed in hospital?	COVID-19 Clinical requirement for stepdown	Testing required for stepdown
Patients being discharged to their own home - General	10 days from symptom onset (or first positive test if symptom onset undetermined)	May complete at home (if not already completed as an inpatient) and follow Stay at home guidance. Once home, isolation rules in line with community self isolation requirements should be followed. Must be given clear advice for what to do if their symptoms worsen.	Clinical improvement with at least some respiratory recovery. Absence of fever for 48 hours without use of antipyretics.	Not routinely required
Patients being discharged to their own home – someone in household is severely immunocompromised or at risk of severe illness **Chapter 14a of the Green Book**	10 days from symptom onset (or first positive test if symptom onset undetermined)	Wherever possible, patient should be discharged to a different household from anyone immunocompromised or at severe risk of infection. If not possible – see 'testing required for stepdown' column.	Clinical improvement with at least some respiratory recovery. Absence of fever for 48 hours without use of antipyretics.	Testing for clearance is encouraged

5.12.1 Non COVID-19 discharges from hospital to care homes

All non-COVID-19 residents being discharged from hospital who are on the non respiratory pathway at point of discharge do not require to complete a period of self isolation on return to the care home provided they have a single negative COVID-19 test result in the 48 hours prior to discharge, have had no known exposure to a COVID-19 case in the 10 days prior to discharge and answer no to all of the respiratory screening questions prior to transfer.

A single negative result should be available preferably within 48 hours prior to discharge from hospital. The exception is where a resident is considered to suffer detrimental clinical consequence or distress if they were not able to be discharged to a care home. In these cases, the resident may be discharged to the care home prior to the test result being available and transmission based precautions applied on return to the care home until a negative test result is achieved.

If a resident is admitted to hospital for a single overnight inpatient stay, they do not require to complete a period of self isolation on return to the care home provided they answer no to all of the respiratory screening questions prior to transfer.

For further guidance on admission of COVID-19 recovered and non-COVID-19 residents from hospital or from community to a care home please refer to PHS COVID-19: Information and Guidance for Care Home Settings (Adults and Older People)

5.12.2 Management of contacts of COVID-19

In some settings (see setting specific content below) management of contacts in health and care settings may now align more closely with contacts in the general community. An individual who has had exposure to a case of COVID-19 may go on to develop COVID-19 with or without symptoms and this presents a risk of transmission to other users of health and care facilities. Measures should be taken as described below to reduce transmission risk associated with COVID-19 contacts.

Secondary care settings – Management of contacts of COVID-19

Patients who have an overnight admission within a hospital setting who have been managed as a contact of a confirmed case of COVID-19 either

- during their hospital inpatient stay,

- in the community and within the 10 days prior to admission to hospital

must be isolated or cohorted for 10 days from the date of exposure if they are not fully vaccinated.

For contacts who are fully vaccinated and asymptomatic of respiratory viral symptoms, a daily Rapid Diagnostic Testing (including POCT) or LFD test should be performed for 10 days following the date of exposure. Application of transmission based precautions are only required should the Rapid Diagnostic Testing (including POCT) or LFD tests positive at any point and a follow up COVID-19 PCR undertaken. Whilst Rapid Diagnostic Testing (including POCT) or LFD tests remain negative, application of SICPs is sufficient and there is no need to isolate the contact.

For contacts who are not fully vaccinated, transmission based precautions are required for 10 days from the date of COVID-19 exposure. Provided they remain asymptomatic at day 10, no testing is required to end isolation.

Any patient who has been COVID-19 positive (confirmed by PCR or Rapid Diagnostic Testing (including POCT) or LFD test) in the last 28 days does not need to be considered a contact should there be a subsequent exposure during that 28 period. Daily Rapid Diagnostic Testing (including POCT) or LFD testing of these patients is therefore not required during this time period.

Primary Care and Community Health and Social Care settings – Management of contacts of COVID-19

Primary care services offering appointments should undertake an individual risk assessment of patients who have been identified as a contact of a COVID-19 case to determine if it is appropriate to go ahead with the planned appointment. This should take account of daily LFD testing requirements in the community. Where the appointment takes place as planned, the patient may be placed on the non-respiratory pathway provided daily LFDs are negative including an LFD undertaken on the day of the appointment. Care homes (see below), prison settings and social community and residential care settings still need to apply the 10 days' self-isolation period for contacts of COVID-19 cases even if they meet the contact self-isolation exemption community criteria. The 10 day self isolation period starts from the date of last exposure to the case.

Care home settings - Management of contacts of COVID-19

Residential care settings and care homes will also still need to apply the 10 days' self-isolation period for contacts of COVID-19 cases even if they meet the contact self-isolation exemption community criteria. The 10 days period starts from the date of last exposure to the case and should be agreed between the hospital and care home manager, supported by HPTs and include an negative PCR test. This precautionary approach recognises the vulnerability of the other residents living in the care home.

Any resident who has been COVID-19 positive (confirmed by PCR) in the last 28 days does not need to be considered a contact should there be a subsequent exposure during that 28 period. Daily Rapid Diagnostic Testing (including POCT) or LFD testing is therefore not required during this time period.

5.12.3 HCWs isolation and exemption requirements

HCWs who test positive for COVID-19 must not report to work and must commence isolation in line with Self Isolation Policy for Health and Social Care Staff. If an LFD was undertaken whilst in the workplace and returns a positive result, the HCW must don a Type IIR FRSM (unless exempt), inform their line manager and go home immediately. If the PCR is COVID-19 positive, the HCW must self isolate at home for 10 days in line with advice on NHS inform.

Health and care staff who have been exposed to a case of COVID-19 should follow advice laid out in the Self Isolation Policy for Health and Social Care Staff.

If a COVID-19 PCR test is negative and the HCW remains symptomatic of a respiratory virus, they should consider the risk to service users if they are to return to work particularly if the service user they care for are immunosuppressed or otherwise medically vulnerable. If in doubt about any risk they may pose to patients or colleagues, this should be discussed with their line manager in the first instance.

5.13 Hand hygiene

Hand hygiene is considered one of the most important practices in preventing the onward transmission of any infectious agents including respiratory viruses. Hand hygiene should be

performed in line with section 1.2 of SICPs. Within this section you will find videos demonstrating how to perform a hand wash and how to perform a hand rub.

Care Home Settings – Hand Hygiene

Staff in care homes settings can refer to the hand hygiene section of the Care Home IPCM (CHIPCM) for older people and adult care homes for more information and resources specific to this setting.

5.14 Respiratory etiquette

Respiratory and cough hygiene is designed to minimise the risk of cross transmission of respiratory pathogens including COVID-19. The principles of respiratory and cough hygiene can be found in section 1.3 of SICPs.

The 'Catch it, Bin it, Kill it' poster can be downloaded.

Care Home Settings - Respiratory and cough hygiene

Staff in care homes settings can refer to the respiratory and cough hygiene section of the CH IPCM for older people and adult care homes for more information and resources specific to this setting.

5.15 PPE

PPE exists to provide the wearer with protection against any risks associated with the care task being undertaken. As part of SICPs, all staff undertaking in procedure, should assess any likely exposure and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken. More information on PPE including donning and doffing resources can be found in the NIPCM.

Care Home Settings - PPE

Staff within Care Homes can find more general information on PPE in the CHIPCM for Older People and Adult Care Homes. Staff in care homes must follow the PPE guidance below.

When caring for a service user who has respiratory symptoms PPE should be selected to protect against droplet or in some circumstances, airborne spread.

PPE must not be used inappropriately. It is of paramount importance that PPE is worn at the appropriate times, selected appropriately and donned and doffed properly to prevent transmission of infection.

PPE is the least effective control measure within the hierarchy of controls and other mitigation measures must be implemented and adhered to wherever possible.

5.15.1 Extended use of face masks for staff, visitors and outpatients

The extended use of facemasks by health and care workers and the wearing of face coverings by visitors and outpatients (unless exempt) is designed to protect staff and service users as part of the COVID-19 pandemic. This is because COVID-19 may be transmitted by individuals who are not displaying any symptoms of the illness (asymptomatic or pre-symptomatic).

- View further Scottish Government guidance and associated FAQs.
- View a poster detailing the 'Dos and donts' of wearing a face mask.
- View a poster that supports the wearing of a non-medical face mask/face covering.

In Scotland, staff are provided with Type IIR FRSM for use as part of the extended wearing of facemasks.

Primary Care and Community Health and Social Care settings – Face coverings for Individuals and service users

Any service users attending a health and care facility must wear a face covering in line with Scottish Government guidance unless exempt. Type II FRSM should be available should an individual or service user attend without a face covering.

Dental settings – Face Coverings for patients and service users

Any patient attending a health care facility must wear a face covering in line with Scottish Government guidance unless exempt. Type II FRSM should be available should a patient attend without a face covering.

Secondary care settings – Face masks for Inpatients

A facemask should be worn by all inpatients across all inpatient areas regardless of respiratory symptoms unless exempt and where it can be tolerated and does not compromise their clinical care for example when receiving oxygen therapy. All patients should be encouraged to adhere to this which ~~is~~ part of COVID-19 pandemic control measures. The purpose of this is to minimise the dispersal of respiratory secretions and reduce environmental contamination. This should be actively promoted throughout the healthcare setting.

It is recognised that it will be impractical for inpatients to wear facemasks at all times and these will have to be removed for reasons such as eating and drinking or showering. There is no need for inpatients to wear a facemask when sleeping provided bed spacing requirements in line with current guidance are met.

A facemask should be worn by all inpatients across all pathways during transfer between departments within the hospital unless exempt.

Where an inpatient is isolated in a single room, they do not need to wear a facemask. However, the inpatient must be asked to don their mask when any staff or visitors enter the room unless exempt.

Care home settings – Face masks for residents

Residents on the respiratory pathway should be encouraged to wear a facemask, if these can be tolerated and do not compromise care, when moving around the care home and when care staff, other residents or visitors enter their individual room.

5.15.2 Sessional use of FRSMs, FFP3 respirators and/or eye/face protection

FRSMs and eye/face protection (goggles/visors) may be used sessionally. This means that FRSMs and eye/face protection (where required) can be used moving between service users and for a period of time where a HCW is undertaking duties in an environment where there is exposure to respiratory pathogens. A session ends when the healthcare worker leaves the clinical setting or exposure environment.

Typically, sessional use of any PPE is not permitted within health and care settings at any time as it is associated with transmission of infection between service users within health and care settings.

Due to the much wider and frequent use of FRSMs eye/face protection (where required) by HCWs during the ongoing COVID-19 pandemic and during periods of increased respiratory activity in health and care settings both as part of service user direct care delivery and extended use of facemasks policy, sessional use of FRSMs and eye/face protection is permitted at this time.

However, in using FRSMs/eye and face protection/RPE sessionally, it is important to note the following;

- FRSMs/FFP3 must be replaced if visibly contaminated, wet, damaged, uncomfortable, when moving between the respiratory and non-respiratory pathway
- Eye/face protection must be replaced if damaged, visibly contaminated, when moving between the respiratory and non-respiratory pathway
- HCWs must not touch their FRSM, eye/face protection or FFP3 respirator whilst in situ. If they inadvertently do so, they must perform hand hygiene immediately afterwards

The above measures in conjunction with safe donning and doffing of PPE ensure the safety of the HCW and the service user.

No other PPE is permitted to be worn sessionally moving between service users or care tasks. This includes gloves, aprons and gowns.

Dental settings – Sessional use of FRSMs, FFP3 respirators and/or eye face protection

Within dental settings, HCWs may wear FRSMs sessionally to account for the extended use of facemask policy outside of direct patient care delivery and provided they are changed at the points listed above. It should be noted that due to the procedures being undertaken in dentistry and the splash/spray generated during those procedures, that FRSMs should be changed between patients in line with standard practices. FFP3 respirators should not be worn sessionally at any time.

Secondary care settings – Sessional use of FFP3 respirators

Sessional use of FFP3 respirators is also permitted only where unit wide airborne precautions are applied throughout a unit/care area however all other AGP PPE should be removed when no longer within 2 metres of a patient or, if still within 2 metres of the patient, then after the AGP is complete and fallow time has elapsed. It is not necessary to wear sessional gowns moving around a unit or department. Gowns protect against excessive splash and spray which is associated with AGPs and other direct patient care procedures.

5.15.2 Filter Face Piece 3 (FFP3) Respirators

FFP3 respirators must only be worn by staff who have undergone and passed a fit test. FFP3 respirators must be worn by HCWs in the following scenarios;

- When performing an Aerosol Generating Procedure (AGP) on a service user with a known or suspected respiratory viral infection (respiratory pathway)
- When performing an AGP on any service user with a positive COVID-19 PCR , Rapid Diagnostic Testing (including POCT) or LFD test.
- When working within the respiratory pathway where AGPs are being performed unit wide (service users having AGPs undertaken who cannot be placed in single isolation rooms)
- When working in the respiratory pathway in a clinical area deemed as having an unacceptable risk of transmission by the NHS Board (see hierarchy of controls section)

More information can be found on RPE within chapter 2 of the NIPCM.

5.15.3 PPE worn when caring for service users on the respiratory pathway

Table 7 details the PPE which should be worn when providing direct care for service users on the respiratory pathway.

Type IIR FRSM should be worn for all direct care delivery regardless of whether the service user is on the respiratory pathway or not. This measure has been implemented alongside physical distancing specifically for the COVID-19 pandemic.

Type IIR FRSMs can be worn sessionally when going between service users on the respiratory pathway. Type IIR FRSMs should be changed if wet, damaged, soiled or uncomfortable and must be changed after having provided care for a service user isolated with any other suspected or known infectious pathogens and when leaving respiratory pathway areas.

It is recommended that Type IIR FRSMs should be well fitting and fit for purpose, covering the mouth and nose in order to prevent venting (exhaled air 'escaping' at the sides of the mask). A poster provides some suggested ways to wear facemasks to help improve fit.

Health and care staff moving between different settings, wards and departments to provide care/consultations or undertake service user transfers (e.g. portering and theatre staff) throughout the course of their working day must ensure they first clarify with the person in charge or named health and care worker what pathway the service user they are attending to is on and what PPE is required.

Table 7 PPE worn for SICPs and TBPs (see table 8 for AGP PPE)

PPE item	Non Respiratory pathway (SICPs)*	Respiratory pathway (TBPs)
Gloves	Risk assessment - wear if contact with blood and body fluid (BBF) is anticipated. Single-use	Worn for all direct care delivery. Single use.
Apron or gown	Risk assessment - wear apron if direct contact with service user, their environment or BBF is anticipated. (Gown if extensive splashing anticipated)	Apron to be worn for all direct care delivery (Gown if extensive splashing anticipated) Single-use

PPE item	Non Respiratory pathway (SICPs)*	Respiratory pathway (TBPs)
	Single use	
Face mask (FRSM)/FFP3 respirator	Always within 2 metres of a service user- Type IIR FRSM (Wearing a Type IIR FRSM as part of SICPs would normally only be worn when splash/spray is anticipated. Use of FRSM for all service user direct care exists as an ongoing COVID-19 pandemic measure) Single use or Sessional use	Always within 2 metres of a service user - Type IIR FRSM FFP3 respirator required when caring for service user with a known or suspected pathogen transmitted by the airborne route e.g. pulmonary TB Single use or Sessional use
Eye & face protection	Risk assessment - wear if splashing or spraying with BBF including coughing/sneezing anticipated. Single-use or reusable following decontamination.	Worn for all direct care delivery provided to service users with respiratory symptoms Single-use, sessional or reusable following decontamination.

*Ensure that PPE is worn appropriately for TBPs as per NIPCM/ on the non-respiratory pathway if caring for service users with any other known or suspected infectious pathogen requiring TBPs.

5.15.4 Access to PPE

NHS staff should continue to obtain PPE through their health board procurement contacts, who will raise their needs via an automated procurement portal to NHS National Services Scotland (NHS NSS). This automated internal procurement system has been specifically developed to deal with increased demand, give real time visibility to Health Boards for ordered stock, as well as enabling quick turnaround for delivery.

Those providing services within social care settings (including personal assistants and unpaid carers) who have an urgent need to access PPE, can contact the PPE support centre on 0300 303 3020 or their local HSCP PPE hub.

Please note that hubs are to be used only in cases where there is an urgent supply shortage after “business as usual” routes have been exhausted.

The contact details below will direct social care providers to the NHS National Services Scotland Social Care PPE Support Centre, and the team there will point you towards your local Hub.

Email: support@socialcare-nhs.info

Phone: 0300 303 3020.

The helpline is open (8am - 8pm) 7 days a week.

Further information can be found at: Coronavirus (COVID-19): PPE access for social care providers and unpaid carers.

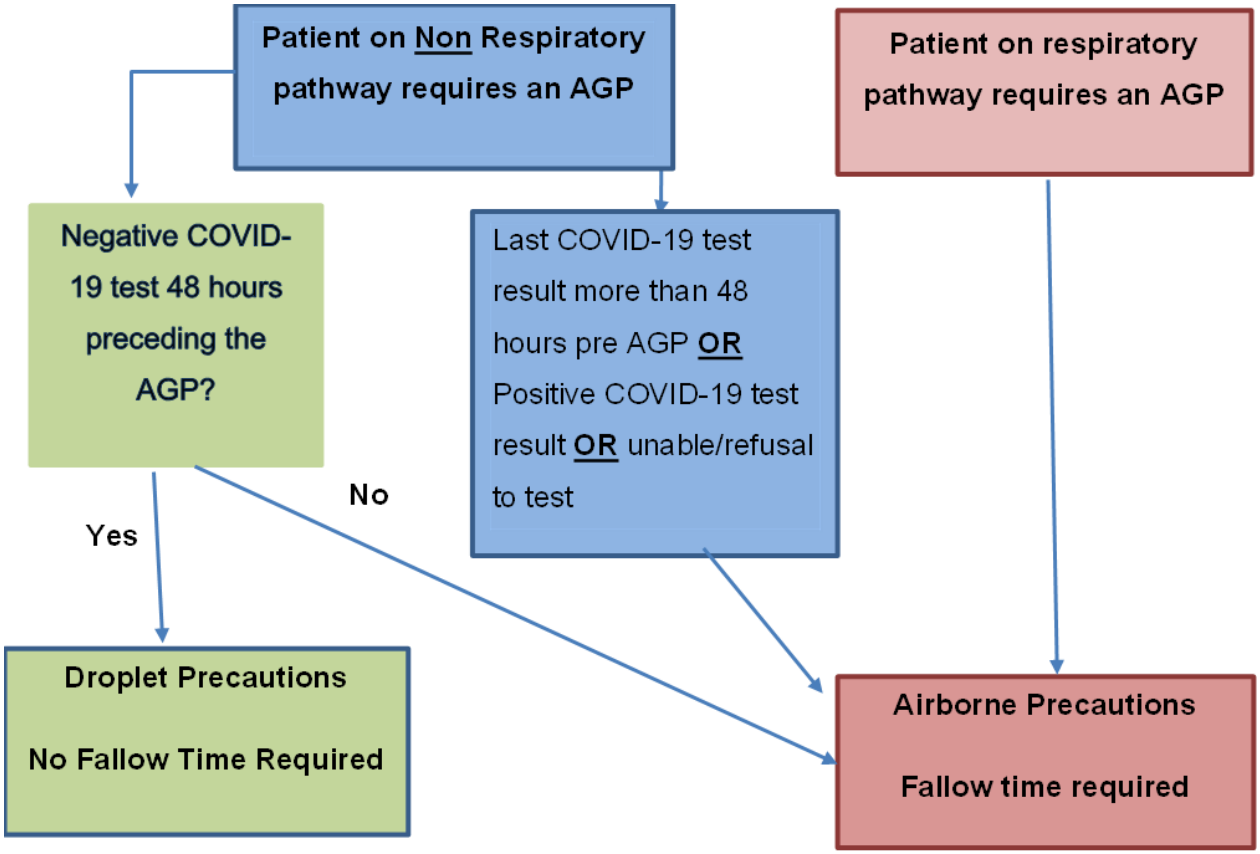
5.15.5 AGPs

An AGP is a medical procedure that can result in the release of airborne particles 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. Transmission of SARS-CoV-2 (and other respiratory pathogens) during AGPs is also possible from patients in asymptomatic or pre-symptomatic phases of infection.

A full list of AGPs can be found in Appendix 17 of the NIPCM.

Determining the IPC precautions required for AGPs.

Airborne precautions and subsequent post AGP fallow times are required for all patients undergoing an AGP on the respiratory pathway. A risk assessment should be undertaken prior to performing an AGP on patients on the non-respiratory pathway and take account of any presenting respiratory symptoms. COVID-19 Rapid Diagnostic Testing (including POCT) or LFD testing may also be used to support the risk assessment. Where there is no evidence of a respiratory virus, the AGP may be performed using droplet precautions negating the need for post AGP fallow times.



Dental Settings - Determining IPC precautions required for AGPs

Airborne precautions and post AGP fallow times must be applied for any patients requiring treatment on the respiratory pathway as outlined in the respiratory screening questions. Dental teams must continue to ask patients the respiratory screening questions prior to attendance for appointments to determine the IPC precautions required prior to undertaking AGPs. Dental teams may ask patients to perform an LFD test prior to attending for their appointment to support this risk assessment. Where there is no evidence of a respiratory virus, the AGP may be performed using droplet precautions negating the need for post AGP fallow times.

5.15.6 PPE for AGPs

The required PPE when undertaking AGPs is listed in table 8 below.

**Work is currently underway by the UK Re-useable Decontamination Group examining the suitability of respirators, including powered respirators, for decontamination. This literature review will be updated to incorporate recommendations from this group when available. In the interim, ARHAI Scotland are unable to provide assurances on the efficacy of re-useable respirator decontamination methods and the use of re-useable respirators is not recommended.

Table 8: PPE for AGPs

PPE item	Non Respiratory pathway (SICPs) where there is no evidence of a respiratory virus	Respiratory pathway (TBPs)
Gloves	Single-use	Single use
Apron or gown	Single-use Risk assess – use fluid resistant gown if excessive splashing/spraying anticipated otherwise apron is sufficient	Single-use fluid resistant gown
Face mask (FRSM) or Respirator	Type IIR FRSM* Single or Sessional use	FFP3 mask or powered respirator hood Single or Sessional use
Eye & face protection	Single use or reusable following decontamination	Single-use, sessional or reusable following decontamination

*Where staff have concerns about potential COVID-19 exposure to themselves during this ongoing COVID-19 pandemic, they may choose to wear an FFP3 respirator rather than an FRSM when performing an AGP on any patient provided they are fit tested. This is a personal PPE risk assessment

5.15.7 Post AGP Fallow Times

Time is required after AGPs undertaken with airborne precautions ~~is~~ are performed to allow the actual/potential infectious aerosols still circulating to be removed/diluted. This is referred to as the post AGP fallow time (PAGPFT) and is a function of the room ventilation air change rate. The PAGPFTs can be found in appendix 17 of the NICPM.

Dental settings - AGPs

Staff within dental settings should refer to the 'Mitigation of AGPs in dentistry; A Rapid Review' which details fallow times specific to this setting and the mitigations used. The methodology work was undertaken by SDCEP and Cochrane oral Health. Post AGP down time (fallow time) is not considered necessary for successive appointments between members of the same household within dental settings; to minimise aerosol spread dentists should use mitigating measures such as high volume suction/rubber dam. It is essential that staff change their PPE and adhere to SICPs between family members.

Treatment rooms in dental practices should be aiming for a minimum of 10ACH.

5.16 Safe Management of Care Equipment

See NIPCM for routine safe management of care equipment as per SICPs.

Care Home Settings - Safe Management of Care Equipment

Care homes should refer to the NIPCM for older people and adult care homes for more general information on safe management of care equipment in this setting as per SICPs.

Care equipment used for service users on the respiratory pathway may become contaminated with infectious transmissible pathogens and must be cleaned as per table 9.

Table 9: Equipment cleaning determined by SICPs/TBPs

Pathway	Product
Routine care areas (non-respiratory pathway) – cleaning as per SICPs	General purpose detergent for routine cleaning.
Respiratory pathway - cleaning as per TBPs	Combined detergent/disinfectant solution at a dilution of 1000 ppm av chlorine or general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm av chlorine for routine cleaning.

See Appendix 7 of the NIPCM for cleaning of equipment contaminated with blood or body fluids (including saliva) or if it has been used on a patient with any other known or suspected infectious pathogen.

Primary Care and Community Health and Social Care settings – equipment cleaning for care at home services

Re-useable care equipment used on the respiratory pathway in the community health and care settings such as stethoscopes, syringe drivers and pumps must be decontaminated prior to removal from the service user's home. Where this is not possible, they should be bagged and transported back to base for decontamination.

5.17 Safe Management of Care Environment

See NIPCM for routine safe management of care environment as per SICPs.

Care Home Settings - Safe management of Care Environment

Care homes should refer to the Care Home IPCM for older people and adult care homes for more general information on safe management of the care environment in this setting as per SICPs.

Environmental cleaning in the respiratory pathway should be undertaken as per table 10. A minimum of 4 hours should have elapsed between the first daily clean and the second daily clean. Where a room has not been occupied by any staff or service user since the first daily clean was undertaken, a second daily clean is not required.

Table 10 – Environmental cleaning determined by SICPs/TBPs

Pathway	Frequency	Product
Routine care areas (non-respiratory pathway) – cleaning as per SICPs	At least daily as per NHS Scotland National Cleaning Services Specification.	General purpose detergent*1
Respiratory pathway -cleaning as per TBPs (incl post AGP for service users requiring airborne precautions for AGPs)	At least twice daily **1st clean** - Full clean (domestic services) **2nd clean** - *2 Touch Surfaces within clinical and care delivery areas	Combined detergent/disinfectant solution at a dilution of 1000 ppm av chlorine or general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm av chlorine.

*1 Cleaning in routine care areas should be carried out with chlorine based detergent for rooms where the service user is known to have any other known or suspected infectious agent.

*2 Touch surfaces as a minimum should include door handles/push pads, taps, bed heads/bed ends, cot sides, light switches, lift buttons. Clinical and care delivery areas should include the service user's bedroom and treatment areas and staff rest areas.

Any areas contaminated with BBF (including saliva) in any clinical/care area require to be cleaned as per Appendix 9 of the NIPCM.

In settings such as outpatient departments, GP practices, dental practices, where there are multiple service users undergoing a consultation each day, cleaning should be undertaken between service users in addition to the environmental cleaning described above using the appropriate cleaning product depending on the pathway the service user is on. Ensure that any surfaces touched by the service user are cleaned e.g. chair, treatment bed and where the service user is symptomatic of a respiratory virus, cleaning should include items in the immediate environment which may have become contaminated.

5.18 Safe Management Linen

All linen should be handled routinely as per section 1.7 of SICPs – Safe Management of Linen

Care Home Settings - Safe Management of Linen

Care homes should refer to the Care Home IPCM for older people and adult care homes for more general information on safe management of linen in this setting as per SICPs.

Linen used on service users who are on the respiratory pathway should be treated as infectious.

Routinely on the respiratory pathway, provided curtains around examination bays have no visible contamination and are kept tied back when not in use, they may remain in situ between patients however regular curtain change regimes should be in place. Curtains should also be cleaned as part of terminal cleaning following discontinuation of TBPs and following discharge of a patient from inpatient settings where transmission based precautions were in place at the time of discharge. When changed, curtains should be treated as infectious linen.

Primary Care and Community Health and Social Care settings – Safe Management of Laundry

Community Health and Care Settings with their own in-house laundries may also refer to National Guidance for Safe Management of Linen in NHS Scotland for more information.

See also staff uniforms.

5.19 Safe management Blood and Body Fluid (BBF) spillages

All BBF spillages should be managed as per section 1.8 of SICPs – Safe management of Blood and Body Fluid Spillages and Appendix 9.

Care Home Settings - Safe Management of Blood and Body Fluid spillages

Care homes should refer to the Care Home IPCM for older people and adult care homes for general information on safe management of Blood and Body Fluid spillages.

Waste generated during the management of BBF spillages should be disposed of as waste section.

5.20 Safe management of Waste

Waste should be handled in accordance with Section 1.9 of SICPs. Any items contaminated with BBF (including saliva) for any patient regardless of infectious status should be disposed of as clinical waste.

Care Home Settings - Safe Management of Waste

Care homes should refer to the Care Home IPCM for older people and adult care homes for more general information on safe management of waste in this setting. If the care home does not have a clinical waste contract ensure all waste items (e.g. used tissues and disposable cleaning cloths) that have been in contact with residents who are known or suspected to have COVID-19 are disposed of securely within disposable bags. When full, the plastic bag should then be placed in a second bin bag and tied. These bags should be stored in a secure location for 72 hours before being put out for collection.

Waste generated from patients/individuals who are on the respiratory pathway or where there is a confirmed outbreak, should be disposed of as clinical waste where clinical waste contracts are in place.

Primary Care and Community Health and Social Care settings - Safe Management of Waste

If the community health and care setting does not have a clinical waste contract, or for care at home, ensure all waste items (e.g. used tissues and disposable cleaning cloths) that have been in contact with service users who are known or suspected to have COVID-19 are disposed of securely within disposable bags. When full, the plastic bag should then be placed in a second bin bag and tied. These bags should be stored in a secure location for 72 hours before being put out for collection.

5.21 Occupational Safety

Employers have a duty of care to their staff. This is enshrined in health and safety legislation as is the requirement to undertake a risk assessment and then to mitigate any risks as low as reasonably practicable.

Section 1.10 of the NIPCM details occupational safety as per SICPs.

Care Home Settings - Occupational safety

Care homes should refer to the Care Home IPCM for older people and adult care homes for more general information on occupational safety in this setting.

PPE is provided for occupational safety and should be worn as per Tables 7 and 8.

Staff testing negative for SARS-CoV-2 by PCR who remain **symptomatic of another respiratory virus** should consider the risk to service users particularly if they are immunosuppressed or otherwise medically vulnerable before returning to work. Once medically fit to return to work, if staff are in doubt about any risk they may pose to service users or colleagues, this should be discussed with their line manager in the first instance.

Decisions to deploy any staff members into areas of higher infection risk must take into account many factors. These include the nature of the biologic agent, the general risks, and the specific risks to each individual member of staff. The individual risk assessment may need to take account of age, gender, underlying health conditions, race and vaccine status amongst other

factors. Occupational health expertise should be sought regarding both the overall process and for individuals deemed at significantly higher risk of either acquiring the infection or of an adverse outcome should they acquire infection.

Boards must have systems for risk assessment and mitigation with clearly defined responsibilities, routes to obtain advice from health and safety, occupational health, and other specialist advisers where required.

Occupational risk assessment guidance specific to COVID-19 is available. Further information for at risk or pregnant healthcare workers can be found in Guidance for Staff and Managers on Coronavirus.

5.22 Staff uniforms

It is safe to launder uniforms at home. If the uniform is changed before leaving work, then transport this home in a disposable plastic bag or a launderable bag. If your role requires you to wear a uniform to and from work, then change as soon as possible when returning home.

Uniforms should be laundered daily, and:

- separately from other household linen;
- in a load not more than half the machine capacity;
- at the maximum temperature the fabric can tolerate, then ironed or tumble dried.

Scottish Government uniform, dress code and laundering policy is available.

Contaminated uniforms and surgical scrubs should be laundered in hospital (dedicated laundry) facilities as per local policies.

5.23 Caring for someone who has died

For deceased who were on the respiratory pathway at the time of death, the IPC measures described in this document continue to apply whilst the deceased remains in the health and care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living service users. Where the deceased was known or suspected to have been infected with COVID-19, there is no requirement for a body bag, and

viewing, hygienic preparations, post-mortem and embalming are all permitted. Body bags may be used for other practical reasons such as maintaining dignity or preventing leakage of body fluids. See IPC during care of the deceased within the NIPCM for more information.

Care Home Settings - Care of the Deceased

Care homes should refer to the Care Home IPCM for older people and adult care homes for more general information on care of the deceased in this setting.

For further information see the Scottish Government Coronavirus (COVID-19): guidance for funeral directors on managing infection risks.

5.24 Visiting to health and care settings

Scottish government have guidance available for visiting which can be found at the following links;

Hospital visiting - https://www.gov.scot/publications/coronavirus-covid-19-hospital-visiting-guidance/

Care home visiting - https://www.gov.scot/publications/coronavirus-covid-19-adult-care-homes-visiting-guidance/

All visitors must be informed on arrival at any health and care facility of IPC measures and adhere to these at all times. Visitors should wear face coverings in line with current Scottish Government guidance and must not attend with COVID-19 symptoms or before a period of self-isolation has ended, whether identified as a case of COVID-19 or as a contact. Visiting may be suspended on the advice of the local IPCT/HPT. Consider alternative measures of communication including telephone or video call where visiting is not possible.

Visitors must:

- Not visit if they have suspected or confirmed COVID-19 or if they have been advised to self-isolate for any reason unless prior agreement with clinical teams during specific circumstances;
- Not visit if they have symptoms of another viral infection e.g. respiratory symptoms, GI symptoms unless prior agreement with clinical teams during specific circumstances.

- Wear a face covering on entering the facility;
- Be provided with appropriate PPE (see table 11);
- Perform hand hygiene at the appropriate times;
    - on entry to the facility
    - prior to putting on PPE
    - after removing PPE
- No unnecessary movement around the facility and should stay at the bed or chairside of the individual they are visiting (if the individual has their own room, visitors should remain within the room);
- Not visit other service users in the facility;
- Not touch their face or face covering/mask once in place;
- Not eat whilst visiting;
- Avoid sharing mobile phone devices with the individual unnecessarily – if mobile devices are shared to enable communications with other friends and family members, the phone should be cleaned between uses using manufacturer's instructions.

Visitors entering an AGP area should do so after the fallow time has elapsed. Where this is not possible (continual AGP zone), visitors should be advised that there may be a risk of exposure to respiratory viruses. Visitors must wear an FRSM where respirator fit testing is not possible. Visitors should also be advised to regularly test for COVID-19 in line with community advice and refrain from returning to the health and care setting if positive for COVID-19 unless deemed essential and arranged with staff in advance.

Table 11 – Visitor PPE

Pathway	Gloves	Apron	Face covering/mask	Eye/Face Protection
Routine care areas (SICPs)	Not required[*1]	Not required[*2]	Face covering or provide with Type IIR FRSM if visitor arrives without a face covering	Not required[*3]
Respiratory pathway (TBPs)	Not required[*1]	Not required[*2]	Type IIR FRSM	If within 2 metres of service user with respiratory symptoms

[*1] unless providing direct care which may expose the visitor to blood and/or body fluids i.e. toileting.

[*2] unless providing care resulting in direct contact with the service user, their environment or blood and/or body fluid exposure i.e. toileting, bed bath.

[*3] Unless providing direct care and splashing/spraying is anticipated

5.25 Resources

PPE posters

PPE for delivery of COVID-19 vaccination (staff)

PPE for attending for your COVID-19 vaccination (public)

Wearing a facemask poster (staff)

Wearing a facemask – information for patients' poster

Suggested ways of wearing a facemask