ARHAI Scotland
Antimicrobial Resistance and Healthcare Associated Infection

NHS
National Services Scotland

Scottish COVID-19 Infection Prevention and Control Addendum for Community Health and Care Settings

Version history

Version	Date	Summary of changes
V1.0	07/01/2021	First publication
V1.1	25/01/2021	Addition of section 7.2.5 'Discontinuing IPC control measures in community health and care settings for COVID-19 individuals

This addendum has been developed in collaboration with a wide range of stakeholders to provide Scottish context to the UK COVID-19 IPC remobilisation guidance in community settings. Some deviations from the UK COVID-19 IPC remobilisation guidance exist for Scotland and these have been agreed through consultation with NHS Boards and approved by the CNO Nosocomial Review Group. These processes deviate from the National Infection Prevention & Control Manual normal process for sign off due the timescales for COVID-19 guidance approval.

This guidance is for use within the following settings:

- GP practices

- Health and social care services provided in peoples own homes

- Community based settings for people with mental health needs

- Community based settings for people with a learning disability

- Community based settings for people who misuse substances

- Supported accommodation settings

- Rehabilitation services

- Residential children's homes

- Stand alone residential respite for adults (settings not registered as care home)

- Stand alone residential respite/short breaks services for children

- Sheltered housing

- Hospice settings

- Community Optometry

- Community Pharmacy

- Specialist Palliative Care In-patient units/Hospices

- Prison and Detention settings

Within this document, service users are referred to as patients and/or individuals depending on the facility/setting in which care is provided.

The purpose of this addendum is to provide COVID-19 specific IPC guidance for community health and care settings on a single platform improving accessibility for users. The guidance within this addendum is in line with the UK IPC remobilisation guidance however some deviations for NHSScotland exist.

IMPORTANT: Whilst these additions are specific to COVID-19, clinicians must consider the possibility of infection associated with other respiratory pathogens spread by the droplet or airborne route and therefore Transmission Based Precautions (TBPs) should not be automatically discontinued where COVID-19 has been excluded.

Contents

7.1 COVID-19 case definitions and triage questions

7.1.1 Definition of a confirmed case

A laboratory confirmed (detection of SARs-CoV-2 RNA in a clinical specimen) case of COVID-19.

7.1.2 Definition of a suspected case

The case definition being used across the UK reflects current understanding from the epidemiology available and may be subject to change. Case definitions can be found within Public Health Scotland (PHS) primary care guidance and below.

An individual meeting one of the following case criteria taking into account atypical and non-specific presentations in older people with frailty, those with pre-existing conditions and patients who are immunocompromised.

Community definition

- Recent onset new continuous cough
  OR

  fever
  OR
  loss of/change in sense of taste or smell (anosmia)

Definition for individuals requiring hospital admission

- Clinical or radiological evidence of pneumonia

  OR

  Acute Respiratory Distress Syndrome

  OR

  Influenza like illness (fever ≥ 37.8°C and at least one of the following respiratory symptoms, which must be of acute onset; persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing)

  OR

  A loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms

Individuals must be assessed for bacterial sepsis of other causes of symptoms as appropriate.

7.1.3 Testing

Clinicians should test all individuals who meet either of the case definitions described in section 7.1.2 Further information on testing can be found in the PHS Primary Care guidance.

Guidance for coronavirus testing including who is eligible for a test, how to get tested and the different types of test are available on the Scottish Government web pages.

7.1.4 Triaging individuals

The mechanism for triage will vary dependant on both the geographical location and service within primary care but wherever possible, triage questions should be undertaken by telephone prior to an arranged arrival at the facility. To enable early detection of suspected or confirmed COVID-19, triage questions should be undertaken again on arrival at community health facilities. For unplanned arrivals, triage questions should be completed immediately on arrival where it is safe to do so without delaying any necessary immediate lifesaving interventions.

Individuals with symptoms consistent with COVID-19 could present to your facility. Information posters for NHS settings should be displayed so they can be seen before individuals enter the premises, encouraging them to return home and be advised to contact NHS24. Posters are available on NHS Inform.

If providing a home visit, staff should contact the patient/individual by telephone at home prior to the visit to undertake the triage questions. These should be repeated on arrival at the patient/individual's home. If patient lacks capacity to answer these questions by telephone, an assessment should be made on arrival keeping 2 metres from the individual where possible. If this is not possible, treat as medium risk category or high risk category if COVID-19 symptoms can be observed.

If it is an emergency and you need to call an ambulance for an individual, dial 999 and inform the ambulance call handler of the concerns about COVID-19 infection. While awaiting ambulance transfer, show the individual into a room and ask that they wear a fluid resistant surgical mask where it can be tolerated. Leave the room if safe to do so. If you have to enter the room, stay at least 2 metres away from the individual if possible and if not, wear PPE in line with section 7.5. The room should be cleaned as per section 7.7 once the patient safely leaves the premises.

Staff within residential and detention settings must ensure individuals are monitored for new onset of any symptoms and action taken at the earliest opportunity.

The following are examples of triage questions:

- **Do you or any member of your household/family have a confirmed diagnosis of COVID-19?**

  If yes, wait until self-isolation period is complete before attending the facility/undertaking the home visit or if urgent care is required, follow the high risk category.

- **Are you or any member of your household/family waiting for a COVID-19 test result?**

  Is yes, ascertain if appointment/consultation/home visit can be delayed until results are known. If urgent care is required, follow the high risk category.

- **Have you travelled internationally to any country which isn't exempt from self-isolation rules in the last 14 days?**

  If yes, 14 days' self-isolation will apply. Only urgent care should be provided during the self-isolation period. The individual should be placed on the medium or high risk category depending on a clinical and individual assessment – see footnote 1 in section 7.2 (See Scottish Government list of countries exempt from self-isolation).

- **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 until self-isolation period is complete before appointment/consultation/home visit or if urgent care is required, follow high risk category

- **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). If urgent appointment/consultation/home visit still required, follow high risk category.

- **Is there any reason why you are unable to wear a face covering when attending for your appointment/when your care provider visits?**

  If No, remind individual to wear face covering on arrival or supply facemask.

  A word version of these questions for triage is available to download.

7.2 Individual placement/Assessment of Infection Risk

Defined category areas/pathways must be established to ensure segregation of individuals determined by their risk of COVID-19. Any other known or suspected infections and the need for any Aerosol Generating Procedures (AGPs) must be considered before individual placement within each of the category areas. Establishing which category an individual is in will determine Personal Protective Equipment (PPE) and decontamination requirements.

Examples of categories are described below. Your setting may use different names for each of the categories from those described below and you should familiarise yourself with the categories in your setting that align with those described here. Any services providing care at home should phone ahead to the individual prior to a visit and ask the triage questions in (examples in section 7.1) to determine what category they will be on. Within Acute care settings there is an additional low risk pathway which can be found in the Scottish Acute Care COVID-19 Addendum however it is expected that all individuals in community and care at home settings will fall into the Medium or High risk categories. Guidance beyond this section will only refer to the medium and high risk categories.

1. **Known as the High Risk COVID-19 category in the UK IPC remobilisation guidance .**

    a. Confirmed COVID-19 individuals.

    b. Symptomatic or Suspected COVID-19 individuals (as determined by hospital or community case definition or clinical assessment where there is a suspicion of COVID-19 taking into account atypical and non-specific presentations in older people with frailty those with pre-existing conditions and patients who are immunocompromised).

    c. Those who are known to have had contact with a confirmed COVID-19 individual and are still within the 14-day self-isolation period and those who have been tested and results are still awaited.

    d. See footnote 1.

2. **Known as the Medium Risk COVID-19 category in the UK IPC remobilisation guidance.**

    a. All other individuals who have been triaged and who do not meet the criteria for the pathways above and who <u>do not</u> have any symptoms of COVID-19.

    b. Asymptomatic individuals who refuse testing or for whom testing cannot be undertaken for any reason.

    c.   Recovered COVID-19 individuals– see [footnote 2](#).

    d.   See [footnote 1](#).

Footnote 1. When deciding placement for untriaged individuals where symptoms are unknown (e.g. unconscious) or individuals who have returned from a country on the quarantine list in the last 14 days, a full clinical and individual assessment should be carried out prior to placement on the **High** <u>OR</u> **Medium** risk category. This assessment should take account of risk to the individual (immunosuppression, frailty) and clinical care needs (required for any specialist treatment).

Footnote 2. Recovered individuals can generally be defined as those who have completed 14 days isolation whilst resident in a community care facility starting from the date of symptom onset (or from positive test date if asymptomatic) <u>and</u> have had absence of fever for 48 hours (without use of antipyretics) <u>and</u> have a negative COVID-19 PCR test. However, individual risk assessment is required to take account of those who are severely immunocompromised and those at extremely high risk of illness. These individuals are at increased risk of prolonged viral shedding.

Some individuals who no longer require medical care in hospital will be discharged home or to their long term care facility to fully recover. These people may still have COVID-19 and can be safely cared for at home if this guidance is followed. The hospital will provide information to the organisation or local authority on the results and a date of any testing and a plan for stepping down infection prevention and control measures.

See [COVID-19: Guidance for stepdown of Infection Control Precautions and discharging COVID-19 patients from hospital to residential settings](#) for further information.

7.2.1 Category implementation and the surrounding environment

Ideally, facilities should have designated areas for the high risk category and designated areas for the medium risk category. Depending on the nature of the services, it may be possible to run clinics at specific times of the day determined by category i.e. Medium risk category in morning session, high risk category in afternoon session. As per triage questions above, patients on the high risk category should have their appointment postponed until they have completed their isolation period wherever possible. Ensure category areas have signage in place to support and separate entrances to facilities and departments utilised where available.

Clutter and excess storage items should be removed from all areas to facilitate effective cleaning and minimise the potential for contamination.

Soft furnishings which can't be cleaned appropriately should be avoided where possible such as fabric chairs and carpets.

All non-essential items including toys, books and magazines should be removed from receptions, waiting areas, consulting and treatment rooms.

7.2.2 Managing individual placement in self-contained residential settings

All admissions from the community to a residential facility should be assessed first using the triage questions in section 7.1. This applies to all types of residential facilities and admissions (including for respite).

For individuals who fall into the high risk category, the admission should be delayed until they have completed their self-isolation period wherever possible. Conduct a local risk assessment if the admission cannot be delayed to ensure it is done safely. See PHS Social Care and Residential Care COVID-19 guidance for further information on admissions to these settings including for respite.

If the admission must go ahead, the individual can start isolation in their own room and must be managed in line with the high risk category.

Where all single occupancy rooms are occupied, cohorting may be considered and should be discussed with your local Health Protection Team (HPT). Cohorting may take place as follows;

- All individuals in the medium risk category;

- All confirmed COVID-19 individuals in the high risk category;

- All unconfirmed COVID-19 asymptomatic individuals in the high risk category.

Individuals who are symptomatic of COVID-19 but are still awaiting test results must not be cohorted together. This is because symptoms may be associated with another respiratory pathogen and cohorting increases the risk of onward transmission to others. These individuals should be isolated in their own single room facility and mixing with others must be avoided wherever possible. Additionally, individuals previously considered to be in the shielding category should not be cohorted with other residents/individuals.

Meals should be provided for the individual in the high risk category to eat within their room to avoid them entering any communal spaces.

Ensure that personal toiletries such as towels (unless laundered to a satisfactory standard between individuals) toothbrushes and razors are not shared amongst individuals. Consider a rota for showering and bathing placing the individuals in the high risk category last.

Only essential staff wearing appropriate PPE should enter the rooms of individuals in the high risk category. All necessary care should be carried out within the individual's room.

Any individual in the medium risk category who develop symptoms of COVID-19 should be isolated immediately and tested for COVID-19. Any individual who goes on to test positive for COVID-19 (whether symptomatic or asymptomatic) should be transferred to the high risk category.

7.2.3 Care provided in an individual's home

All efforts should be made to establish which COVID-19 category the individual is in before arrival at an individual's home. Establish whether or not the individual has any aerosol generating procedures (AGPs) in progress so that the correct PPE can be donned – see section 7.5.6.

An FRSM should be worn on entering an individual's home. On arrival, assess the activities and tasks to be undertaken. If possible, they should be performed in such a way that 2 metre physical distancing is maintained. Where 2 metre physical distancing cannot be maintained, PPE should be worn in line with table 2. Donning and doffing of PPE in the care at home settings is covered in section 7.5.4.

Scottish Government advice on providing care at home is available.

7.2.4 Staff cohorting

Efforts should be made as far as reasonably practicable to dedicate assigned teams of staff to care for individuals in each of the different categories. There should be as much consistency in staff allocation as possible, reducing movement of staff and the crossover between categories wherever possible. Rotas should be planned in advance wherever possible, to take account of different categories and staff allocation. For staff groups who need to go between categories, efforts should be made to see individuals in the medium risk category first then the high risk category.

Providers or employers delivering a service in an individual's own home should identify individuals at extremely high risk of severe illness, assess their needs and allocate dedicated staff (if possible) to care for them. This should be reviewed regularly to ensure it is up to date. Other staff members should be allocated to consistently care for the needs of those not at extremely high risk of severe illness. During the pandemic it is important to minimise the visits to those individuals at extremely high risk of severe illness and, if possible, the number of staff undertaking the visits. The person receiving care may make the decision to suspend some of the care or for this to be provided by a carer or guardian. This should be discussed with the relevant authorities and care providers. Where it is not possible to allocate specific staff to care for individuals who are at extremely high risk of severe illness, it may be possible to schedule visits to these groups of patients before visits to others.

7.2.5 Discontinuing IPC control measures in community health and care settings for COVID-19 individuals

The following applies to individuals in the community health and care settings listed on page 1 of this addendum.

Before IPC control measures are stepped down for COVID-19, it is essential to first consider the ongoing need for **transmission based precautions** (TBPs) necessary for any other alert organisms, e.g. MRSA carriage or *C. difficile* infection, or patients with ongoing diarrhoea.

Key notes to be referred to in conjunction with table 1 below;

- **Completing the isolation period** - – Individuals living in their own home should complete a period of 10 days isolation. Individuals recently discharged from hospital (within the self-isolation period) must complete a total of 14 days isolation. This is because, in general, those with COVID-19 who are admitted to hospital will have more severe disease than those who remain in the community, especially if they require critical care. In addition, those admitted are more likely to have pre-existing conditions such as severe immunosuppression.

  Other household members should complete their 10 day stay at home period (as described in **Stay at Home** guidance). If this did not start before the individual was admitted to hospital, then it should commence from the day the individual returns to the household, unless the individual has already completed their appropriate period of isolation within hospital.

  Staff identified as a COVID-19 case or contact should complete a total of 10 days self-isolation in line with Public Health Scotland guidance.

  All other individuals should follow stay at home guidance on NHS inform.

- **COVID-19 clinical requirements for stepdown** – Clinical improvement with at least some respiratory recovery. Absence of fever (>37.8oC) for 48 hours without use of antipyretics. A cough or a loss of/ change in normal sense of smell or taste may persist in some individuals, and is not an indication of ongoing infection when other symptoms have resolved.

- **Testing required for stepdown** – No testing is required routinely to stepdown IPC precautions in community health and care settings.

  For severely immunocompromised individuals or those at extremely high risk of severe illness, negative tests may be required where ongoing care is required as an outpatient in a healthcare setting. This would be determined by the discharging clinician.

Table 1: Stepdown requirements for community health and care settings

	Number of isolation days required	COVID-19 Clinical requirement for stepdown*1	Testing required for stepdown
Individuals who have recently discharged from hospital	14 days from symptom onset (or first positive test if symptom onset undetermined)	Absence of fever for 48 hours without use of antipyretics & at least some respiratory recovery	Not routinely required
Individuals who are severely immunocompromised or at high risk of severe illness	10 days from symptom onset (or first positive test if symptom onset undetermined)	Absence of fever for 48 hours without use of antipyretics & at least some respiratory recovery	Not routinely required unless returning to healthcare as an outpatient
People in prisons	10 days from symptom onset (or first positive test if symptom onset undetermined)	Absence of fever for 48 hours without use of antipyretics & at least some respiratory recovery	Not routinely required
All other individuals including staff in residential and detention settings	10 days from symptom onset (or first positive test if symptom onset undetermined)	Absence of fever for 48 hours without use of antipyretics & at least some respiratory recovery	Not routinely required

Transferring between pathways on stepdown

Residents/individuals should be managed in the high risk category for any outpatient care or care at home until criteria described in this table is met and can then transfer to the medium risk category.

7.3 Hand Hygiene

Hand hygiene is considered one of the most important practices in preventing the onward transmission of any infectious agents including COVID-19. Hand hygiene should be performed in line with section 1.2 of SICPs, bare below the elbow and must be performed before every episode of direct individual/resident care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of personal protective equipment (PPE), equipment decontamination and waste handling.   Within this section you will find videos demonstrating how to perform a hand wash and how to perform a hand rub. Posters

detailing hand washing techniques and alcohol based hand rub (ABHR) technique can be found in the resources section of this addendum. Hand washing should be extended to the forearms if there has been exposure of forearms to respiratory secretions.

7.3.1 Hand hygiene in the community

Staff working in the community should carry a supply of Alcohol Based Hand Rub (ABHR) to enable them to perform hand hygiene at the appropriate times. Where staff are required to wash their hands (when visibly contaminated) in the individual's own home they should do so for at least 20 seconds using any hand soap available. Staff should carry a supply of disposable paper towels for hand drying rather than using hand towels in the individual's own home. Once hands have been thoroughly dried, ABHR should be used.

Staff may also carry antimicrobial hand wipes if they are going to be attending a property where there is no running water. The use of antimicrobial hand wipes is only permitted where there is no access to running water. Staff must perform hand hygiene using ABHR immediately after using the hand wipes and perform hand hygiene with soap and water at the first available opportunity.

7.4 Respiratory and cough hygiene

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.

7.5 Personal Protective Equipment (PPE)

PPE exists to provide the wearer with protection against any risks associated with the care task being undertaken. PPE requirements as per standard infection prevention and control precautions are detailed in section 1.4 of the NIPCM. PPE requirements during the COVID-19 pandemic are determined by the COVID-19 care categories and are detailed in Table 2.

7.5.1 Extended use of Face Masks for staff, visitors and outpatients

New and emerging scientific evidence suggests that COVID-19 may be transmitted by individuals who are not displaying any symptoms of the illness (asymptomatic or pre-symptomatic). The extended use of facemasks by health and social care workers and the wearing of face coverings by visitors is designed to protect staff and individuals in their care and the full guidance and associated FAQs is available on the Scottish Government's COVID-19 web page.

A poster detailing the ['Dos and don'ts' of wearing a face mask](#) is available.

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

A poster intended to [support the wearing of a non-medical face mask/face covering](#) is available.

Where staff are providing 'live in' support/care for individuals, the should maintain 2 metres physical distancing when not providing direct care. When providing direct care, a Type IIR mask should be worn as well as any other PPE required as outlined in [section 7.5.2](#).

7.5.2 PPE determined by COVID-19 care category

The PPE worn for direct care differs depending on the COVID-19 care category and the task being undertaken. It is important that the need for PPE required for any other known or suspected pathogens is also risk assessed.

[Table 2](#) details the PPE which should be worn when providing care in each of the COVID-19 care categories.

Type IIR facemasks should be worn for all direct care regardless of the category. This is a measure which has been implemented alongside physical distancing specifically for the COVID-19 pandemic. Facemasks should be changed if wet, if damaged or if soiled.

Table 2: PPE for direct patient/individual care determined by pathway

	Gloves	Apron/Gown	Face mask	Eye face protection
Medium Risk category	If contact with BBF[*1] is anticipated, then Single use	If direct contact with patient, their environment or BBF is anticipated (Gown if splashing spraying anticipated), then Single use	Always within 2 metres of a patient - Type IIR fluid resistant surgical face mask	If splashing or spraying with BBF anticipated Single use or reusable

	Gloves	**Apron/Gown**	**Face mask**	**Eye face protection**
High Risk category	Worn for all direct patient care Single use	Always within 2 metres of a patient (Gown if splashing spraying anticipated). Single Use	Always within 2 metres of a patient - Type IIR fluid resistant surgical face mask	Always within 2 metres of a patient Single use, sessional[2] or reusable following decontamination

[1] BFF – Blood & Body Fluids

[2] – See section 7.5.9 for details of sessional use

NB: Where a physical partition is insitu e.g. at reception desks/pharmacy counters, Staff need only wear FRSM in line with extended face mask policy described in section 7.5.1. No other PPE is required.

A flowchart detailing appropriate glove use and selection can be found in Appendix 5 of the NIPCM.

7.5.3 PPE – Putting on (Donning) and Taking off (Doffing)

All staff must be trained in how to put on and remove PPE safely. A short film showing the correct order for putting on and the safe order for removal of PPE is available. The video will also describe safe disposal of PPE. A poster describing the donning and doffing of PPE is available in the NIPCM Appendix 6 and is also described below.

Putting on PPE

Before putting on PPE:

- Check what the required PPE is for the task/visit
- Select the correct size of PPE
- Perform hand hygiene

PPE should be put on before entering the room.

- The order for putting on is apron, surgical mask, eye protection and gloves – you may require some of these items or all of them – See Table 2.

- When putting on mask, position the upper straps on the crown of head and the lower strap at the nape of the neck. Mould the metal strap over the bridge of the nose using both hands.

When wearing PPE:

- Keep hands away from face and PPE being worn.
- Change gloves when torn or heavily contaminated.
- Limit surfaces touched in the care environment.
- Always perform hand hygiene after removing gloves

Removal of PPE

PPE should be removed in an order that minimises the potential for cross-contamination.

Gloves

- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand.
- Slide the fingers of the un-gloved hand under the remaining glove at the wrist.
- Peel the glove off and discard appropriately.

Gown

- Unfasten or break ties.
- Pull gown away from the neck and shoulders, touching the inside of the gown only.
- Turn the gown inside out, fold or roll into a bundle and discard.

Eye Protection

- To remove, handle by headband or earpieces and discard appropriately.

Fluid Resistant Surgical facemask

- Remove after leaving care area.
- Untie or break bottom ties, followed by top ties or elastic and remove by handling the ties only (as front of mask may be contaminated) and discard as clinical waste.
- For face masks with elastic, stretch both the elastic ear loops wide to remove and lean forward slightly. Discard as clinical waste.

To minimise cross-contamination, the order outlined above should be applied even if not all items of PPE have been used.

Perform hand hygiene immediately after removing all PPE.

7.5.4 Putting on (donning) and taking off (doffing) in an individual's home

PPE should be put on in a safe area either inside the premises, such as a porch or a separate room, or, if there is no available area then the mask can be put on immediately prior to entering the home, and gloves and apron when in the home.

PPE should be removed before leaving the home or care setting and should not be worn out with the home or to the next visit. If caring for more than one individual in the same house, then only the mask/eye protection can be considered sessional use until completion of the tasks/care. Hand hygiene must be carried out on immediately after removing PPE.

Disposal of PPE can be found in section 7.10.

7.5.5 Aerosol Generating procedures (AGPs)

An Aerosol Generating Procedure (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. The most common AGPs undertaken in the community are Continuous Positive Airway Pressure Ventilation (CPAP) or Bi-level Positive Airway Pressure Ventilation (BiPAP).

Below is the full extant 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

* NB: The available evidence relating to Respiratory Tract Suctioning is associated with ventilation. In line with a precautionary approach open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current (COVID-19) AGP list.   It is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is currently considered an AGP i.e. oral/pharyngeal suctioning is not an AGP. The evidence on respiratory tract suctioning is currently being reviewed by the AGP Panel.

Chest compressions and defibrillation (as part of resuscitation) are not considered AGPs; first responders (any setting) can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other clinicians to undertake airway manoeuvres. This recommendation comes from Public Health England and the New and Emerging Respiratory Viral Threat Assessment Group (NERVTAG) published evidence view and consensus opinion.

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.

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.

An SBAR produced by Health Protection Scotland (HPS) and agreed by NERVTAG specific to AGPS during COVID-19 is available.

The NERVTAG consensus view is that the HPS document accurately presents the evidence base concerning medical procedures and any associated risk of transmission of respiratory infections and whether these procedures could be considered aerosol generating. NERVTAG supports the conclusions within the document and supports the use of the document as a useful basis for the development of UK policy or guidance related to COVID-19 and aerosol generating procedures (AGPs).

7.5.6 Aerosol Generating Procedures (AGPs) in an individual's home

Wherever possible, staff should avoid visiting patients/individuals in the medium and high categories who require a routine consultation and where AGPs are undertaken in the home. This is because potentially infectious aerosols will still be circulating in the air (see section 7.5.8). The most common AGPs undertaken in the community are Continuous Positive Airway Pressure Ventilation (CPAP) or Bi-level Positive Airway Pressure Ventilation (BiPAP).

Consider phone/digital consultations in the first instance to assess whether the individual requires a home visit. If it is safe to postpone the visit, then do so.

Care at home staff will not be able to postpone visits. In such instances where a home visit cannot be avoided;

- Find out what time the individual is on CPAP/BiPAP and plan to visit at least an hour or more after the CPAP or BiPAP has been switched off

- Ask the individual to move to another room in the property and close the door to the room where the CPAP or BiPAP is undertaken.

- If the visit must take place when the patient is on the CPAP/BiPAP or if the above measures cannot be followed, the member of staff must wear AGP PPE in line with section 7.5.7. It is the responsibility of care providers to ensure that all staff have been fit tested for FFP3 respirators where appropriate.

7.5.7 PPE for Aerosol Generating Procedures (AGPs)

Airborne precautions **are required** for the medium and high risk categories where AGPs are undertaken and the required PPE is detailed in table 3 below.

All FFP3 respirators must be:

- Fit tested (by a competent fit test operator) on all healthcare staff who may be required to wear a respirator to ensure an adequate seal/fit according to the manufacturers' guidance.

- Fit checked (according to the manufacturers' guidance) every time a respirator is donned to ensure an adequate seal has been achieved.

- Compatible with other facial protection used i.e. protective eyewear so that this does not interfere with the seal of the respiratory protection. Regular corrective spectacles are not considered adequate eye protection. If wearing a valved, non-shrouded FFP3 respirator a full face shield/visor must be worn.

- Changed after each use. Other indications that a change in respirator is required include: if breathing becomes difficult; if the respirator becomes wet or moist, damaged; or obviously contaminated with body fluids such as respiratory secretions.

Table 3: PPE for Aerosol Generating Procedures determined by pathway

	Gloves	Apron/ Gown	Face mask/Respirator	Eye face protection
Medium Risk category	Single use	Gown – Single use	FFP3 mask or Powered respirator hood	Single use or re-useable
High Risk category	Single use	Gown – Single use	FFP3 mask or Powered respirator hood	Single use or re-useable

7.5.8 Post AGP Fallow Times (PAGPFT)

Time is required after an AGP is performed to allow the 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 post aerosol generating procedure fallow time (PAGPFT) calculations are detailed in table 4. It is often difficult to calculate air changes in areas that have natural ventilation only.

All point of care areas require to be well ventilated. Natural ventilation, provides an arbitrary 1-2 air changes per hour. To increase natural ventilation in many community health and social care settings may require opening of windows. If opening windows staff must conduct a local hazard/safety risk assessment.'

If the area has zero air changes and no natural ventilation, then AGPs should not be undertaken in this area.

The duration of AGP is also required to calculate the PAGPFT and clinical staff are therefore reminded to note the start time of an AGP. It is presumed that the longer the AGP, the more aerosols are produced and therefore require a longer dilution time. During the PAGPFT staff **should not** enter this room without FFP3 masks. Patients, other than the patient on which the AGP was undertaken, must not enter the room until the PAGPFT has elapsed and the surrounding area has been cleaned appropriately. As a minimum, regardless of air changes per hour (ACH), a period of 10 minutes must pass before rooms can be cleaned. This is to allow for the large droplets to settle. Staff must not enter rooms in which AGPs have been performed without airborne precautions for a minimum of 10 minutes from completion of AGP. Airborne precautions may also be required for a further extended period of time based on the duration of the AGP and the number of air changes (see table 4). Cleaning can be carried out after 10 minutes regardless of the extended time for airborne PPE.

Table 4: Post AGP fallow time calculation

Duration of AGP (min)	Air change rate (AC/h)									
	1	2	4	6	8	10	12	15	20	25
3	230	114	56	37	27	22	18	14	10	8* (10)
5	260	129	63	41	30	24	20	15	11	8*(10)
7	279	138	67	44	32	25	20	16	11	9*(10)
10	299	147	71	46	34	26	21	16	11	9*(10)
15	321	157	75	48	35	27	22	16	12	9*(10)

- The minimum fallow time (to allow for droplet settling time) is 10 minutes

7.5.9 Sessional use of PPE

During the peak of the pandemic, some PPE was used on a sessional basis and this meant that these items of PPE could be used moving between residents and for a period of time where a member of staff was undertaking duties in an environment where there was exposure to COVID-19. A session ended when the member of staff left the care setting or exposure environment.

As supplies of PPE are now sufficient, sessional use of PPE **is no longer required** other than when wearing a visor/eye protection in a communal area where residents in the high risk category and when wearing a fluid resistant surgical face mask (FRSM) across all categories.

FRSMs can be worn sessionally when providing direct care or as part of extended use of facemask policy. FRSMs and visors or eye protection must be changed if wet, damaged, soiled compromised or uncomfortable or after having provided care for a resident isolated with a suspected or known infectious pathogen and when leaving high-risk (red) category areas. The same principles should be observed for staff post toilet and meal breaks, when a new face mask should be put on, once removed the FRSM must **never** be reused.

Employers are encouraged to plan breaks in such a way that allows 2 metre physical distancing and therefore staff not having to wear a face mask, with natural ventilation where possible.

7.5.10 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 Service Scotland. 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.

All services who are registered with the Care Inspectorate that are providing health and/or care support and have an urgent need for PPE after having fully explored

local supply routes/discussions with NHS Board colleagues, can contact a triage centre run by NHS National Services for Scotland (NHS NSS).

Please note that in the first instance, this helpline is to be used only in cases where there is an urgent supply shortage after "business as usual" routes have been exhausted.

The following contact details will direct social care providers to the NHS NSS triage centre for social care PPE:

Email: support@socialcare-nhs.info
Phone: 0300 303 3020.
The helpline will be open (8am - 8pm) 7 days a week.

7.6 Safe management of Care Equipment

Care equipment is easily contaminated with blood, other body fluids, secretions, excretions and infectious agents. Consequently, it is easy to transfer infectious agents from communal care equipment during care delivery. All care equipment should be decontaminated as per Table 5.

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

Table 5: Equipment cleaning determined by category

Pathway	Product
Medium Risk category	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.
High Risk category	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.

7.7 Safe Management of the Care Environment

During this ongoing pandemic, cleaning frequency of the environment should be increased across **all** categories in care facilities. A minimum of 4 hours should have elapsed between the first daily clean and the second daily clean – see table 6 for cleaning requirements. Where a room has not been occupied by any staff or

individuals since the first daily clean was undertaken, a second daily clean is not required.

It is the responsibility of the person in charge to ensure that the care environment is safe for practice (this includes environmental cleanliness/maintenance). The person in charge must **act** if this is deficient.

The care environment must be:

- visibly clean, free from non-essential items and equipment to facilitate effective cleaning
- well maintained and in a good state of repair

Ideally rooms which are carpeted should be avoided when carrying out consultations in healthcare facilities

Environmental cleaning in the Medium and High Risk COVID-19 categories should be undertaken using either a combined detergent/disinfectant solution at a dilution of 1000 ppm available chlorine or a general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1000ppm.

Cleaning across the categories is summarised in table 6.

Table 6: Environmental cleaning determined by category

	1st daily clean	2nd daily clean	Product
Medium Risk category	Full clean	*High Risk Touch Surfaces within clinical inpatient 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.
High Risk category	Full clean	*High Risk Touch Surfaces within clinical inpatient 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.

Any areas contaminated with blood and body fluids across any of the 3 pathways require to be cleaned as per Appendix 9 of the National Infection Prevention Control Manual (NIPCM).

7.7.1 Cleaning practice points

NHS healthcare facilities will be cleaned by NHS domestic services who will adhere to the National Cleaning Specification Standards. For all care facilities (excluding patients own home) the following good practice points apply

- Use disposable cloths/paper roll/disposable mop heads, to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room.

- Clean, dry and store re-usable parts of cleaning equipment, such as mop handles.

- For carpeted floors/items that cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use following, or combined with, detergent cleaning.

- Decontamination of soft furnishings may require to be discussed with the local HPT/ICT. If the soft furnishing is heavily contaminated, you may have to discard it. If it is safe to clean with standard detergent and disinfectant alone then follow appropriate procedure.

7.8 Safe Management of Linen

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

Linen used on individuals in the High and Medium Risk category should be treated as infectious.

Provided curtains around examination bays have no visible contamination and are kept tied back when not in use, they may remain insitu however regular curtain change regimes should be in place and when changed, curtains should be treated as infectious linen.

Where care providers are supporting individuals with laundering in the community, If the individual does not have a washing machine, the laundry items should be bagged, held for 72 hours before being taken to a public launderette.

Care at home staff who manage linen in the individual's own home should wash linen as normal unless the individual is on the high risk category. In this instance, any linen belonging to the individual should be washed separately from others living in the same household.

See section 7.12 for staff uniforms.

7.9 Safe Management of Blood and Body Fluid Spillages

All blood and body fluid spillages across the 3 pathways should be managed as per section 1.8 of SICPs – Safe management of Blood and Body Fluid Spillages and Appendix 9.

Waste generated during the management of blood and body fluid spillages should be disposed of as per section 7.10.

7.10 Safe Disposal of waste (including sharps)

Waste should be handled in accordance with Section 1.9 of SICPs. Waste generated in individual bedrooms and treatment areas within the High and Medium Risk categories should be treated as infectious (category B) where clinical waste contracts are in place.

NB: Type IIR facemasks worn as part of the extended use of facemasks policy should be disposed of as clinical waste.

If the facility does not have a clinical waste contract, or you are providing care at home, ensure all waste items that have been in contact with the individual (e.g. used tissues and disposable cleaning cloths) 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.

7.11 Occupational Safety

Section 1.10 of SICPs remains applicable to COVID-19 individuals.

Occupational risk assessment guidance specific to COVID-19 is available.

PPE is provided for occupational safety and should be worn as per Tables 2 and 3.

7.11.1 Car/vehicle sharing for staff including trainees/students

Wherever possible, car sharing should be avoided with anyone outside of your household or your support bubble. This is because the close proximity of individuals sharing the small space within the vehicle increases the risk of transmission of COVID-19. All options for travelling separately should be explored and considered such as;

- Staff travelling separately in their own cars

- Geographical distribution of visits – can these be carried out on foot or by bike?

- Use of public transport where social distancing can be achieved via use of larger capacity vehicles

However, it is recognised that there are occasions where car sharing is unavoidable such as:

- Staff who carry out community visits.

- Staff who are commuting with students as part of supported learning/mentorship.

- Staff working in emergency response vehicles (not patient vehicles).

- Staff living in areas where public transport is limited and car sharing is the only means of commuting to and from the workplace.

Where car sharing cannot be avoided, individuals should adhere with the guidance below to reduce any risk of cross transmission:

- Staff (and students) **must not** travel to work/car share if they have symptoms compatible with a diagnosis of COVID-19.

- Ideally, no more than 2 people should travel in a vehicle at any one time.

- Use the biggest car available for car sharing purposes.

- Car sharing should be arranged in such a way that staff share the car journey with the same person each time to minimise the opportunity for exposure. Rotas should be planned in advance to take account of the same staff commuting together/car sharing as far as possible.

- The car must be cleaned regularly (at least daily) and particular attention should be paid to high risk touch points such as door handles, electronic buttons and seat belts. General purpose detergent is sufficient unless a symptomatic or confirmed case of COVID-19 has been in the vehicle in which case a disinfectant should be used.

- Occupants should sit as far apart as possible, ideally the passenger should sit diagonally opposite the driver.

- Windows in the car must be opened as far as possible taking account of weather conditions to maximise the ventilation in the space.

- Occupants in the car, including the driver, should wear a fluid resistant surgical mask (FRSM) provided it does not compromise driver safety in any way.

- Occupants should perform hand hygiene using an alcohol based hand rub (ABHR) before entering the vehicle and again on leaving the vehicle. If hands

are visibly soiled, use ABHR on leaving the vehicle and wash hands at the first available opportunity.

- Occupants should avoid eating in the vehicle.

- Passengers in the vehicle should minimise any surfaces touched – it is not necessary for vehicle occupants to wear aprons or gloves.

- Keep the volume of any music/radio being played to a minimum to prevent the need to raise voices in the car.

Adherence with the above measures will be considered should any staff be contacted as part of a COVID-19 contact tracing investigation.

7.12 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. If wearing 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.

7.13 Caring for someone who has died

The IPC measures described in this document continue to apply whilst the individual who has died remains in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living individuals. 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.

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

7.14 Physical distancing

All staff working with NHS Scotland healthcare facilities, including non-clinical areas, must maintain 2 metres physical distancing wherever possible. This does not apply to the provision of direct care where appropriate PPE should be worn in line with section 7.5. Outbreaks amongst staff have been associated with a lack of physical

distancing in recreational areas during staff breaks and when car sharing. There are many areas within healthcare facilities where maintaining 2 metres physical distancing is a challenge due to the nature of the work undertaken. Where 2 metres physical distancing cannot be maintained, staff must ensure they are wearing face masks/coverings in line with the extended use of facemasks 7.5.1.

Staff must adhere to physical distancing as much as possible and should;

- Stagger tea breaks to reduce the number of staff in recreational areas at any one time.

- Maintain 2 metre physical distancing when removing Type IIR facemasks to eat and drink.

- Not car share when commuting to and from work unless absolutely necessary. Where this is absolutely necessary, staff should sit as far apart as possible, wear a face covering or face mask and keep windows open in the car to improve ventilation.

7.14.1 Engineering & Administration control measures in healthcare settings

Boards and departments should apply administrative controls to establish separation of patient pathways and minimise contact between the pathways. Due to the wide variance in the lay out, structure and fabric of NHS facilities across Scotland it is not possible to be descriptive in exactly how these should be applied and full assessment should be undertaken locally. The following bullet points provide guidance which boards and departments may use when considering how best to develop pathways and promote 2 metre physical distancing.

- Signage on entry to buildings, wards and departments advising of the necessary precautions to take (face coverings, hand hygiene, physical distancing) including advice for visitors not to enter the premises if symptomatic of COVID-19.

- Ensure signage is clearly displayed to clearly identify pathways. Floor markings may also be used. Physical barriers may be used where appropriate to prevent cross over of pathways.

- Ensure there are adequate hand hygiene facilities (wash hand basins or alcohol based hand rub stations) available including the use of posters promoting hand hygiene and detailing the effective method for doing so.

- Where required, facilitate the use of screens to reduce exposure risk, for example at admission desks or help desks. Screens may be used in clinical care areas to help segregate patients however installation of these must not hinder the ability of staff to observe their patients and must be assessed by fire officers and health and safety teams first to ensure all other regulations

remain compliant. There is limited evidence supporting the use of partitions for face-to-face interactions or between bed spaces, but it appears logical that a physical barrier can reduce contact between individuals and reduce the spread of infected particles from an infective source.

- Full bed length, floor to ceiling partitions are likely to be the most efficacious in preventing transmission of COVID-19. Partitions for face-to-face interactions, as a minimum, should cover both individuals breathing zone which encompasses a radius of 30cm from the middle of the face.

- Consider remote consultations where possible rather than face to face.

- Ensure areas are well ventilated where possible – open windows if temperature/weather conditions allow

7.15 Visiting in residential facilities

All visitors must be informed on arrival of IPC measures and adhere to these at all times. Visitors should wear face coverings in line with current Scottish Government guidance (see section 7.5.1) 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 if an area moves to Level 4, or on the advice of the local 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;

- Wear a face covering on entering the facility;

- Be provided with appropriate PPE (see table 7);

- Perform hand hygiene at the appropriate times;
  - on entry to the facility
  - Prior to putting on PPE
  - After removing PPE

- Observe physical distancing;

- Not move around the facility and should stay at the bed or chairside of the individual they are visiting;

- Not visit other individuals 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.

Table 7: Visitor PPE

	Gloves	**Apron**	**Face covering/mask**	**Eye/Face Protection**
Medium Risk category	Not required*1	Not required*2	Face covering or provide with FRSM if visitor arrives without a face covering	Not required*3
High Risk category	Not required*1	If within 2 metres of patient	FRSM	If within 2 metres of patient

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

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

*3 Unless providing direct care to the patient and splashing/spraying is anticipated.

7.16 Resources & Tools

This section contains resources and tools which can be used by clinical teams and IPCTs during the COVID19 pandemic.

- PPE poster - Medium Risk Pathway

- PPE poster - High Risk pathway

- COVID-19 Safe Practice in acute healthcare settings poster

- COVID-19 Wearing a facemask poster (staff)

- Wearing a non-medical face mask or face covering

- Key messages in the workplace poster

- 4 moments for hand hygiene poster – residential and care home settings

- How to wash hands – Appendix 1 - NIPCM

- [How to use alcohol based hand rub – Appendix 2 - NIPCM](#)

- [PHS Primary Care COVID-19 guidance](#)

- [PHS Social Care and Residential Care settings COVID-19 guidance](#)

7.17 Rapid Reviews

This section contains rapid reviews of the literature undertaken to support the Infection prevention and Control response to the COVID-19 pandemic.

- [Rapid Review of the Literature: Assessing the Infection Prevention and Control Measures for the Prevention and Management of COVID-19 in Healthcare Settings.](#)

- [Review of the National and International Guidance on Infection Prevention and Control Measures for Personal Protective Equipment (PPE) and Aerosol Generating Procedures (AGPS) for COVID-19.](#)

- [Eye protection in health and care settings for the prevention of COVID-19 transmission.](#)

- [Infrared Thermal Imaging in Health and Care Settings](#).

- [SBAR: Assessing the evidence base for medical procedures which create a higher risk of respiratory infection transmission from patient to healthcare worker.](#)

- [Provision of gloves for COVID-19 in health and care settings.](#)

- [Respirators in health and care settings for the prevention of COVID-19 transmission.](#)

7.18 COVID-19 Education resources

This section contains a number of educational resources to support the COVID-19 response in partnership with a range of stakeholders

- [Correct use of Alcohol Based Hand Rub](#)

- [Correct Hand Hygiene Technique using soap and water](#)

- COVID-19 an overview

- [Correct order for putting on, the safe order for removal, and the disposal of PPE](#)

7.19 COVID-19 Compendium

This section contains links to current national and international policy, guidance and resources on COVID-19 from key organisations.

- [COVID-19 compendium](#)