ARHAI Scotland

Antimicrobial Resistance and Healthcare Associated Infection

NHS National Services Scotland

COVID-19: Care Home Infection Prevention and Control (IPC) Addendum

Version 1.2

31 March 2021

The purpose of this addendum is to provide COVID-19 specific Infection and prevention control (IPC) guidance for care home staff and providers on a single platform to improve accessibility. When an organisation adopts practices that differ from those recommended/stated in this national guidance, that individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures.

IMPORTANT: Whilst guidance contained within this addendum is specific to COVID-19, staff 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.

Any resident who has a coinfection with COVID-19 must not be cohorted with other COVID-19 residents.

Version History

Version	Date	Summary of changes
V1.0	16/12/2020	First publication
V1.1	25/01/2021	Inclusion of new section 6.2.4 'Discontinuing IPC precautions in care homes for residents who are COVID-19 positive'
V1.2	31/03/2021	6.1.2 Definition of suspected case; Additional information and links included 6.1.3 Triaging of residents being admitted to a care home. International travel isolation changed to reflect current guidance 6.2 Resident Placement/Assessment of Infection Risk section updated. 6.2.5 Residents returning from overnight stay included 6.2.4 Stepdown table renamed (Discontinuation of IPC) to be consistent with Acute Addendum. Discontinuing IPC precautions in care homes for residents who are COVID-19 positive information clarified. Residents discharged from hospital to care homes – additional information included to clarify 14 day isolation requirements. 6.2.4 Links have been removed that are no longer available. 6.5 Additional information included on PPE & link to hierarchy of control. 6.5.1 New FRSM poster (ways to improve fit) link included 6.5.2 Face masks for residents, additional advice on wearing masks when moving around the care home 6.5.3 Table 1 PPE for direct resident care determined by risk category. Update to PPE guidance specifically in relation to visors. 6.5.4 PPE – Putting on (Donning) and Taking off (Doffing) further detailed information included 6.5.4 Aerosol Generating procedures (AGPs) Additional information added under table on requirements for respirators/fluid resistant requirement.

Version	Date	Summary of changes
		6.5.8 Additional section added on delivery of COVID-19 vaccinations. 6.7 Safe Management of the Care Environment. Additional detail provided where items cannot stand application of chlorine releasing agents. Also additional information if an organisation adopts practices that differ from those recommended/stated. 6.8 Wording amended to clarify linen categorisation where no outbreak. 6.9 Safe disposal of waste. Wording amended to provide clarity. 6.11 New section on hierarchy of control added; including additional detail on Engineering and Administration control measures. 6.13 Visiting in care homes updated following publication of 'Open with Care' 6.15 Resources and Tools section updated. 6.16 Rapid reviews section added 6.17 Education resources added.

Contents

6.1 COVID-19 case definitions and triage questions

6.1.1 Definition of a confirmed case

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

6.1.2 Definition of a suspected case

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 residents who are immunocompromised; (further information on presentations and management of COVID-19 in older people and Scottish Government and Appendix 1 :Think COVID:Covid-19 Assessment in the Older Adult - Checklist).

Community definition:

Recent onset new continuous cough

OR

Fever

OR

Loss of/change in sense of taste or smell (anosmia)

Definition for residents who may require 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

6.1.3 Triaging of residents being admitted to a care home

Residents being admitted to the care home must complete a total of 14 days of isolation either starting on or including the date of transfer. Screening of residents for transfer purposes may only provide partial reassurance as infection may still develop subsequently at any time during the incubation period.

To aid single room prioritisation for residents who may be at most risk, admission triage should be undertaken to enable early recognition of potential COVID-19 cases. Wherever possible, triage questions should be undertaken prior to arrival at the care home. If the resident has capacity issues this should be undertaken with the individual's guardian or power of attorney.

Suggested questions for triage:

- **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 admission or if urgent transfer is required, follow high risk category.

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

  If yes, follow the high risk category.

- **Have you been an inpatient in hospital in the past 14 days?**

  If yes, 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, should wait for 10-day quarantine before admission to care home, or if urgent transfer is required, follow high risk category.

  The Scottish Government website details quarantine (self- isolation) rules and information on the process for people entering the UK.

- **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 admission or if urgent transfer 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/HPT) and follow high risk category, or delay admission.

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

6.2 Resident placement/assessment of infection risk

Defined risk categories have been agreed at UK level to inform resident placement and the precautions required. Any other known or suspected infections must be taken into consideration before resident placement within each of the risk categories.

Examples of risk categories for care homes are described below and staff should familiarise themselves with these.

Details of the Low Risk Category are not included here as it is expected that all residents in care home settings will fall into the Medium (Amber) or High (Red) risk categories. Guidance beyond this section will only refer to the medium and high risk categories.

1. **Known as the High Risk COVID-19 risk category in the UK IPC remobilisation guidance and is more commonly known as the red risk category.**

   a) Confirmed COVID-19 residents within the first 14 days of onset (or test date if asymptomatic). Symptomatic or suspected COVID-19 residents (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).

   b) Those who are known to have had close contact with a confirmed COVID-19 individual and are still within the 10-day self-isolation period

c) Residents who are symptomatic or suspected COVID-19 but who decline testing or who are unable to be tested for any reason.

2. **Known as the Medium Risk COVID-19 risk category in the UK IPC remobilisation guidance and may be commonly known as the amber risk category.**

   a) All residents who do not meet the criteria for the pathways above and who **do not** have any symptoms of COVID-19.

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

   c) Those who are asymptomatic, have been tested and results are awaited.

6.2.1 Staff cohorting

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

6.2.2 Requirements for risk category movement

Any resident on the medium risk category who develops symptoms of COVID-19 should be isolated on the high risk category immediately and tested for COVID-19 and notify your local Health Protection Team (HPT). Any resident who is asymptomatic and tests positive for COVID-19 should be then cared for as per the high risk category.

Care homes are likely to have residents with dementia and/or cognitive impairment and so staff are advised to conduct a local risk assessment to ascertain appropriate placement. This does not mean resident needs to move their room or be moved to a different area but advises of the relevant risk category precautions that require to be put in place.

6.2.3 Resident cohorting

Any resident who has a coinfection with COVID-19 and any other known or suspected infectious pathogen **must not** be cohorted with other COVID-19 residents.

Cohorting in care homes should be undertaken with care. Residents who are shielding (extremely high risk of severe illness) 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 whilst ensuring that:

- Confirmed COVID-19 residents are placed in multi-occupancy rooms together.
- Suspected COVID-19 residents are placed in multi occupancy rooms together.
- Confirmed and suspected residents should not be cohorted together.

6.2.4 Discontinuing IPC precautions in care homes for residents who are COVID-19 positive

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;

- **Completing the 14 day isolation period** - – In care homes residents must complete 14 days isolation. This is because there are considerable numbers of immunocompromised and vulnerable residents who will be at risk of nosocomial infection.
- **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 residents, 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 a care home unless discharged from hospital.

Table 1: Discontinuation of IPC requirements for care homes

	Number of isolation days required	COVID-19 Clinical requirement for stepdown[*1]	Testing required for stepdown	Transferring between risk categories on stepdown
Care home current residents (known COVID-19 positive)	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 unless being discharged from hospital	Residents should be managed on the high risk category until criteria described in this table is met and can then transfer to the medium risk category
Care home residents, being admitted 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	2 negative tests required commencing on day 8 & taken 24 hrs apart	Residents should be managed on the high risk category until criteria described in this table is met and can then transfer to the medium risk category
Care home staff	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	Staff can return to work as normal once criteria is met

Residents discharged from hospital to care homes

COVID-19 residents being discharged from hospital into a care home should have 2 negative tests prior to transfer back to the care home, unless there are overriding clinical reasons where this is not appropriate, prior to discharge. They **do not** require to spend all 14 days' isolation period in hospital but should have 2 negative tests

before discharge from hospital to the care home (testing can be commenced on day 8). Tests should be taken at least 24 hours apart and preferably within 48 hours of discharge**.** Where it is in the clinical interest of the resident and negative testing is not possible (e.g. resident doesn't consent, detrimental consequences or it would cause distress) a risk assessment and a care plan for the remaining period of isolation up to 14 days in the home must be agreed and documented. On return to the care home, the resident must be managed as per the high risk category until the 14-day self-isolation period (day 14 from date of symptom onset or date of positive test if asymptomatic) is complete.

Note: the 14-day total isolation period for admission to a care home from hospital and any isolation days completed as an in-patient should be taken into consideration on admission to the care home i.e. 14 days in total only and **not** 14 days commencing on admission to the care home.

Note: an admission to hospital is considered to include only those patients who are admitted to a ward. An attendance at A&E that didn't result in an admission would not constitute an admission.

6.2.5 Residents returning from day visit or overnight stay

Residents who leave care home for the day or for an overnight stay should be triaged in advance of their immediate return to the care home and again on arrival at the care home to determine which category they should be placed on.

6.3 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.

Hand hygiene is essential to reduce the transmission of infection in care home settings. All staff, residents and visitors should clean their hands with soap and water or, where this is unavailable, alcohol-based hand rub (ABHR) when entering and leaving the care home and when entering and leaving areas where care is being delivered.

Hand hygiene must be performed immediately before every episode of direct 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.

Before performing hand hygiene:

- expose forearms (bare below the elbows)

- remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene)
- ensure finger nails are clean, short and that artificial nails or nail products are not worn
- cover all cuts or abrasions with a waterproof dressing

If wearing an apron rather than a gown (bare below the elbows), and it is known or possible that forearms have been exposed to respiratory secretions (for e.g. cough droplets) or other body fluids, hand washing should be extended to include both forearms. Wash the forearms first and then wash the hands.

Staff should support residents with hand hygiene regularly where required.

6.4 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.

Residents, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures which are:

- disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose – used tissues should be disposed of promptly in the nearest waste bin
- tissues, waste bins (lined and foot operated) and hand hygiene facilities should be available for residents, visitors and staff
- hands should be cleaned (using liquid soap and water if possible, otherwise using alcohol based hand rub (ABHR) after coughing, sneezing, using tissues or after any contact with respiratory secretions and contaminated objects
- encourage residents to keep hands away from the eyes, mouth and nose

Some residents may need assistance with containment of respiratory secretions; those who are immobile will need a container (for example a plastic bag) readily at hand for immediate disposal of tissues.

6.5 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 IPC measures

are detailed in section 1.4 of SICPs. PPE requirements during the COVID-19 pandemic are determined by the care pathways and are detailed in 6.5.3.

It is of paramount importance that PPE is worn only at the recommended appropriate times, selected appropriately and donned and doffed properly to prevent transmission of infection.

PPE is the **least** effective control measure for COVID-19 and other mitigation measures as per the hierarchy of controls must be implemented and adhered to wherever possible. More details on the hierarchy of controls can be found in section 6.11.

6.5.1 Extended use of Face Masks for staff and visitors

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 all health and social care workers and the wearing of face coverings by visitors is designed to protect staff and residents and guidance and associated FAQs for extended use of facemasks is available.

A poster detailing the 'Dos and don'ts' of wearing a face mask is also available for use in the care home.

Extended use of face masks relates to the specific guidance that staff should wear Fluid Resistant (Type IIR) Surgical Mask (FRSM) at all times for the duration of their shift in the care home setting. Face masks must be removed and replaced as necessary (observing hand hygiene before the mask is removed and before putting another mask on).

In Scotland, health and social care staff, within a care home setting, should be provided with Type IIR masks for use as part of the extended wearing of facemask.

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

6.5.2 Face masks for residents

Residents in the medium or high risk category should be encouraged to wear a FRSM, if these can be tolerated and do not compromise care, when moving around the care home and when individuals enter the room.

Appropriate physical distancing and wider IPC measures are critical, with the use of face masks being a further line of defence.

Scottish Government guidance is available on the extended use of face masks in hospitals and care homes.

Where clinical waste disposal is not available, used face masks should be double bagged and disposed of in domestic waste.

6.5.3 PPE determined by COVID-19 risk categories

Table 2 details the PPE which should be worn when providing direct resident care in each of the COVID-19 care risk categories.

Type IIR Fluid Resistant Surgical Masks (FRSMs) should be worn for all direct care regardless of the risk category. This is a measure which has been implemented alongside physical distancing specifically for the COVID-19 pandemic. FRSMs should be changed if wet, damaged, soiled or uncomfortable and must be changed after having provided care for a resident isolated with a suspected or known infectious pathogen and when leaving resident areas on high risk categories.

Further guidance on glove use can be found in Appendix 5.

Table 2: PPE for direct resident care determined by risk category

	Gloves	Apron	Face mask	Eye face protection
Medium Risk Category	If contact with blood and body fluids (BBF) is anticipated Single use.	If direct contact with resident, their environment or BBF is anticipated, (Gown if splashing anticipated). Single use.	Always within 2 metres of a resident - Type IIR fluid resistant surgical face mask.	If splashing or spraying with BBF including coughing/sneezing anticipated. Single use or reusable following decontamination.
High Risk Category	Worn for all direct care. Single use.	Always within 2 metres of a resident (Gown if splashing anticipated). Single-use.	Always within 2 metres of a patient - Type IIR fluid resistant surgical face mask.	Always within 2 metres of a resident. Single-use, *sessional or reusable following decontamination.

*Sessional use see section 6.5.7

6.5.4 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 .

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 (if required) and gloves – you may require some of these items or all of them
- When putting on mask, the mask should be well fitting, 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. Further link to a poster on fitting masks can be found in section 6.5.1

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 (if worn)

- 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.

6.5.5 Aerosol Generating procedures (AGPs)

An Aerosol Generating Procedure (AGP) is a 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.

Below is the list of procedures for COVID-19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

- Respiratory tract suctioning*
- Dental procedures (using high speed devices such as ultrasonic scalers and high speed drills)
- High Flow Nasal Oxygen (HFNO)
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum using nebulised saline
- Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)

- Tracheal intubation and extubation
- Upper ENT airway procedures that involve respiratory suctioning

* 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 can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other personnel who will undertake airway manoeuvres. On arrival of the team, the first responders should leave the scene before any airway procedures are carried out and only return if needed and if wearing AGP PPE.

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). The published evidence view and consensus opinion can be found at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/phe-statement-regarding-nervtag-review-and-consensus-on-cardiopulmonary-resuscitation-as-an-aerosol-generating-procedure-agp--2.

Certain other procedures/equipment may generate an aerosol from material other than an individual's secretions but are not considered to represent a significant infection risk and do not require AGP PPE. Procedures in this category include:

- administration of humidified oxygen;
- administration of medication via nebulisation.

Note: During nebulisation, the aerosol derives from a non-resident source (the fluid in the nebuliser chamber) and does not carry resident-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 residents to remove nebulisers and oxygen masks.

For residents with suspected/confirmed COVID-19, any of the potentially infectious AGPs listed above should only be carried out when essential. The required PPE for AGPs should be worn by those undertaking the procedure and those in the room, as detailed above. Where possible, these procedures should be carried out in a single room with the doors shut. Only those staff who are needed to undertake the procedure should be present.

It is the responsibility of care home providers to ensure that all staff have been fit tested for FFP3 respirators, when appropriate. If you do not anticipate the need for FFP3 respirators and are not caring for anyone currently receiving AGPs such as CPAP, these should not be ordered or stockpiled and any surplus stock should be returned.

A Situation, Background, Assessment and Recommendations (SBAR) has been produced by Health Protection Scotland (HPS)/ARHAI Scotland and agreed by New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) specific to AGPS during COVID-19.

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).

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

****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 respirator decontamination methods and the use of re-useable respirators is not recommended.**

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	FFP mask or Powered respirator hood	Single use or re-useable
High Risk Category	Single use	Gown – Single use	FFP mask or Powered respirator hood	Single use or re-useable

**FFP3 masks must be fluid resistant. Valved respirators may be shrouded or unshrouded. Respirators with unshrouded valves are not considered to be fluid-resistant and therefore should be worn with a full face shield if blood or body fluid splashing is anticipated

6.5.6 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 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. Residents, other than the resident 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

6.5.7 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 not recommended with the exception of when wearing a visor/eye protection in a communal area where residents in high risk pathway and when wearing a fluid resistant surgical face mask (FRSM) across all pathways. Sessional use of all other PPE is associated with transmission of infection amongst residents and is considered poor practice.

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) pathway 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.

6.5.8 PPE for delivery of COVID-19 vaccinations

Healthcare workers (HCWs) delivering vaccinations must;

- wear a fluid resistant surgical facemask (FRSM) for all direct contact and where 2 metre physical distancing cannot be maintained. This will protect both the HCWs and resident from exposure to COVID-19 should either be pre-symptomatic or an asymptomatic carrier of COVID-19.
- perform hand hygiene regularly including before and after each resident /individual contact and as per 4 moments for hand hygiene laid out in the National Infection Prevention & Control Manual (NIPCM).
- wear a visor where there is anticipated splashing to the face. For example, where nasal vaccinations induce sneezing, HCWs may choose to wear a visor to prevent droplet contamination to the face following risk assessment.

The resident on whom the nasal vaccination is being administered should be provided with disposable tissues to cover their mouth where any sneezing is likely. They should dispose of the tissues in a suitable waste receptacle and wash hands with warm soap and water. If there are no hand hygiene facilities available, ask the individual to use alcohol based hand rub (ABHR) and wash their hands at the earliest opportunity.

- other items of PPE are unlikely to be required for routine vaccination and a risk assessment should be carried out considering both IPC and COSHH guidance.

As per SICPs;

- Aprons should be worn where there is anticipated contamination to the healthcare workers uniform or clothing.
- Gloves should be worn where blood and body fluid exposure is anticipated. Tiny amounts of blood resulting from vaccination site pose little risk to a HCW where the skin of the healthcare workers hands is intact. There is therefore no need to wear gloves when delivering a vaccination provided the skin on the HCWs hands is intact and the skin of the person receiving the vaccination is intact. An SBAR which considered the need for HCWs to wear gloves when delivering vaccinations was produced by HPS in 2014.

A poster detailing safe PPE practice for staff vaccinators and poster aimed at those attending vaccination clinics is available.

6.6 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.

Table 5– Equipment cleaning determined by risk 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.

6.7 Safe management of the care environment

There are many areas in care homes that become easily contaminated with micro-organisms (germs) for example toilets, waste bins, kitchen surfaces.

Furniture and floorings in a poor state of repair can harbour micro-organisms (germs) in hidden cracks or crevices.

To reduce the spread of infection, the environment must be kept clean and dry and where possible clear from litter or non-essential items and equipment.

Maintaining a high standard of environmental cleanliness is important in care homes as residents living there are often elderly and vulnerable to infections.

During this ongoing pandemic, cleaning frequency of the environment should be increased across **all** risk categories. 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 residents 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 should consider and implement what improvements are required if this is deficient.

The care home environment should be:

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

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 av chlorine.

Cleaning across the categories is summarised in table 6.

Table 6 – Environmental cleaning determined by risk category

	1st daily clean	2nd daily clean	Product
Medium Risk Category	Full clean.	High Risk Touch Surfaces* within resident 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. If the item cannot withstand chlorine releasing agents consult the manufacturer's instructions for a suitable alternative to use following or combined with detergent cleaning.
High Risk Category	Full clean.	High Risk Touch Surfaces*within resident 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. If the item cannot withstand chlorine releasing agents consult the manufacturer's instructions for a suitable alternative to use following or combined with detergent cleaning.

*High risk touch surfaces as a minimum should include door handles/push pads, taps, light switches, lift buttons. Resident areas should include the resident bedroom and any treatment areas and staff rest areas.

Any areas contaminated with blood and body fluids across any of the 2 pathways require to be cleaned as per Appendix 9 of the National Infection Prevention Control Manual (NIPCM).

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.

If the item cannot withstand chlorine releasing agents staff are advised to consult the manufacturer's instructions for a suitable alternative to use following or combined with detergent cleaning. However, when an organisation adopts practices that differ from those recommended/stated in this national guidance with regards to cleaning agents, the individual organisation is fully responsible for ensuring safe systems of work, including the completion of local risk assessment(s) approved and documented through local governance procedures.

6.8 Safe Management of Linen

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

Linen used on residents who are known to be COVID positive or suspected or where there is a confirmed outbreak should be treated as infectious. Following local risk assessment/ if no outbreaks in the care home laundry can be processed as normal.

Care homes with their own in-house laundries may also refer to https://www.nss.nhs.scot/publications/national-guidance-for-safe-management-of-linen-in-nhsscotland/ for more information.

6.9 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.

6.10 Safe disposal of waste (including sharps)

Waste should be handled in accordance with Section 1.9 of SICPs. Waste generated from patients/individuals who are known to be COVID positive, or suspected or where there is a confirmed outbreak, should be disposed of as clinical waste 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 community health and care setting does not have a clinical waste contract, or for care at home, ensure all waste items that have been in contact with the patient/ 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.

6.11 Occupational Safety

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

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.

6.11.1 Car/vehicle sharing for staff

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 to and from work;
- Geographical distribution of visits (if this is required)– consider if these can 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 residents as part of supported care;
- Staff who are commuting with students as part of supported learning/mentorship;
- 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.

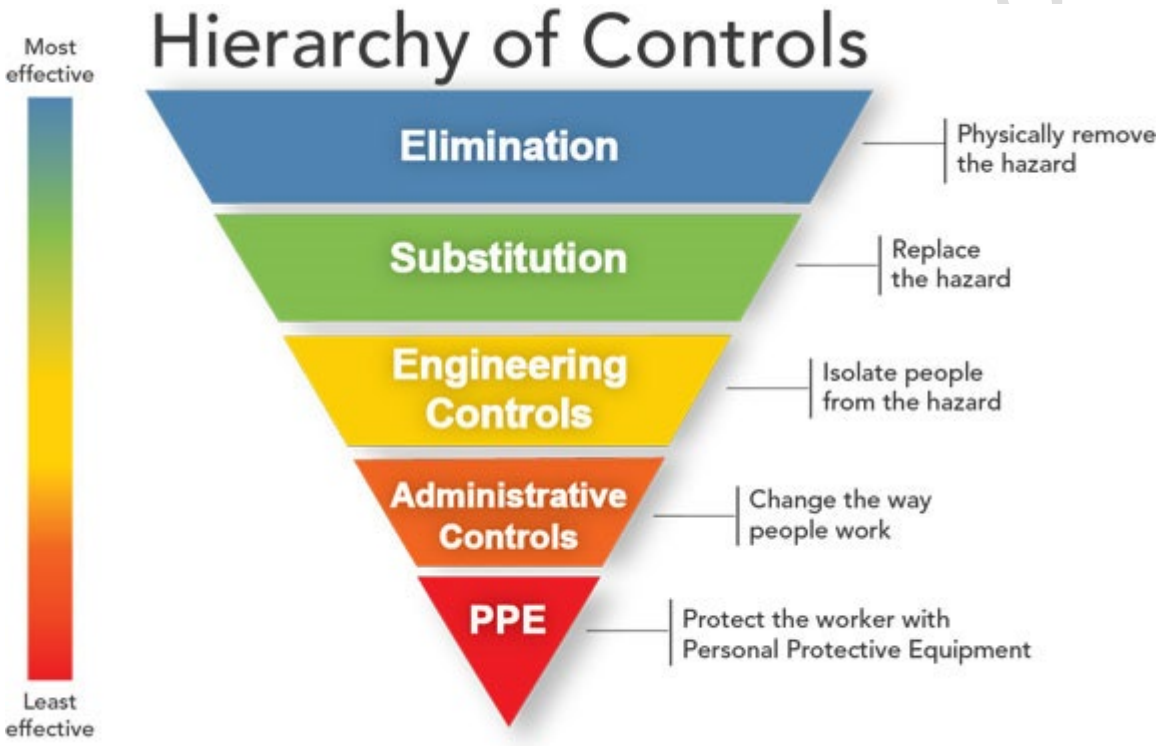
6.11.2 Engineering and administration control measures in care home settings

Care homes should apply administrative controls to establish separation of resident categories and minimise contact. Due to the wide variance in the layout, structure and fabric of care homes across Scotland it is not possible to be descriptive in how these should be applied and full risk assessment should be undertaken locally. The following bullet points provide guidance which may use when considering how best to develop pathways and promote 2-metre physical distancing.

- Signage on entry to the care home 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 resident category. Floor markings may also be used, if considered appropriate. Physical barriers may be used where appropriate to prevent cross over of categories.
- 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. Appendix 1 how to hand wash and Appendix 2 how to hand rub.
- Where required, facilitate the use of screens to reduce exposure risk, for example at reception desks.
- Ensure areas are well ventilated where possible, open windows if a local risk assessment and temperature/weather conditions allow.

6.12 Hierarchy of controls

Controlling exposures to occupational hazards, including the risk of infection, is the fundamental method of protecting staff. Below is a graphic specifying the general principles of prevention legislated in the Management of Health and Safety at Work Regulations 1999, Regulation 4, Schedule 1. It details the most to the least effective hierarchy of controls and can be used to help implement effective controls in preventing the spread of COVID-19 within health and care settings. Staff should employ the most effective method of control first. Where that is not possible, all others must be considered. PPE is the last in the hierarchy of controls.



Hierarchy of Risk Controls graphic //commons.wikimedia.org/index.curid=90190143 (original version: NIOSH Vector version: Michael Pittman)

Application of the hierarchy of control in health and social care settings is as follows;

1. **Elimination**

   - Residents must not attend for an appointment if they have symptoms of COVID-19 or have been advised to self-isolate
   - Staff must not report to work if they have symptoms of COVID-19 or have been advised to self-isolate

- Staff who can work from home should be supported to do so
- Consideration should be given to non-clinical staff who typically enter clinical areas as part of their job role and alternative arrangements made wherever possible

2. **Substitute**
   - Clinical consultations over phone as far as possible rather than in person
3. **Engineering controls**
   - Installations of partitions at appropriate places (e.g. reception desks)
   - 2 metre physical distancing on the premises (see section 6.11.2)
   - Efforts made to reduce number of people on premises at any one time
   - improve ventilation by opening windows on the premises
   - Optimal chair spacing
4. **Administrative Controls (more detail below)**
   - Working from behind or at the side of the resident (no face to face close contact)
   - development of one way systems on the premises
   - use of various COVID-19 related signage (see section 6.11.2)
   - provision of additional hand hygiene stations
   - increased cleaning.
5. **PPE**
   - Use of face coverings (although not classed as PPE) by residents and visitors – in care homes they can be provided with a Type IIR mask
   - PPE when a risk assessment indicates this (see PPE section of this addendum)

6.13 Caring for someone who has died

The IPC measures described in this document continue to apply whilst the resident who has died remains in the care home. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living residents. 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, please see the following guidance produced by Scottish Government Coronavirus (COVID-19): guidance for funeral directors on managing infection risks.

6.14 Visiting in care homes

The Scottish Government has published new visiting guidance, Open with Care: supporting meaningful contact in care homes, which supports meaningful contact to resume between care home residents and their loved ones, from early March 2021.

Care homes should familiarise themselves with the content of this guidance to ensure resident, staff and visitor safety. The guidance also provides Frequently Asked Questions (FAQs) which are intended for everyone involved in resuming meaningful contact in care homes, whether a resident, family member, a visiting professional, care home provider or other partner. These FAQs were developed to provide a bit more detail than the guidance provides.

Open with Care sets out how indoor contact in care homes will gradually increase while minimising COVID-19 risks to residents, staff and visitors. Continued attention to safety measures in relation to the pandemic are essential for everyone. This includes hand hygiene, PPE as appropriate, ensuring good airflow (as far as reasonably comfortable), and rigorous cleaning of surfaces before and after visits.

Visitors must be informed of and adhere to IPC measures in place, including FRSM, hand hygiene, physical distancing and not attending 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.

A log of all visitors must be kept, which may be used for **Test and Protect** purposes.

6.15 Physical distancing

All staff working in the care home must maintain 2 metres physical distancing wherever possible. This does not apply to the provision of direct resident care where appropriate PPE should be worn in line with section 6.5. 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 a care home 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 guidance. See section 6.5.1.

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 FRSMs to eat and drink.
- not care share with colleagues 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 FRSM and keep windows open in the car to improve ventilation.

6.16 Resources and Tools

- PPE poster – Low Risk Pathway
- PPE poster - Medium Risk Pathway
- PPE poster - High Risk pathway
- PPE COVID-19 Vaccinations (Staff)
- PPE for COVID-19 vaccinations (public)
- 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
- Suggested ways of wearing a FRSM poster
- Key messages in the workplace poster
- Stop the spread: COVID-19 good practice points 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
- COVID-19 Outbreak Checklist

6.17 Rapid Reviews

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

- 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.
- Rapid review of the literature: SARS-CoV-2 variants VOC-202012/01 (B.1.1.7) and 501Y.V2 (B.1.351) – implications for infection control within health and care settings
- Ultraviolet light technology for decontamination of health and care settings in the context of COVID-19
- Risk of SARS-CoV-2 acquisition in healthcare workers

6.18 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.

- TURAS - COVID-19 vaccination programme
- Correct use of Alcohol Based Hand Rub
- Correct Hand Hygiene Technique using soap and water
- Correct order for putting on, the safe order for removal, and the disposal of PPE
- Obtaining a sample swab test in care homes

- Protecting yourself and your work environment

6.19 COVID-19 Compendium

Additional IPC resources can be found https://www.hps.scot.nhs.uk/web-resources-container/covid-19-compendium/