



Management of Respiratory Type Viruses

This procedural document supersedes: PAT/IC 10 v.9 – Management of Respiratory Influenza Type Viruses.



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Executive Sponsor(s):	David Purdue Deputy Chief Executive & Chief Nurse
Author/reviewer: (this version)	Carol Scholey Infection Prevention and Control Practitioner
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Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
10	24 Sept 2021	<ul style="list-style-type: none"> • Added section on the management of severe acute respiratory syndrome coronavirus 2 (COVID-19) • Removed some hyperlinks due to data not being found 	Carol Scholey
9	22 October 2018	<ul style="list-style-type: none"> • Updated evidence • Added POCT • Updated Hyperlinks • Added Appendix 1. When to use a surgical face mask or FFP3 respirator, and removed 'What's the difference between a mask and a respirator' 	Carol Scholey
8	2 March 2016	<ul style="list-style-type: none"> • Revised title to take out Influenza heading • Expansion on symptom definition • Headed section for PPE with integral visor/ mask use • Added section on virology diagnostic testing • Added section with hyperlink to PHE Influenza Antiviral Prophylaxis and Treatment • Added section on the management of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) 	Julie Hartley
7	31 July 2013	<ul style="list-style-type: none"> • New style Trust format included. • Enhanced guidance on use of FFP3 masks • Staff vaccination • Sections within the contents page have been 'Booked Marked' to relevant page. 	Maurice Madeo

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1. INTRODUCTION

Respiratory infections are common, principally causing colds in both adults and children. Most are fairly mild, self-limiting and confined to the upper respiratory tract. However, these can progress and cause more severe infections and even death. There is a wide variety of viral causes of respiratory infection including rhinoviruses, respiratory syncytial virus, influenza viruses A, B and C, para-influenza viruses and coronaviruses. There are also newly emerging respiratory corona viruses such as Severe Acute Respiratory Syndrome (SARS), MERs Middle eastern respiratory syndrome or more recently, severe acute respiratory syndrome **coronavirus 2** (SARS-CoV-2) commonly referred to as COVID-19, which resulted in a pandemic event in 2020.

2. PURPOSE

The purpose of this document is to provide concise guidance for all staff to minimize the potential risks of infection and to ensure prompt recognition of those patients who are at risk of infection. This document applies to all staff either employed or contracted within in-patient areas in Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

3. DUTIES AND RESPONSIBILITIES

This policy covers infection prevention and control management issues for Trust staff this includes:-

- Employees
- Volunteers
- Agency/Locum/Bank Staff
- Contractors whilst working on the Trust premises

Each individual member of staff, volunteer or contracted worker within the Trust is responsible for complying with the standards set out in the Policy to ensure that they adhere to best practice. They need to be aware of their personal responsibilities in preventing the spread of infection. It is the responsibility of Directors and Managers to ensure compliance with this standard.

4. INDIVIDUAL AND GROUP RESPONSIBILITIES

Seasonal influenza vaccine is strongly recommended for all front line clinical staff on an annual basis. It is the responsibility of all front line clinical staff to access this service in order to minimise the risk to patients.

Since the COVID-19 Pandemic in 2020, all staff was vaccinated with two vaccines 12 weeks apart. Currently it is unknown what or how long this will provide cover for and it maybe that all staff will be vaccinated annually in the future.

Trust Board

The Board, via the Chief Executive, is ultimately responsible for ensuring that systems are in place that effectively manages the risks associated with Infection Control. Their role is to support the implementation of a Board to Ward culture to support a Zero Tolerance approach to Health Care Associated Infections.

Director of Infection Prevention and Control: Is responsible for the development of infection and prevention and control strategies throughout the Trust to ensure best practice.

The Director of Infection Prevention and Control will provide assurance to the board that effective systems are in place.

The Infection Prevention and Control Team: is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required.

Heads of Nursing & Matrons: are responsible for ensuring implementation within their area by undertaking regular audits in ward rounds activities. Any deficits identified will be addressed to comply with policy.

Ward and Department Managers: are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles at all times.

Consultant Medical Staff: are responsible for ensuring their junior staff read and understand this policy, and adhere to the principles contained in it at all times.

On-call Managers: are responsible for providing senior and executive leadership to ensure implementation of this policy.

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

5. KEY POINTS

Infected healthcare workers and visitors are potential sources of infection by respiratory viruses. Influenza and COVID-19 vaccine is recommended for all front line clinical staff each year as stipulated by the Department of Health to reduce risk of staff to patient transmission.

Infection can be acquired by direct and indirect contact and the airborne route. Transmission occurs from person to person by close contact, predominantly by large droplet/airborne respiratory secretions and /or contamination of hands. Standard and respiratory precautions must be maintained at all times.

Patients with a suspected upper respiratory tract infection (URTI), a history of travel and suspected exposure to infection with a new emerging or re-emerging infection and meet the clinical criteria below, must be nursed in a single room and the Infection Prevention Team informed.

Fever 38°C or more plus two or more of the following:

- cough (with or without sputum)
- nasal discharge or congestion
- sneezing
- Sore throat
- headache
- muscle or joint pains
- Chest pain

Or severe illness of sudden onset suggestive of an infectious process without another obvious or proven cause.

- On presentation to hospital, if the patient meets the above criteria, they must be isolated immediately (for step by step guidance see **below**).
- All staff should wear surgical face masks when within 2 metres of the patient. Correctly fit tested respirators (FFP3) **must** be worn during **aerosolizing procedures. (Appendix 1)**
- Surgical face masks should be removed and disposed of inside the patient room once more than two metres from the patient and be disposed of in a **closable** pedal operated clinical waste bin, followed by hand hygiene.
- FFP3 masks are available via supplies and made available to high risk units during peak activity. (Staff must be FIT mask tested for appropriate FFP3)

<http://www.hse.gov.uk/respiratory-protective-equipment/>

Visitors with symptoms of respiratory infection must be discouraged from visiting. Face coverings to be encouraged.

6. WHAT TO DO IF YOU HAVE A PATIENT WITH SUSPECTED VIRAL RESPIRATORY INFECTION

This purpose of this policy is to ensure that all staff within Doncaster & Bassetlaw Teaching Hospital takes prompt action in the management of any patient identified (or suspected) of having a RTI, by implementing general principles of infection prevention and control. During normal working hours advice must be sought from the Infection Prevention and Control Team (IPCT) on actions to be implemented, including isolating patients. Out of hours, advice must be sought from the on call Microbiologist. Please note that clinical care must not be compromised and discharge planning and services should continue, for example Dieticians, Therapies, Integrated discharge and Nursing home assessments can be undertaken during the acute phase of a RTI. Any patient admitted with a suspected virus such as influenza, respiratory syncytial virus (RVS) or COVID-19 must be nursed immediately in a single room.

During an annual epidemic it may be necessary to cohort nurse symptomatic patients. Obtain relevant investigation to confirm illness at the earliest opportunity, including use of point of care testing (POCT) for influenza A & B, also RSV in children, and COVID-19, a viral/PCR swab to be sent for confirmation of diagnosis.

7. VIROLOGY DIAGNOSTIC TESTING

To test for influenza or other respiratory viruses **in adults** a green viral swab must be taken from the throat (for influenza) or nose (for COVID-19). Staff must wear appropriate PPE including gloves, apron, face and eye protection when obtaining a swab.

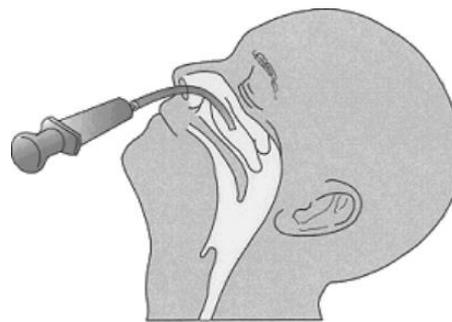


Take the swab. Take green virology swab and gently rub it against the back of the throat on the area near the tonsils. This ensures that a proper sample in the area is captured well onto the swab

In children to test for respiratory viruses a nasopharyngeal swab or aspirate is taken (commonly for respiratory syncytial virus RSV). The viral medium is in a green swab.

Nasopharyngeal Aspirate Specimen Collection:

- Insert tubing attached to syringe (or compressed bulb for infants) through nose and direct toward nasopharynx.
- Pull back on syringe (or decompress bulb for infants) to withdraw secretions
- Expel secretions into viral transport media
- This process also used for nasopharyngeal swabs for COVID-19 detection, swabbing the throat first and proceeding to the nostrils.



Nose swab.

Take a nose swab using a dry swab and insert into both nostrils. Wear PPE – Apron, gloves, face mask and eye protection. Do not exert too much force.

8. MANAGEMENT OF A PATIENT WITH VIRAL RESPIRATORY INFECTION

8.1 Respiratory Isolation

The patient must be nursed in a single room or cohort bay with the doors closed. Continue isolation for 7-14 days after the onset of clinical symptoms or until the patient is asymptomatic, if symptoms persist longer than 7-14 days isolation must be continued until these resolve. N.B. immunocompromised patients' may excrete viruses for a longer period; discuss management with the physician in charge of patient care and with IPC team/microbiologists.

Staff contact should be kept to a reasonable minimum without compromising patient care.

Effective hand hygiene before and after patient contact or contact with the patients' immediate environment. Please refer to the Trust PAT/IC 5 Hand Hygiene Policy.

8.2 Respiratory Hygiene/Cough Etiquette

Actively encourage patients to cover their nose and mouth with disposable tissues when coughing, sneezing, wiping or blowing their nose and dispose of the tissue in a disposal bag on the bedside prior to be disposed of as clinical waste.

For patients with COVID-19 encourage the wearing of a fluid resistant surgical mask (FRSM) where possible to prevent spreading and contamination of the environment.

Encourage/assist the patient to clean their hands after coughing, sneezing, wiping or blowing their nose.

Restrict patient movement unless clinically indicated, if they need to travel to other areas within the hospital they should wear a surgical mask (if tolerated) at all times.

8.3 Personal Protective Equipment (PPE)

Health care workers delivering direct patient care must wear personal protective equipment (PPE):

- An integral combined visor and mask, FRSM plus visor or goggles must be worn to protect from the risk of contamination by splashes, aerosols and droplets.
- A disposable apron must be worn whenever there is a risk of contamination by a patient's blood or bodily fluids and during activities that involve close patient contact.
- Long sleeved fluid repellent gowns must be worn if there is risk of excessive soiling or contamination from aerosol generating procedures (AGP's).
- Disposable gloves must be worn when in direct contact with blood and body fluids including mucus.

8.4 Disposable Respirators (FFP3) for Aerosol Generated Procedures (AGP)

For suspected influenza or COVID-19 an FFP3 mask must be worn where there is a risk of aerosolisation of respiratory secretions (**See appendix 2**).

If staff fail to pass FIT testing for a particular FFP3 mask they must be provided with access to a hood for protection.

According to PHE published January 2020, last updated June 2021- COVID-19: Guidance for maintaining services within health and care settings Infection prevention and control recommendations Version 1.2

The following are classified as aerosol generating procedures (AGP):

- tracheal intubation and extubating
- 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 beyond the oro-pharynx
- high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

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

The following procedures are **not** classified as aerosol generated procedures:

Certain other procedures/equipment may generate an aerosol from material other than patients' secretions but are NOT considered to represent a significant infectious risk. Procedures in this category include:

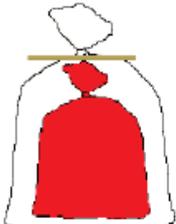
- obtaining diagnostic nose and throat swabs
- administration of humidified O₂
- administration of medication via nebulisation

Chest physiotherapy is **not** considered an AGP but a surgical mask should be worn by the patient if tolerated and Health Care Workers should wear PPE as recommended for routine care (surgical mask) during the procedure.

All PPE must be disposed of as clinical waste in the patient's room, once more than one metre from the patient, dispose of in a **closable** pedal operated clinical waste bin.

8.5 Linen

Linen must be treated as infected by placing it in a red soluble bag inside a white plastic bag tied and sealed at the point of use.

Infected linen	All used and soiled linen including patient wear from patients with known infections or suspected infectious.	Put in to a red soluble (alginate) bag and tie, then into a WHITE polythene bag CFPP 0104 states the outer bag must be tied and secured around the neck of the bag with tape which indicates 'Infected linen'	Red Soluble Bag <i>Inside a White Polythene Bag</i>	
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8.6 Environmental Cleaning

All floors and flat surfaces must be cleaned twice daily with the recommended disinfectant. Communal clinical equipment must be cleaned after each use.

An Isolation door notice must be displayed at all times. The door to the isolation room **must** remain closed at all times.

8.7 Ending Isolation

Isolation of the patient may be discontinued after 7-14 days depending on illness of the onset of clinical illness providing symptoms are no longer present, if symptoms persist for longer than 7-14 days isolation should be continued until these resolve.

N.B. Immunocompromised patients (and children) may excrete viruses for a longer period. The IPC team may be contacted for advice.

9. INFLUENZA ANTIVIRAL TREATMENT AND PROPHYLAXIS

For the latest PHE guidance on the use of antiviral agents for the treatment and prophylaxis of influenza. Please access the internet, PHE guidance for seasonal influenza antiviral treatment guidelines, also for COVID-19 treatment options.

10. MANAGEMENT OF MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS (MERS-COV)

Coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions. They have also been detected in blood, faeces and urine and, under certain circumstances, airborne transmission is thought to have occurred from aerosolised respiratory secretions and faecal material.

As coronaviruses have a lipid envelope, a wide range of disinfectants and detergents are ineffective. Personal protective equipment and good infection control are extremely useful in preventing the spread of the infection.

If a patient fitting the case definition for possible MERS-CoV or COVID-19 is admitted ([see PHE website for latest definition](#)) infection control personnel should follow transmission-based precautions (droplet and contact precautions).

All patients being admitted into hospital will be tested for COVID-19 on admission. The samples required for the testing for MERS-CoV will be advised by the microbiologist and virologist.

In addition to standard precautions, infection control measures for inpatients should include:

Airborne precautions, e.g.:

- Isolation room with own bathroom and toilet facilities wherever possible.
- Use of FFP3 respirators conforming to EN 149:2001 for persons entering the room. Fit testing should be undertaken prior to using this equipment.
- Contact and droplet precautions (including use of long-sleeved fluid-repellent gown and latex or similar non-latex gloves with long tight-fitting cuffs for contact with the patient or their environment if AGPs).
- Standard precautions to include careful attention to hand washing and hygiene.
- When caring for patients, clinicians should wear eye protection for all patient contact.
- Enteric precautions for MERS-CoV
- Standard precautions when handling any clinical waste, which must be placed in leak-proof clinical waste bags or bins and disposed of safely.
- Laundry should be classified as infected.

11. MEMBERS OF STAFF – STAFF VACCINATION

Seasonal influenza vaccine is strongly recommended for all front line clinical staff on an annual basis. It is the responsibility of all front line clinical staff to access this service in order to minimise the risk to patients.

COVID-19 vaccination, currently the ongoing programme is unknown, access PHE for further details.

Staff suffering from persistent, unexplained respiratory symptoms, especially following foreign travel, must report to their General Practitioner and should not attend work. Staff suspected and/or diagnosed with a communicable respiratory disease must inform the occupational health service and their line manager immediately.

12. VISITORS

All visitors with symptoms of respiratory disease should be discouraged from visiting. Visitors will undertake an assessment on entry to the Hospital to exclude symptoms of illness. The additional wearing of face coverings which persists through the COVID-19 pandemic has no end date, so face coverings, social distancing and hand hygiene must continue for any visitor to the Hospital. Appendix 3

13. TRAINING/ SUPPORT

The training requirements of all staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead or nominated person.

IPC must be included in individual Annual Development Appraisal and any training needs for IPC addressed.

Staff will receive instructions and direction regarding infection prevention and control practice and information from a number of sources:-

- Trust Policies and Procedures available on the intranet
- Infection Prevention & Control web-site on the intranet
- Ward/departmental/line managers
- As part of the mandatory SET training.
- Infection Prevention and Control Educational displays/ posters
- Trust Infection Prevention and Control Team
- Ward link practitioners
- Public Health England website

14. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

It is the responsibility of all department heads/professional leads to ensure that the staff they manage adhere to this policy. The Infection Prevention and Control Team will review this policy in the following circumstances:-

- When new national or international guidance are received.
- When newly published evidence demonstrates need for change to current practice.
- Every three years routinely.

Incidents where non-compliance with this policy is noted and are considered an actual or potential risk should be documented on an Adverse Incident and near miss report form.

Monitoring	Who	Frequency	How Reviewed
The policy will be reviewed in the following circumstances:-	APD Process Group IPCT	Every three years routinely, unless: <ul style="list-style-type: none"> When new national or international guidance are received. When newly published evidence demonstrates need for change to current practice. Action required from Root Cause Analysis Serious Incident Investigation Report 	Approved Procedural Document (APD) database Policy will be approved and ratified by the Infection Prevention and Control Committee
Compliance with policy to negate cross-infection	The Infection Prevention and Control Practitioners	Weekly	“Alert organism review” to monitor adherence with the policy.
Effective hand hygiene	Hand hygiene audits completed by ward/ department staff	Monthly	Deficits identified will be addressed via agree action plan to comply with policy.
Environmental cleanliness	Audits completed by domestic teams IPC environmental audits	According to risk category for each ward/ department	Deficits identified will be addressed via agree action plan to comply with policy.
Clinical equipment cleaning and room cleaning check list	Cleaning checklist completed by ward staff. Isolation checklist completed by Hotel service worker	Daily/twice daily while isolation required	Via IPC system (Ward Accreditation Dashboard) and cleaning checklist outside patients room

15. DEFINITIONS

URTI – Upper Respiratory Tract Infection

RSV – Respiratory Syncytial Virus

FFP3 respirator – Filter Face Piece Respirator Mask

AGP – Aerosol Generating Procedures e.g. intubation.

COVID-19 - severe acute respiratory syndrome **coronavirus 2** (SARS-CoV-2)

16. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (**Appendix 4**).

17. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

PAT/IC 5 - [Hand Hygiene](#)

PAT/IC 16 – [Isolation Policy](#)

PAT/IC 19 – [Standard Infection Prevention and Control Precautions Policy](#)

PAT/IC 21 – [Laundry Policy – Bagging Procedure for Linen](#)

PAT/IC 24 – [Cleaning and Disinfection of Ward based Equipment Policy](#)

PAT/PA 19 - [Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards \(DoLS\)](#)

PAT/PA 28 - [Privacy and Dignity Policy](#)

18. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under ‘Current data protection legislation’ as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:

<https://www.dbth.nhs.uk/about-us/our-publications/information-governance/>

19. REFERENCES

Public Health England (2019) PHE guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/773369/PHE_guidance_antivirals_influenza.pdf

Public Health England (August 2018) Infection Control Advice Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732267/Algorithm_case_v31-Aug2018.pdf

COVID-19: Guidance for maintaining services within health and care settings Infection prevention and control recommendations Version 1.2

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990923/20210602_Infection_Prevention_and_Control_Guidance_for_maintaining_services_with_H_and_C_settings_1_.pdf

Public Health England (2020) UK Pandemic preparedness.

<https://www.gov.uk/government/publications/uk-pandemic-preparedness>

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

APPENDIX 1

WHEN TO USE A SURGICAL FACE MASK OR FFP3 RESPIRATOR

When caring for patients with **suspected or confirmed infectious respiratory virus**, all healthcare workers need to – prior to any patient interaction – assess the infectious risk posed to themselves and wear the appropriate personal protective equipment (PPE) to minimise that risk.

When to use a surgical face mask		When to use an FFP3 respirator
		
In cohorted area (but no patient contact)	Close patient contact (within one metre)	Carrying out potentially infectious aerosol generating procedures Where a patient is known/suspected to have an infection spread via the aerosol route When caring for patients known/suspected to be infected with a newly identified respiratory virus
For example: Cleaning the room, equipment cleaning, discharge patient room cleaning, etc.	For example: Providing patient care, direct home care visit, diagnostic imaging, phlebotomy services, physiotherapy, etc.	For example: bronchoscopy, endotracheal intubation, tracheostomy procedures, cardiopulmonary resuscitation, diagnostic sputum induction;
PPE to be worn	PPE to be worn	PPE to be worn
<ul style="list-style-type: none"> • Surgical face mask (along with other designated PPE for cleaning) 	<ul style="list-style-type: none"> • Surgical face mask • Apron • Gloves • Eye protection (if risk of contamination of eyes by splashes or droplets) 	<ul style="list-style-type: none"> • FFP3 respirator • Gown • Gloves • Eye protection
		<ul style="list-style-type: none"> • Fit testing should be carried out by a properly trained competent fit tester.

These images are for illustrative purposes only. Always follow the manufacturer's instructions.

Remember

- PPE should be put on and removed in an order that minimises the potential for cross-contamination.
- The order for PPE removal is gloves, apron or gown, eye protection, surgical face mask or FFP3 respirator.
- Hand hygiene must always be performed following removal of PPE.
- Healthcare workers who have had influenza vaccination, or confirmed influenza infection, are still advised to use the above infection control precautions.

APPENDIX 2

COUGHS AND SNEEZES SPREAD DISEASES

Coughs and sneezes spread diseases



always carry
tissues



cover your
coughs and
sneezes



throw used
tissues in
a bin



always clean
your hands

Stop germs spreading

APPENDIX 3

WEARING FACE MASKS IN HOSPITAL



**You still need to
wear a face covering
in this building after
19 July.**



**If you don't have a face covering (that covers your mouth
and nose) please speak to a member of staff.
You do not need to wear a face covering if you are exempt.**

APPENDIX 4 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

APPENDIX 4 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING				
Service/Function/Policy/Project/ Strategy	Division/Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
The Management of Respiratory Influenza Type Viruses.	Corporate Nursing, infection Prevention & Control	Carol Scholey, Infection Prevention & Control Practitioner.	Existing Policy	August 2021
1) Who is responsible for this policy? Infection Prevention & Control Team				
2) Describe the purpose of the service / function / policy / project/ strategy? Policy Updated using the latest evidence to promote the screening and management of respiratory type viruses				
3) Are there any associated objectives? Public Health England Policy				
4) What factors contribute or detract from achieving intended outcomes? Nil				
5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No				
<ul style="list-style-type: none"> • If yes, please describe current or planned activities to address the impact [e.g. Monitoring, consultation] 				
6) Is there any scope for new measures which would promote equality? [any actions to be taken]				
7) Are any of the following groups adversely affected by the policy?				
Protected Characteristics	Affected?	Impact		
a) Age	No	Neutral		
b) Disability	No	Neutral		
c) Gender	No	Neutral		
d) Gender Reassignment	No	Neutral		
e) Marriage/Civil Partnership	No	Neutral		
f) Maternity/Pregnancy	No	Neutral		
g) Race	No	Neutral		
h) Religion/Belief	No	Neutral		
i) Sexual Orientation	No	Neutral		
8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box				
Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4	
Date for next review: September 2024				
Checked by: Miriam Boyack			Date: August 2021	