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

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Version History

Version	Date	Summary of changes
V1.0	07/01/2021	First publication
V1.1	25/01/2021	IPC Stepdown guidance added
V1.2	05/03/2021	Health Centres included in list Additional paragraph added clarifying position when organisations adopts practices that differ from those in this national guidance. 7.1.2 Definition of suspected case; Additional information and links included 7.1.4 Triaging individuals. International travel isolation changed to reflect current guidance 7.2 Individual placement/Assessment of Infection Risk section updated. 7.2.3 Individuals returning from day or overnight stay, new section included. 7.2.4 Providing care at home; Title amended 7.2.6 Table 1 Stepdown requirements for community health and care settings amended. 7.5.1 Extended use of Face Masks for staff, visitors and outpatients; additional information with link to new FRSM poster (ways to improve fit) link included. 7.5.2 Table 2: PPE for direct patient/individual care determined by pathway; Eye/face protection updated to include coughing & sneezing in medium pathway. 7.5.7 Table 3: PPE for Aerosol Generating Procedures determined by category; additional information below table included on respirators. After 7.5.10 New section on PPE for delivery of COVID-19 Vaccinations 7.7 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.

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Version 1.4. 25/08/2021

Version	Date	Summary of changes
		7.7.1 Cleaning practice points; Additional detail also included where items cannot stand application of chlorine releasing agents. Additional information if an organisation adopts practices that differ from those recommended/stated. 7.8 Safe management of linen amended to clarify linen categorisation where no outbreak. 7.10 Safe Disposal of waste (including sharps). Wording amended to provide clarity. 7.11.1 Vehicle sharing for all staff; title amended 7.12 New section on hierarchy of controls added. 7.1.6 Resources and tools section updated
V1.3	25/06/2021	Update to PPE table to emphasise Risk Assessment in low and medium risk pathway Addition of risk associated with valved respirators Change in controls for management of linen, waste and environmental cleaning from TBPs to SICPs within the Medium Risk pathway
V1.4	25/08/2021	Inclusion of dental services within the addendum Additional wording added to 'patient placement in primary care settings'

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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.

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.

When an organisation adopts practices that differ from those recommended/stated in this national guidance, the individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures.

This guidance is for use within the following settings;

- GP practices
- Health centres
- 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
- Standalone residential respite for adults (settings not registered as care home)
- Standalone residential respite/short breaks services for children
- Sheltered housing
- Hospice settings
- Community Optometry
- Community Pharmacy
- Primary care dentistry (private dentistry may also follow this guidance) – any dental services operating from acute sites should follow the Scottish COVID-19 Acute addendum

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- 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 health and care is provided.

IMPORTANT: Whilst guidance contained within this addendum is 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.

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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; (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 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

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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 website.

If point of care testing is available in primary care settings, then it may be used to inform risk prior to any procedures being carried out e.g within dentistry. It should be noted that Lateral Flow Devices are not considered point of care testing.

7.1.4 Triaging individuals

The mechanism for triage will vary dependant on both the Healthcare facility Estate and type of service provision but wherever possible, triage questions should be undertaken by telephone **prior** to an arranged arrival at the facility. This will help inform the primary care team of respiratory status and potential associated risk before face to face consultation should this be deemed appropriate. If following telephone consultation, the patient is suspected or confirmed as having COVID-19, the face to face consultation should be deferred until the self-isolation period has elapsed if the matter is non urgent. If it is necessary to review the patient by means of a face to face consultation then they should be advised of the most suitable way to enter the healthcare facility, and on arrival be directed to a suitable waiting area identified for symptomatic individuals as per high risk category. Only the individual requiring a consultation should attend unless a carer or escort is required. See section 7.2.1 for information detailing individual placement of patients in primary care settings.

To enable early detection of suspected or confirmed COVID-19, triage questions should be undertaken again on arrival at the facility. For unplanned arrivals, triage questions should be completed immediately on arrival to the facility, where it is safe to do, so without delaying any necessary immediate lifesaving interventions.

Individuals with symptoms consistent with COVID-19 may present to your facility. COVID-19 information posters including symptoms should be displayed clearly 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

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on arrival at the patient/individual's home. If a patient/individual lacks capacity to answer questions by telephone, an assessment should be made on arrival keeping 2 metres from the patient/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 patient/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 patient/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/individual 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, 10 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

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- **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

Risk categories must be established in the facility to ensure appropriate segregation of patient/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 a patient/individual is in will determine Personal Protective Equipment (PPE) and decontamination requirements.

Examples of risk 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.

Details of the Low Risk Category are not included here however it is expected that all patients/individuals within primary care and community 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.

Any services providing care at home should phone ahead to the patient/individual prior to a visit and ask the triage questions (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 health and care settings will fall into the medium or high risk categories. NHS Boards must also undertake risk assessments of clinical areas to help ensure that the high risk pathway is placed appropriately reducing risk to staff, patients and visitors and taking account the hierarchy of controls (see section 7.15 Hierarchy of controls)

Guidance beyond this section will only refer to the medium and high risk categories.

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1. High-risk COVID-19 category

A. Confirmed COVID-19 patients/individuals.

B. Symptomatic or suspected COVID-19 patients/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. Individuals who are symptomatic or suspected COVID-19 but who decline testing or who are unable to be tested for any reason.

E. See footnote 1.

2. Medium-risk COVID-19 category

A. All other patients/individuals who have been triaged and who do not meet the criteria for the high risk category and who do not have any symptoms of COVID-19.

B. Asymptomatic patients/ individuals who refuse testing or for whom testing cannot be undertaken for any reason.

C. Those who are asymptomatic have been tested and results are still awaited.

D. Recovered COVID-19 patients/individuals – see footnote 2.

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Footnote 1: When deciding patient/individual placement where symptoms are unknown – for e.g. where the patient/individual is unconscious, or patients/individuals who have returned from a country on the quarantine list in the last 10 days, a full clinical and individual assessment of the patient/individual should be carried out prior to placement in a side room on the high or medium category. This assessment should take account of risk to the patient/individual (immunosuppression, frailty) and clinical care needs (treatment required in specialist unit).

Footnote 2:

Further information on Discontinuing IPC control measures in community health and care settings for confirmed COVID-19 patients/individuals can be found in section 7.2.6.

Some patients/individuals who no longer require medical care in an acute hospital may be discharged home or to their health and care setting to fully recover. These people may not have completed their isolation period and can be safely cared for at home if this guidance is followed. The acute hospital should provide information regarding test results and a plan for stepping down IPC measures on discharge.

7.2.1 Individual placement of patients in primary care settings

Community health and care settings should aim to have separate designated areas for both high and medium risk categories. 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/individuals on the high risk category should have appointments postponed until they have completed their isolation period if the matter is non urgent. However, it is recognised that primary care settings may need to undertake face to face consultations with some patients/individuals meeting the case definition for COVID-19.

To allow the safe remobilisation of primary care services, primary care settings must identify areas/routes which allow segregation of suspected and confirmed patients who require a face to face consultation from all other patients attending the healthcare facility. This segregated area/route would be identified as the high risk pathway and controls should be followed in line with this as stated within this addendum. Segregated reception areas, waiting areas and consultation rooms should be identified wherever possible. In smaller facilities, practices may choose to use screens or partitions to separate suspected/confirmed COVID-19 from all other patients. Patients should be advised not to move around the facility including waiting areas and be encouraged to remain seated until called. Toys and books should be removed to discourage children to circulate around common areas and parents may be encouraged to bring a toy or book belonging to the child to keep them occupied during the wait time.

Ensure risk category areas have signage in place to support and separate entrances to category areas 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.

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7.2.2 Managing individual placement in self-contained residential settings

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

For patients/ 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 patient/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 and cohorting is unavoidable, then cohorting could be considered whilst ensuring that:

- Confirmed COVID-19 patients/individuals are placed in multi-occupancy rooms together.
- Suspected COVID-19 patients/ individuals are placed in multi occupancy rooms together.

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

Meals should be provided for the patients/ 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. Consider a rota for showering and bathing placing the patients/individuals in the high risk category last.

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

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

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7.2.3 Individuals returning from day or overnight stay

Individuals who have been allowed to leave the community health and care facility for the day or for an overnight stay should be triaged in advance of their immediate return and again on arrival at the facility to determine which category they should be placed on.

7.2.4 Providing care at home

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

A FRSM should be worn on entering the 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 for care at home is covered in section 7.5.4.

Scottish Government advice on providing care at home is available.

7.2.5 Staff cohorting

Efforts should be made as far as reasonably practicable to dedicate assigned teams of staff to care for patients/individuals in each of the risk categories. There should be as much consistency in staff allocation as possible, reducing movement of staff and the crossover between categories wherever possible.

Staff 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 care at home service should identify patients/ 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 patients/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 patients/ individuals who are at extremely high risk of severe illness, it may be possible to schedule visits to these groups of patients/individuals before visits to others.

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7.2.6 Discontinuing IPC control measures in community health and care settings for confirmed COVID-19 patients/individuals

The following applies to patients/individuals in the community health and care settings listed on page 4 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/individuals with ongoing diarrhoea.

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

- **Completing the isolation period** – patients/individuals living in their own home should complete a period of 10 days' isolation. Patients/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 isolation period did not commence 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 (>37.8^{o}C) 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.

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Table 1: Stepdown requirements for COVID-19 cases in 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 to either their own home or a community health and care setting	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 living at home or in a community health and care setting and who are severely immunocompromised as determined by Chapter 14a of the Green Book.	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 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

Transferring between categories on stepdown

Patients/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,

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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

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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.

For medical grade face masks, a poster detailing the 'Dos and don'ts' of wearing a face mask is available for use.

For non-medical face mask/coverings, a poster intended to support the wearing of a non-medical face mask/face covering is available for use.

Where staff are providing 'live in' support/care for patients/individuals, they 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 risk category

The PPE worn for direct care differs depending on the COVID-19 risk 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 risk category. This is an IPC 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 (see table 3 for AGP PPE)

	Gloves	Apron/Gown	Face mask	Eye face protection
Medium Risk category	Risk assessment – wear if contact with BBF is anticipated, Single use	Risk assessment – wear if direct contact with patient, their environment or BBF is anticipated (Gown if extensive splashing anticipated),	Always within 2 metres of a patient - Type IIR fluid resistant surgical face mask	Risk assessment – wear - if splashing or spraying with BBF, including coughing/sneezing, is anticipated Single use or reusable following decontamination

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	Gloves	Apron/Gown	Face mask	Eye face protection
		Single use		
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 (if required) 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.

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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.

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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) Dental teams may also choose to consider the rapid review undertaken by SDCEP and Cochrane oral health
- 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

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- upper gastro-intestinal endoscopy where open suction occurs beyond the oro-pharynx 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. This applies to upper gastro-intestinal endoscopy also and as such it has also been changed to reflect risk associated with suctioning beyond the oro-pharynx.

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).

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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 7.5.4. 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. Ongoing requirement for airborne precautions in the medium risk pathway when an individual is undergoing an AGP recognises the potential aersolisation of COVID-19 from an asymptomatic carrier.

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.

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- 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 category

	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

**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.

There is a theoretical risk of exhaled breath from the wearer of a valved respirator transmitting COVID-19 where asymptomatic carriage is present however, following introduction of staff testing and uptake of vaccination, this risk is likely to be low. Valved respirators should not be used when sterility directly over a surgical field/surgical site is required and instead a non-valved respirator should be worn.

Work is currently underway by the UK Re-useable Decontamination Group examining the suitability of 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.

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. Staff within dental settings should refer to the 'Mitigation of AGPs in dentistry; A Rapid Review' which details fallow times specific to this setting and the mitigations used. The methodology work was undertaken by SDCEP and Cochrane oral Health.

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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.

Dental settings should be aiming for a minimum of 10 ACH in treatment rooms. Post AGP down time (fallow time) is not considered necessary for successive appointments between members of the same household within dental settings; to minimise aerosol spread dentists should use mitigating measures such as high volume suction/rubber dam; cleaning and disinfection of the environment should be carried out between patients of the same household.

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 and should be undertaken using 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.

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

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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.

Sessional use of PPE **is no longer 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 patients 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) 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 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 patient/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 e.g. where nasal vaccinations induce sneezing, HCWs may choose to wear a visor to prevent droplet contamination to the face following risk assessment.

The patient/individual 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,

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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.

7.5.11 Access to PPE

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

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 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.

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7.6 Safe management of care equipment

Care equipment can be 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 health and care settings such as stethoscopes, syringe drivers and pumps must be decontaminated prior to removal from the patient/ 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	General purpose detergent for routine cleaning. See Appendix 7 of the NIPCM for cleaning of equipment contaminated with blood or body fluids (including saliva) or it has been used on a patient with a known or suspected infectious pathogen.
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

It is the responsibility of the person in charge to ensure that the care environment is safe for practice across all categories (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 health and care facilities

The cleaning frequency and use of general purpose detergent for cleaning in the Medium Risk pathway as per the NHS Scotland National Cleaning Services Specification is sufficient with the exception of isolation/cohort areas where individuals with a known or suspected infectious agent are being cared for. These

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areas require to be cleaned twice daily with a chlorine releasing agent containing 1000ppm av chlorine.

Environmental cleaning in the high risk category 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. 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 patient/individuals since the first daily clean was undertaken, a second daily clean is not required.

Cleaning across the categories is summarised in table 6.

Table 6: Environmental cleaning determined by category

	Frequency	Product
Medium Risk pathway	At least daily as per NHS Scotland National Cleaning Services Specification.	General purpose detergent*
High Risk Pathway	At least twice daily **1st clean** - Full clean **2nd clean** - * 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.

*Cleaning in the medium risk pathway should be carried out with chlorine based detergent for rooms where the individual is known to have any other known or suspected infectious agent and following an AGP.

* Touch surfaces as a minimum should include door handles/push pads, taps, bed heads/bed ends, cotsides, light switches, lift buttons. Clinical inpatient areas should include the patient bedroom and treatment areas and staff rest areas.

Any areas contaminated with blood and body fluids (including saliva) 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 other health and care facilities (excluding patient/individuals own home) the following good practice points apply:

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- 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 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.
- If an 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.

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.

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 patients/individuals who are in the high risk category should be treated as infectious. Following local risk assessment/ and there is no confirmed outbreak in the setting laundry can be processed as normal.

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

Where care providers are supporting patients/individuals with laundering in the community and there is no washing machine, the laundry items for individuals in the high risk category should be bagged, held for 72 hours before being taken to a public launderette.

Care at home staff who manage linen in the patient/ individual's own home should wash linen as normal unless the patient/individual is in the high risk category. In this

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instance, any linen belonging to the patient/individual should be washed separately from others living in the same household.

See section 7.12 for staff uniforms.

Community Health and Care Settings 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.

7.9 Safe management of blood and body fluid spillages

All blood and body fluid spillages 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 from patients/individuals who are in the high risk category or where there is a confirmed outbreak, should be disposed of as clinical waste where clinical waste contracts are in place. Any items contaminated with BBF (including saliva) for any patient regardless of infectious status 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 patients/ individuals on the high risk category (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 patient/ 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 Vehicle sharing for all staff

Wherever possible, vehicle 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

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COVID-19. All options for travelling separately should be explored and considered such as;

- Staff travelling separately in their own vehicles
- 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 vehicle 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 vehicle sharing is the only means of commuting to and from the workplace.

Where vehicle 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/vehicle 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 vehicle available for sharing purposes.
- Vehicle sharing should be arranged in such a way that staff share the 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/vehicle sharing as far as possible.
- The vehicle 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 vehicle must be opened as far as possible taking account of weather conditions to maximise the ventilation in the space.

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- Occupants in the vehicle, 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 vehicle.

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 patient/individual who has died remains in the community health and care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients/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.

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7.14 Physical distancing

All staff 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 vehicle sharing. There are many areas within community health and care settings 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 all recreational areas at any one time.
- Maintain 2 metre physical distancing when removing Type IIR facemasks to eat and drink.
- Not travel together in the same vehicle 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.

7.15 Hierarchy of controls

Controlling exposures to occupational hazards, including the risk of infection, is the fundamental method of protecting healthcare workers. 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 healthcare settings. The hierarchy of controls will help protect all users of the NHS facility and not just staff. NHS Boards and NHS staff should first employ the most effective method of control which inherently results in safer control systems. Where that is not possible, all others must be considered in sequence. PPE is the last in the hierarchy of controls.

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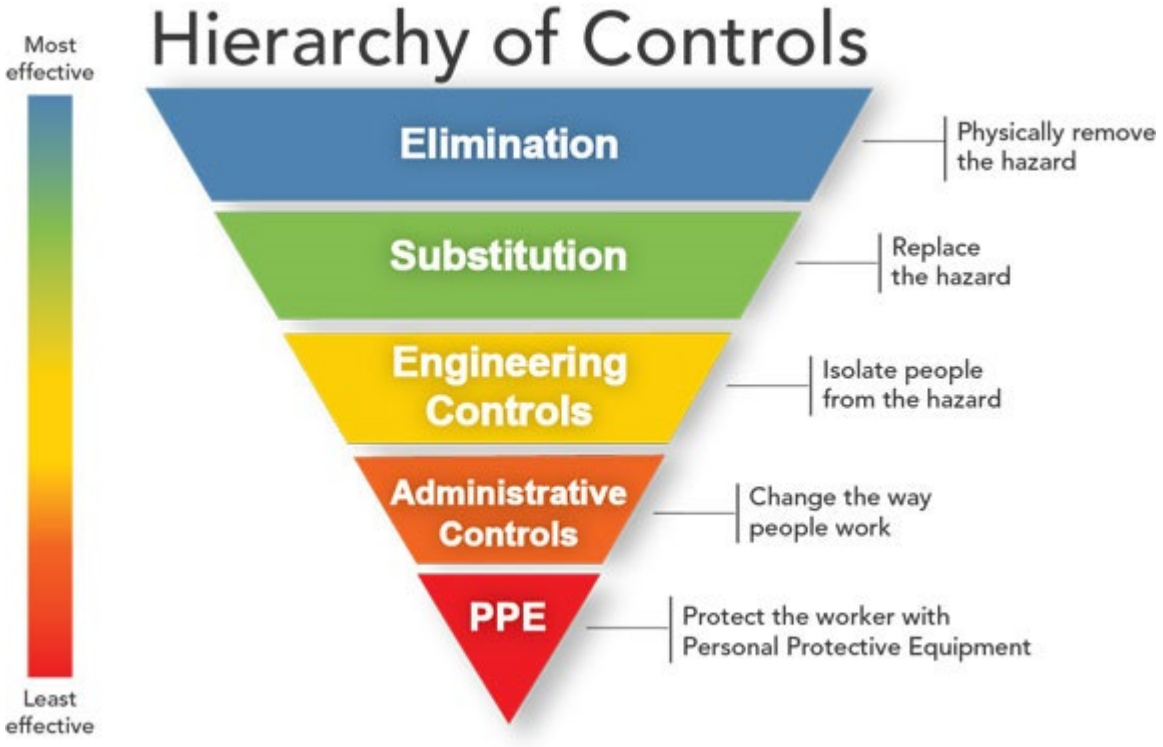

Hierarchy of Risk Controls graphic //commons.wikimedia.org/index.curid=90190143 (original version: NIOSH Vector version: Michael Pittman)

Hierarchy of controls	Examples in practice & Resources
Elimination	• Patients must not attend for an appointment if they have symptoms of COVID-19 or have been advised to self-isolate, unless a dedicated area/pathway can be used • 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
Substitution	• For any patients presenting with respiratory symptoms in keeping with a suspected or confirmed COVID-19 definition – perform patient consultations over phone as far as possible rather than in person

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Hierarchy of controls	Examples in practice & Resources
Engineering controls	• Installations of partitions at appropriate places (e.g reception desks) • 2 metre physical distancing on the premises (see section 7.15.4) • Efforts made to reduce number of people on premises at any one time • reduce waiting time for individuals in waiting areas, e.g. practices, clinic and radiology departments • avoid face to face waiting arrangements in waiting areas where possible • improve ventilation by opening windows on the premises, whilst maintaining comfort • Optimal bed spacing and chair spacing (see section 7.15.5) **Resources** Link to CIBSE guidance Link to SAGE documents Link to HFS document
Administrative controls	• Working from behind or at the side of the individual (no face to face close contact) • development of pathways/one way systems/dedicated assessment rooms on the premises • use of various COVID-19 related signage • provision of additional hand hygiene stations • increased cleaning.
Personal Protection Equipment (PPE)	• Use of face coverings (although not classed as PPE) by patients and visitors – in healthcare they can be provided with a Type IIR mask • PPE when a risk assessment indicates this (see PPE section of this addendum).

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7.15.1 General organisational Preparedness and COVID-19 Risk Assessment of the healthcare Environment

A structured risk assessment should be undertaken with Health and Safety (H&S) representatives, Estates and Facilities representatives, Occupational Health Services (OHS) Infection Prevention and Control Team (IPCT) and the clinical team to systematically consider potential hazards in the context of COVID-19 which could negatively impact users of that environment including staff, patients and visitors and ensure application of mitigation measures to eliminate, reduce or control risk.

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 a full risk assessment should be undertaken locally. Environmental considerations should take account of;

- Ventilation within the building/room/space (see section 7.15.3 for more information)
- Ways in which patient and staff numbers within the area can be reduced (NB: visiting guidance - in areas with high numbers of suspected/confirmed COVID19 cases (high risk pathway) then previous guidance on limiting support to “essential visits only” may need to apply in this area)
- Spacing to adequately allow for physical distancing and related room occupancy (see section 7.15.4) in clinical areas, non-clinical areas and staff only areas e.g office spaces, dining rooms, changing rooms. This should take account of circulating space for staff
- Partitions and individual positioning (consideration needs to be given to impact on air flow and necessary cleaning regimes before installation of partitions)
- Inpatient bed spacing and OPD chair spacing (see section 7.15.5)
- Signage and one way systems
- Administrative controls (e.g. Hand Hygiene stations, Facemask stations, waste bins)
- The planned patient cohort e.g. consider the planned COVID-19 pathway for that setting and clinical group - patients with cognitive impairment present a higher risk of transmission in care settings
- Previous IPC healthcare incidents and outbreaks within the area

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7.15.2 Organisational Preparedness and COVID-19 Risk Assessment when determining appropriate location for High Risk Pathway

Some clinical environments present a greater risk in terms of COVID-19 transmission if used to care for cohorts of suspected and/or confirmed COVID-19 cases. NHS Boards must seek to identify and prepare the most suitable clinical area for planned placement of patients requiring care on the high risk (red) pathway. This is not required for areas used for the medium and low risk pathways where sporadic cases of 'unexpected' positive COVID-19 cases may arise.

Prior to determining areas for placement of the high risk pathway a full risk assessment of the proposed area must be carried out led by Health and safety teams and involving Estates and Facilities representatives, Occupational Health Services (OHS) Infection Prevention and Control Team (IPCT) and the clinical team. This should be undertaken using the hierarchy of controls and recognise that there is lowest risk where elimination can be achieved and highest risk where PPE is the only control in place. Risk assessments should be undertaken regularly as determined by the NHS Board to ensure no change to the level of risk.

The risk assessment should take account of the following questions;

- Which COVID-19 risk pathway is the proposed area to be used for?
- Does the bed spacing in the area meet requirements as per SHPNs in section 7.15.5 below?
- As a minimum, can windows in the area be opened and realistically remain open whilst the space is occupied?

If the risk assessment concludes that an unacceptable risk of transmission remains within the environment after rigorous application of the hierarchy of controls (e.g. inadequate bed spacing AND natural ventilation where windows cannot be opened) and **only** if there are no other more optimal low risk clinical areas suitable for the high risk pathway cohort then the NHS Boards should consider utilising the area for this purpose with provision of Respiratory Protective Equipment (RPE) for the staff working in this area.

The evidence continues to support the most likely route of COVID-19 transmission being via the droplet and contact route. However, it is accepted that in some high risk environments housing COVID-19 cases where mitigations in line with the hierarchy of controls cannot be applied, the level of risk is unknown and as a precautionary approach, the use of RPE by staff in the designated area may be considered by the organisation. This takes account of interim guidance issued by the World Health Organization (WHO) occupational health and safety for healthcare workers.

The following subsections provide information to help support risk assessments.

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7.15.3 Ventilation in the healthcare setting

Adequate ventilation reduces how much virus is in the air by dilution. It helps reduce the risk of COVID-19 transmission - the risk is greater in areas that are poorly ventilated. A number of studies have linked transmission to recirculating air conditioners, with the high velocities created by these units potentially allowing larger viral aerosols to remain airborne over longer distances. It is also possible that directional flow from desk fans could have a similar effect however the evidence of this is weak. Fans should be avoided as much as possible and should not be used without prior risk assessment.

Mechanically ventilated areas

NHS Scotland Boards should seek assurance that their ventilation systems must comply with current guidance, including:

Best practice guidance for healthcare engineering policies and principles (SHTM 00)
Ventilation for Healthcare - Design and validation (SHTM 03-01 Part A)
Ventilation for Healthcare - Operational and verification (SHTM 03-01 Part B)

Ensure ventilation systems are well maintained ensuring functionality of air handling units and correct delivery of assigned air change rates. Controls should be set to maximise the amount of fresh air coming into the space and avoid recirculation of air as much as possible. Dampers should also be opened as far as possible.

Specific guidance applies to specialist ventilation areas such as theatres, ICU, isolations rooms and endoscopy suites. See here for more information.

Naturally ventilated areas (No mechanical ventilation)

Ensure areas are as ventilated as much as possible by opening windows if temperature/weather conditions allow. NHS organisations should consider any other risks with opening the windows where adjacent building works are in progress. If possible open windows at different sides to get a cross flow of ventilation. Where it is safe to do so, doors may be opened. NB fire doors should NEVER be propped open. Airing rooms as frequently as you can will help improve ventilation.

Aerosol Generating Procedures (AGPs) should be avoided in rooms with natural ventilation unless it is a single side room and all staff are wearing appropriate PPE, AGP fallow times are adhered to and door remains closed during the AGP and resulting AGP fallow time.

Air scrubbers (also known as HEPA units)

The Board may consider using portable industrial grade air filtration units containing HEPA filters where air-supply systems to high-risk clinical settings are suboptimal following risk assessment including assurance of the efficacy and safety of the filtration unit. As yet, evidence on the use of air scrubbers is limited and as such

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these should be used with caution. The units should be capable of recirculating all of the room air, without interfering with the existing pressure differential of the room and should provide the equivalent of ≥12 air changes per hour. The unit must be sized appropriately for the room in which it will be utilised and maintenance contracts should be procured to accompany the unit. It should be noted that these units do not provide additional fresh air into a space and there is no standard to measure the efficacy of these devices. NHS Boards should satisfy themselves that these devices are suitable and if required, seek advice from NHS Assure. Boards should also assess (not limited to) the noise levels, power requirements, heat gains and potential trip hazards

Currently, the CIBSE and SAGE resources below provide the best available independent views of air cleaning devices.

“Air purifiers” should not be used.

More information on ventilation in the context of COVID19 can be found at the following resources;

CIBSE: Covid-19 Guidance: Ventilation

SAGE: Role of ventilation in controlling SARS-CoV-2

SAGE: Potential applications of air cleaning devices

7.15.4 Spacing and Physical distancing

NHS Boards should have a process in place for all occupied rooms within wards and departments and healthcare settings to be risk assessed for maximum occupancy using the guide provided by Health Facilities Scotland (HFS) and taking into account the need for all staff working with NHS Scotland healthcare facilities to maintain 2 metres physical distancing (NB: does not apply to the provision of direct patient 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 changing areas and recreational areas during staff breaks and it is particularly important to utilise all available rooms and spaces to allow staff to change and have rest breaks without breaching maximum occupancy in any single area. Staff must ensure they are wearing face masks/coverings in line with the extended use of facemasks section 7.5.1 outside of all clinical care unless exempt or eating/drinking.

7.15.5 Inpatient bed spacing and day patient chair spacing

Health Facilities Scotland have undertaken an assessment of bed and chair spacing within NHS Scotland facilities taking account of compounding factors applied in conjunction with physical distancing. The purpose of this document aims to help support boards in reviewing bed spacing to ensure 2 metre (m) physical distancing

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can be maintained for inpatient beds and treatment chairs. The summary document and the detailed technical diagrams can be accessed here including;

NHSS Social Distancing Guidance & Signage (nhsnss.org) DL(2021)09 & NSS 29 Jan 21 –
NHS Scotland COVID-19 remobilisation –Built Environment incl. physical distancing support diagrams (IM/2020/024) 18 Sep 20

Current NHSScotland Guidance on bed spacing include:

Core guidance - General design for healthcare buildings (HBN 00-01)
Core guidance - Clinical and clinical support spaces (HBN 00-03)
Critical care units (HBN 04-02)
HAI-SCRIBE Manual information for project teams (SHFN 30 Part A)
HAI-SCRIBE Implementation strategy and assessment process (SHFN 30 Part B)
HAI-SCRIBE questionsets and checklists (SHFN 30 Part C)
Adult in-patient facilities (SHPN 04-01)
In-patient accommodation - supp 1 - Isolation facilities in acute settings (SHPN 4 sup 1)

Guidance consistently recognises that bed spacing requirements contribute towards the control of healthcare associated infections. Adult in-patient facilities designed post 2010 should achieve 3.6m (width) x 3.7m (depth) dimensions of SHPN 04-01, HBN 00-03 and SHFN 30. Width of 3.6m is measured from bed centre to bed centre.

Since 2014, HBN 00-03 (Figure 45) states a day treatment bay should achieve 2.45m width. Assuming a 0.5m diameter zone for the patient head, this bay size achieves the minimum 2.5m centre-to-centre dimension between each day treatment couch or chair.

For older facilities, designed post 1995, HBN 40 bed bay minimum of 2.7 x 2.9m, the preferred minimum bed centre is 2.9m. Facilities designed pre 1995, or for clinical specialties e.g. Mental Health (SHPN 35 / HBN 03-01) or Care of Older People (HBN 37), had a bed bay minimum of 2.4 x 2.9m. For this specific group, the pragmatic minimum of 2.7m bed centres should be adhered to, and/or reduction to total patient numbers/ occupation per multi-bed room and ventilation enhancements should be considered where practicable.

7.15.6 Local data to inform risk assessment

Organisations should have local systems in place for monitoring COVID-19 cases in their NHS Board, triggers and a defined escalation process which takes account of bed capacity, COVID-19 cluster data and risks associated with disruption to elective services. These considerations may be site specific or board wide.

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As case numbers of COVID-19 fluctuate, so too will the volume of patients on each of the pathways. Where critical care units need to expand, this action plan should include allocated areas for additional ITU beds and sufficient staffing and equipment to support the expansion.

7.16 Visiting in community health and care settings

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.

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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 which may expose the visitor to blood and/or body fluids i.e. toileting.

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

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

7.17 Resources and tools

This section contains resources and tools which can be used by community health and care settings during the COVID-19 pandemic.

- 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

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- 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
- For dental settings only - Scottish Dental Clinical Effectiveness Programme - SDCEP

7.18 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

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7.19 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

7.20 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

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